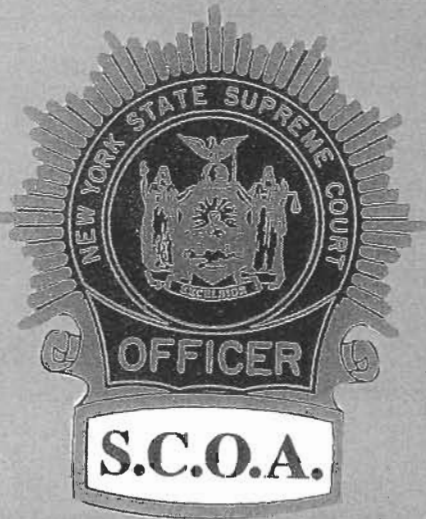


New York State
Supreme Court Officers Association
Retiree Security Benefits Fund Plan



GENERAL INFORMATION

ELIGIBLE MEMBERS

All SCOA Members who are covered by our collective bargaining agreement are eligible for these benefits provided that they have been a permanent employee of the Unified Court System for a period of 3 months.

ELIGIBLE DEPENDENTS

Your spouse (unless legally separated) and unmarried dependent children less than 19 years old. Unmarried children age 19 but less than 23 years old are also eligible provided they depend on you for support and maintenance and are full-time students in an accredited educational institution. Eligible dependents for Term Life Insurance are your wife or husband (unless legally separated) and your unmarried children at least 14 days but less than 19 years old.

Stepchildren, foster children, legally adopted children, and children for whom you act as a legal guardian may be considered eligible dependents the same as your own children, only if they depend on you for support and maintenance and you provide documentary proof of your relationship to the Fund Office. No child, other than one with whom you have one of the specified relationships designated above, may be considered an eligible dependent, regardless of whether the child lives with you or depends on you for support and maintenance.

No one will be eligible as a dependent while covered as an employee or while in military service.

A child who is physically or mentally incapable of self-support upon attaining age 19 and is an eligible dependent may be continued under the health care insurance while remaining incapacitated and unmarried, subject to your own coverage continuing in effect. This privilege also will apply to a child who has remained in the Plan beyond his nineteenth birthday if he later ceases to be a qualified dependent and is physically or mentally incapable of self-support and is not married. To continue a child under this provision, proof of incapacity must be received by the Security Benefit Fund within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

TERMINATION OF COVERAGE

The benefits described for yourself and your dependents will terminate if you cease to be an eligible member or if the Plan is discontinued. A dependent's insurance or coverage will terminate when he or she is no longer an eligible dependent. Benefits will cease upon the death of the SCOA retired member.

QUESTIONS CONCERNING THE PLAN

Contact Maloney Associates, Inc. – Telephone (516) 887-2255 or (800) 334-3680, should you have any questions concerning the Plan.

SECURITY BENEFIT FUND PLAN BENEFITS

FOR RETIREES ONLY

Death Benefit (\$5,000)..... 5

FOR RETIREES and THEIR DEPENDENTS

Dental Benefits
 Scheduled Dental Care Plan 5
 Healthplex Dental Plan 12
Vision Benefit..... 15
Crutches and/or Wheelchair \$100 Maximum (previously \$30) 17
Emergency Ambulance Service \$125 Maximum (previously \$50)..... 17
Hearing Aids (\$500 Maximum) 17

**DEATH BENEFIT
FOR YOU ONLY**

Your \$5,000 Death Benefit will be paid to any beneficiary you name if you die from any cause. You may change your beneficiary whenever you wish by requesting a change of beneficiary form from the Security benefits Fund.

SUBMITTING A DEATH BENEFIT CLAIM

Your beneficiary need only submit an original copy of the death certificate and the letter describing the death benefit coverage you received from the Security Benefits Fund to claim this benefit. If the letter is not available, your beneficiary need only identify the Security Benefits Fund under which you were covered when submitting the death certificate.

**DENTAL BENEFITS
FOR YOU AND YOUR DEPENDENTS**

A) SCHEDULED DENTAL CARE PROGRAM

This program provides scheduled allowances for the following range of Covered Dental Services. These allowances (or the dentist's charge, whichever is less) are available for services performed by a duly licensed dentist anywhere in the world.

- A. Diagnostic and Preventive Services.
- B. Palliative Services
- C. Restorative Services
- D. Oral Surgery
- E. Endodontic Services
- F. Space Maintainers
- G. Repair of Dentures and Bridges
- H. Prosthetic Services
- I. Orthodontic Services

Note:

The allowance for Orthodontic Services is provided only for eligible dependents under age 19 when the treatment began. Additionally, the Orthodontic benefits available under this program will be reduced by the number of months of treatment received while the dependent was covered under any previous Dental Plan.

HOW TO CLAIM SCHEDULED DENTAL PLAN BENEFITS

When you know it is necessary for you or an eligible dependent to be treated by a dentist, you should get a Dental Expense Claim Form from Maloney Associates, Inc. at

211 Broadway, Lynbrook, NY 11563; or from SCOA Union office at 299 Broadway, Suite 1100, New York, NY 10007.

You complete the patient's portion of the form and the dentist completes the rest. It is important that the Member's statement is completed and signed on the form.

PRE-CERTIFICATION

PROSTHETIC AND ORTHODONTIC SERVICES REQUIRE PRE-CERTIFICATION BY THE DENTAL REVIEW BOARD OF THE FUND BEFORE TREATMENT IS BEGUN. HAVE YOUR DENTIST COMPLETE A CLAIM FORM, OUTLINING THE PROPOSED TREATMENTS AND MAIL IT ALONG WITH ANY X-RAYS TAKEN TO THE FUND OFFICE. STUDY MODELS ARE ALSO REQUIRED FOR ORTHODONTIC CLAIMS. THE RESULTS OF THE DENTAL REVIEW WILL USUALLY BE FORWARDED TO THE DENTIST BEFORE YOUR NEXT VISIT. FAILURE TO PRE-CERTIFY ANY REQUIRED BENEFIT MAY RESULT IN A DENIAL AND/OR REDUCTION IN BENEFITS.

The allowances listed do not necessarily represent your dentist's total fee. Discuss with your dentist the amount you are responsible for based upon the Schedule of Allowances outlined in this booklet.

SCHEDULED DENTAL CARE PLAN EXCLUSIONS

Our Scheduled Dental Care Program does not provide benefits for:

- Dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
- Dental services for which the covered individual incurs no charge; dental services for which coverage is available to the covered individual, in whole or in part, under any Workers' Compensation Law or similar legislation whether or not the covered individual claims compensation or receives benefits thereunder and whether or not any claim is had by the covered individual against a third party or damages resulting from a condition, disease, ailment or accidental injury necessitating dental services.
- Dental services primarily for cosmetic or esthetic purposes; dental services furnished or available to a covered individual, in whole or in part, under the laws of the United States or any State or political subdivision thereof (except Medicaid), or for which the covered individual would have no legal obligation to pay in the absence of this or any similar coverage; dental services to be extent of a participating Plan.
- Services rendered by a dentist beyond the scope of his/her license.
- Dental services to the extent that charges for such services exceed the charge that would have been made and actually collected if no coverage existed hereunder.

- Dental services not considered within the scope of normal good dental practice or which are inconsistent with the highest ethical standards of the dental profession
- Dental services other than those specifically listed as Covered Dental Services.
- Prosthetic services involving: periodontal, provisional or temporary splints; appliances used solely to increase vertical dimension; implants; bridges or dentures involving implants.
- Any charges for the replacement and/or repair of any appliance furnished under the Orthodontic Treatment Plan such shall not be covered.
- Fees for the replacement of any full or partial dentures, fixed bridgework or crowns if benefits for these appliances had previously been provided under the Dental Plan or any previous Dental Plan, unless five years have elapsed from the installation of any such appliances. This exclusion also applies to the replacement of a prosthetic appliance by fixed bridgework within a five year period. However, if an immediate (temporary) denture, for which the charge was less than the allowance in the schedule is replaced by a permanent denture within a five year period, the excess schedule allowance over the charge for the immediate (temporary) denture is available as reimbursed toward the charge for a permanent denture.

SCHEDULE OF DENTAL ALLOWANCES

Maximum Allowance

Prior Benefit New Benefit

A. DIAGNOSTIC AND PREVENTIVE SERVICES

1. Clinical oral examination*	\$16.00	\$20.00
2. Cleaning, scaling and polishing	24.00	28.00
3. Fluoride Treatment* (Up to age 19)	18.00	22.00
4. X-Rays		
(a) Full mouth Panorex (at least 10 films**)	40.00	50.00
(b) Bitewing, each	4.00	5.00
(c) Periapical, single, each	4.00	5.00
(d) Intraoral occlusal (edentulous jaw), each	9.00	10.00
(e) Temporo-mandibular joint film	31.00	40.00
(f) Anterior/posterior head and jaws	31.00	40.00
(g) Lateral, head and jaws	31.00	40.00

*Not more than twice annually
**Not more than once in three years

SCHEDULE OF DENTAL ALLOWANCES

Maximum Allowance

Prior Benefit New Benefit

B. PALLIATIVE SERVICES

Emergency treatment for relief of pain\$36.00 \$43.00

C. RESTORATIVE SERVICES

1. FILLINGS

Silver Fillings

(a) One surface 23.00
 (b) Two surfaces 46.00
 (c) Three or more surfaces 69.00

Tooth Color Fillings

(d) Per filling 23.00

2. STAINLESS STEEL CROWN, each (up to age 19)..... 95.00

3. SEALANTS* (permanent teeth only)..... 18.00

*Only available to dependent children under age 16.

D. ORAL SURGERY (including x-rays, anesthesia and post-operative treatment)

1. EXTRACTIONS

(a) Routine or simple..... 40.00 48.00
 (b) Soft tissue impaction 60.00 72.00
 (c) Partial bony impaction 90.00 100.00
 (d) Complete bony impaction 200.00 240.00
 (e) Complex including bone removal and sutures 70.00 84.00

2. FRACTURES

(a) Upper jaw, closed reduction 350.00
 (b) Lower jaw, closed reduction 400.00
 (c) Upper jaw, open reduction 500.00
 (d) Lower jaw, open reduction..... 500.00

3. OTHER ORAL SURGICAL PROCEDURES

(a) Removal of cysts, including necessary extractions.. 60.00 72.00
 (b) Alveolectomy, maximum per arch..... 60.00 72.00
 (c) Apicoectomy 90.00 100.00
 (d) Biopsy, including report 30.00 36.00
 (e) Removal of labial frenum 48.00 56.00

SCHEDULE OF DENTAL ALLOWANCES

Maximum Allowance

Prior Benefit New Benefit

(f) Closure of oro-antral fistula\$90.00 \$100.00
 (g) Incision and Drainage..... 30.00 36.00

E. ROOT CANAL TREATMENT (including X-rays and follow-up care)

1. Filling one canal 238.00
 2. Filling two canals 356.00
 3. Filling three canals 475.00
 4. Pulp capping 16.00
 5. Retrograde filling 24.00

F. SPACE MAINTAINERS

Simple any type (Up to age 19) 95.00

G. PERIODONTIA SERVICES (treatment of gums and associated tissues)

For services provided by a dentist who is a Board Certified Specialist*

Root scaling, prophylaxis, medication and minor bite correction:

Each treatment..... 56.00 70.00
 Maximum in any 12 month period 560.00 700.00

Gingivectomy, each quadrant consisting of a

Minimum of 5 teeth 277.00 332.00

Gingivectomy, each quadrant consisting of

Less than 5 teeth (per tooth)..... 56.00 70.00

Soft Tissue Management (STM) (per quadrant)..... 100.00

Maximum payment two quadrants per office visit

- Benefits paid for Soft Tissue Management in lieu of periodontal surgery per calendar year.
- Maximum payment two quadrants per office visit.
- Payment for Soft Tissue Management includes local anesthesia, periocharting and subgingival irrigation.

Perio Chip Placement (Maximum 4 chips) 50.00

SCHEDULE OF DENTAL ALLOWANCES

Maximum Allowance

Prior Benefit New Benefit

For services provided by a dentist who is not a Board Certified Specialist*

Root Scaling, prophylaxis, medication and minor bite correction:

Each treatment..... \$ 31.00\$ 32.00
 Maximum in any 12 month period310.00320.00

Gingivectomy, each quadrant consisting of a
 Minimum of 5 teeth 120.00 144.00

Gingivectomy, each quadrant consisting of
 Less than 5 teeth31.0037.00

***A dentist who is certified to specialize in periodontics by the American Board of Periodontology will be deemed to be a Board Certified Specialist.**

H. REPAIR OF DENTURES AND BRIDGES

1. Broken full or partial denture
 - (a) No tooth damage30.00
 - (b) Replace one tooth48.00
 - (c) Each additional tooth 18.00
2. Replace broken teeth only
 - (a) First tooth.....30.00
 - (b) Each additional 18.00
3. Reattaching undamaged clasp36.00
4. Replacing broken clasp with new clasp60.00
5. Adding tooth to partial denture to replace natural extracted tooth, each tooth42.00
6. Rebasing upper or lower full or partial denture 72.00

SCHEDULE OF DENTAL ALLOWANCES

Maximum Allowance

Prior Benefit New Benefit

7. Recement crown and inlays..... 18.00
8. Repair broken facing.....30.00

PROCEDURES COVERED UNDER THE PROSTHETIC SERVICES

**THESE SERVICES REQUIRE PRE-CERTIFICATION
 PRIOR TO START OF TREATMENT**

A. INLAYS, GOLD

1. One Surface.....\$ 78.00
2. Two Surfaces.....102.00
3. Three or more surfaces, maximum per tooth 132.00

B. DENTURES FULL (including supplying, inserting and adjustment)

1. Upper, once in five years475.00
2. Lower, once in five years475.00

C. DENTURES, PARTIAL (once in five years)

1. Bilateral acrylic or comparable base, either jaw,
 two or more clasps and rests, each475.00
2. Upper, bilateral, chrome cobalt alloy or gold base, two or
 more clasps and rests, acrylic attachments, each475.00
3. Lower, bilateral, chrome cobalt alloy or gold base, two or
 more clasps and rests, acrylic attachments, each.....475.00

D. CROWNS AND BRIDGEWORK

1. BRIDGEWORK, REMOVABLE (one piece casting with clasps and rests)
 - (a) One tooth replaced 103.00
 - (b) Two teeth replaced 125.00
2. BRIDGEWORK, FIXED (Single abutments only)
 - (a) ¼ crown298.00
 - (b) Full cast crown.....396.00
3. PONTICS
 - (a) Tru-pontic (porcelain or acrylic facing with cast backing)317.00
 - (b) Pontic or other type317.00
4. CROWNS
 - (a) Porcelain jacket396.00
 - (b) Acrylic jacket.....396.00
 - (c) Porcelain fused to metal396.00
 - (d) Temporary30.00
 - (e) Post48.00

SCHEDULE OF DENTAL ALLOWANCE

Maximum Allowance

Prior Benefit New Benefit

5. MARYLAND BRIDGE		
(a) Each retainer	198.00	
(b) Pontic	317.00	

PROCEDURES COVERED UNDER THE ORTHODONTIC SERVICES

THESE SERVICES REQUIRE PRE-CERTIFICATION BEFORE TREATMENT HAS BEGUN

Diagnosis and initial orthodontic appliance	\$317.00	400.00
Active treatment per month, 24 months		79.00
Retention treatment per month, 24 months		12.00

B) HEALTHPLEX COMPREHENSIVE DENTAL PLAN

COMPREHENSIVE OPTION

Under the Comprehensive Dental Plan Option, members of our group select a dentist from a Dentcare's panel of participants. The dentist provides all necessary care referring to a wide range of specialists, should it become necessary. It is important to note that under this option, care provided by a non-participating dentist is **NOT** covered, unless arranged for by Dentcare.

For those members selecting the Comprehensive Option, dental care is available from a panel of participating dentists.

SPECIAL FEATURES

- Eliminates out-of-pocket expenses in most cases.
- **No forms to complete.**
- Specialty services covered and arranged by Dentcare.

In cases of emergency, Dentcare covers a maximum of two visits, per member per contract year, for services rendered by a Dentcare dentist not assigned to you.

However, if the member has had regular checkups or is undergoing treatment, there is no limitation. If an emergency occurs out-of-area, or in the unlikely event the member is unable to reach a Dentcare dentist, Dentcare will reimburse up to \$25 per family

member per contract year, upon presentation of bills for palliative care rendered by a non-Dentcare dentist until treatment can be obtained from your Dentcare dentist.

SCHEDULE OF HEALTHPLEX DENTAL CARE BENEFITS

In the event you are unable to reach your own Dentcare dentist, Dentcare provides 24-hour emergency service operators at the following numbers:

**EMERGENCY REFERRAL
24-HOUR SERVICES**

NEW YORK
(516) 794-3000

NEW JERSEY
(800) 468-0600

Listed below is a general description of your Healthplex Comprehensive Dental Care Program for your use as a convenient reference. All benefits are governed by the provisions of your group's contract with Dentcare Delivery Systems, Inc.

These fees are the most you will have to pay to your participating Dentist for the services listed below.

Diagnostic & Preventive Services

Full Mouth X-Ray	No Charge
Single Films (periapical or bitewing)	No Charge
Bitewing Series	No Charge
Oral Examination	No Charge
Specialty Consultation	No Charge
Cleaning of Teeth (Prophylaxis & polishing)	No Charge
Fluoride Treatment	No Charge
Treatment in case of Dental Emergency	No Charge

Restorative Dentistry

Silver Amalgam, one surface	No Charge
Silver Amalgam, two surfaces	No Charge
Silver Amalgam, three surfaces or more	No Charge
Composite Filling, one surface	No Charge
Composite Filling, two surfaces	No Charge
Composite Filling, three surfaces or more	No Charge

Sealants* (permanent teeth only)\$20.00

*Only available to dependent children under age 16.

Oral Surgery

Routine extractions – per tooth	No Charge
Surgical extraction	No Charge
Soft tissue impaction	No Charge

Bony impactions	No Charge
Alveolectomy, per quadrant.....	No Charge

Root Canal Therapy

Pulp Capping, Direct.....	No Charge
Pulpotomy.....	No Charge
Root Canal Therapy, one canal.....	No Charge
Root Canal Therapy, two canals.....	No Charge
Root Canal Therapy, three canals.....	\$100.00

Periodontics

Scaling of teeth, per quad.....	No Charge
Subgingival curettage, per quad.....	No Charge
Gingivectomy, per quad.....	No Charge
Mucogingival surgery, per quad.....	\$200.00
Osseous surgery, per quad.....	\$200.00

Prosthetics – Crowns

Acrylic with metal crown	No Charge
Porcelain crown	No Charge
Porcelain with metal crown.....	No Charge
Stainless steel crown.....	No Charge
Cast post.....	No Charge
Recementation, per crown.....	No Charge

Prosthetics, Fixed Bridges

Acrylic with metal crown or pontic.....	No Charge
Porcelain with metal crown or pontic.....	No Charge
Recementation, bridge.....	No Charge

Prosthetics - Removable

Full upper or lower denture w/adjustment.....	No Charge
Partial upper and lower denture, cast chrome.....	No Charge
Denture adjustments	No Charge
Broken Body of Denture	No Charge
Replacement of broken/missing teeth	No Charge

Orthodontia (Dependent Children Only)

Maximum Case Fee	No Charge
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Note:

The allowance for Orthodontic Services is provided only for eligible dependents under age 19 when the treatment began. Additionally, the Orthodontic benefits available under this program will be reduced by the number of months of treatment received while the dependent was covered under any previous Dental Plan.

**HEALTHPLEX DENTAL PLAN
EXCLUSIONS AND LIMITATIONS**

Benefits shall not be provided for:

- Any dental services which were not rendered, prescribed, arranged or approved by a plan dentist, except in cases of out-of-area dental emergency under the Comprehensive Option.
- Hospital administered anesthesia and elective general anesthesia.
- Consultation by non-participating dentist, unless specifically directed by Dentcare under the Comprehensive Plan.
- Any dental procedures which are undertaken primarily for cosmetic reasons.
- Any service or appliance, unless required in accordance with accepted standards of dental practice.
- Prosthetic benefits are not covered where, in the view of the Plan Dentist, sound restorations can be achieved by amalgam or alternative methods.
- Replacements or substitutions of appliances supplied by Plan until five (5) years have elapsed.
- Services or appliances used solely as an adjunct to periodontal care or for some cosmetic purposes.
- Implants and attachments thereof.
- More than two (2) oral examinations and oral prophylaxis (cleaning, scaling and polishing of teeth) per member per year (Once every six months).
- Orthodontia – Lost or Broken Appliance – There is a charge of \$100.00 to replace an appliance under the Comprehensive Plan.
- A new denture or bridgework if the existing denture or bridgework can be made serviceable.
- Orthodontic services for eligible dependent children consisting of the necessary diagnosis and treatment of class 2 and 3 malocclusions which cause interference with normal function.
- Services rendered in a hospital or outside of a participating dentist's office.
- Services that are not listed or treatment involving personalized procedures covered. Such procedures (if performed) will be financial responsibility of the patient.

**VISION CARE
FOR YOU AND YOUR DEPENDENTS**

This Benefit applies to expenses for the following services, which are incurred by you or your eligible dependents while you are covered for benefits.

- (a) Eye examinations performed by a licensed optometrist or licensed physician accredited in the specialty of the eye, and
- (b) Lenses and frames ordered by them.

The Benefits – You will be paid the amount charged for examination and materials, up to the maximum shown in the following schedule.

SCHEDULE OF COVERED OPTICAL SERVICES

	Maximum Allowance
I. Complete Examination	\$20.00
II. Materials	
Lens, Single Vision Prescription	15.00
Each Bi-Focal Prescription	17.00
Tri-Focal Prescription	25.00
Lenticular	45.00
Contact – See Limitation	100.00
Frames	50.00

PAID IN FULL FEATURE

Your Association has made arrangements with certain qualified optometrists to provide examinations, frames and lenses for all procedures indicated in the schedule of covered optical services at no additional cost to you. Any items not indicated in the schedule will be provided at a substantial discount. A list of these providers is available from the Association Fund Office or the office of Maloney Associates, Inc.

LIMITATIONS

- Examinations will be limited to one per person, and lenses will be limited to two per person during any 12 consecutive months. Frames will be limited to one set per person during any 12 consecutive months.
- Contact lenses will be covered only after cataract surgery or when visual acuity of patient is not correctable to 20/70 in the better eye by use of conventional type lenses, but can be improved to 20/70 or better by the use of contact lenses. If neither of these requirements are satisfied, a set of cosmetic contact lenses will be reimbursable at \$80 (single vision lenses and frame benefit rate).

EXCLUSIONS

Optical benefits shall not be provided for:

- Services and materials (a) in connection with special procedures such as orthoptics and visual training, or (b) in connection with medical or surgical treatment, or (c) provided under Workers' Compensation benefits.
- Sunglasses, plain or prescription.

- Eye examinations required (a) by an employer as a condition of employment, which the employer is required to provide by virtue of a labor agreement, or (b) by a governing body.
- Replacement of lenses or frames which were furnished under this Plan and which have been lost, stolen or broken.

CRUTCHES AND/OR WHEELCHAIR

This benefit is available for all retired Supreme Court Officers and their eligible dependents. The Fund will pay a maximum of \$100 toward the purchase or rental of crutches and/or wheelchair per illness or injury.

AMBULANCE SERVICE

This benefit is available for all retired Supreme Court Officers and their eligible dependents. The Fund will pay a maximum of \$125 toward the cost of any one way trip in emergency cases only.

HEARING AIDS

This benefit is available for all retired Supreme Court Officers and their eligible dependents. The Fund will pay a maximum of \$500 twice in a lifetime toward the purchase of a hearing aid. The hearing aid must be medically necessary.

COORDINATION OF OTHER PLANS

In the event a covered person under the Dental Care portion of the Security Benefit Fund is also covered under another group benefit plan which provides dental and hearing aid benefits, and such plan is provided through the auspices of any employer or educational institution, there will be a "Coordination of Benefits" regarding reimbursement by this Security Benefit Fund Plan.

This coordination will apply in the event an expense is incurred for a covered event under this Security Benefit Fund Plan which also is covered under the other plan. A determination will be made as to which plan is the "first" plan and which is the "second" plan. The method determining which plan is "first" is based on the following rules:

- A plan covering a person as an employee will pay benefits first. A plan covering a person as a dependent will pay second.
- If a dependent child is covered by both parents' plans, the benefits of the Plan which covers the child of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year will be determined first. The benefits of the plan

which covers the child of the parent whose date of birth excluding year of birth, occurs later in a calendar year, will be determined second.

If a plan containing the "birth-date" rule is coordinating with a plan which contains the gender-based rule and as a result, the plans do not agree on the order of benefits, the gender-based rule will determine the order.

3. When the parents are divorced or separated the order is:

- a) The policy of the parent with custody pays first. The policy of the parent without custody pays second.
- b) If the parent with custody has remarried, the order is,
 - 1) The plan of the parent with custody.
 - 2) The plan of the step-parent
 - 3) The plan of the parent without custody.

If there is a court decree which states that one of the parents is responsible for the child's health care expenses, the plan of that parent will pay first. That order will supersede any order given above.

4. If a person is covered under more than one plan, the plan he or she was covered under longer pays first.

If this Retiree Plan is the first plan, it will pay its benefits as if there were no other such plan.

If this Retiree Plan is the second plan, it will pay its benefits as if there were no other such plan, except that this plan will pay no greater part of a charge covered by this Retiree Plan and other plan(s) than that which when added to the part(s) payable by other plan(s) equal 100% of the allowable charge.

These provisions will not apply to situations where both a husband and a wife are covered under the Plan. In these cases, each will be considered to be the primary insured. However, the Plan will never pay more than the total bill submitted for payment.

If this Security Benefit Fund Plan is the first plan, it will pay its benefits as if there were no other such plan.

If this Security Benefit Fund Plan is the second plan, it will pay its benefits as if there were no other such plan, except that this plan will pay no greater part of the charge covered by this Security Benefit Fund and other plan(s) than that which when added to the part(s) payable by the other plan(s) equal 100% of the allowable charge.

COBRA CONTINUATION OF COVERAGE (ON A SELF-PAY BASIS)

AS REQUIRED BY THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (hereinafter "COBRA") provides that you and your eligible dependents can continue health care coverage under certain circumstances where coverage would otherwise end (called "qualifying events"). This section outlines your rights and obligations with respect to continuation of the health benefits provided under the Plan.

You have the right to choose continuation coverage if you lose your coverage under the Plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of a participant and you are covered by the Plan as of the date of your qualifying event, you have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following four (4) reasons:

- The death of your spouse;
- Termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with a contributing employer;
- Divorce or legal separation;
- Your spouse becomes enrolled in Medicare;

Dependent children of a participant covered under the Plan shall have the right to choose continuation of coverage if coverage under the Plan is lost for any of the following five (5) reasons:

- The death of the participant;
- The termination of the participant-parent's employment (for reasons other than gross misconduct) or a reduction in the parent's hours of employment with a contributing employer;
- Parent's divorce or legal separation;
- The participant-parent becomes enrolled to Medicare; or
- The dependent ceases to be a "dependent child" under the terms of the Plan.

A child born or placed for adoption with a participant during the period of the participant's continuation coverage is also eligible for COBRA coverage. Once a newborn or adopted child is enrolled for COBRA coverage he/she will be treated like all other COBRA "qualified beneficiaries". A new spouse of a participant who is receiving COBRA continuation coverage may also be enrolled for COBRA coverage pursuant to the Plan's enrollment rules for new spouses. However, such a newly enrolled spouse will not have the rights of other qualified beneficiaries.

Under the law, the participant or eligible spouse must inform the Plan Administrator of a divorce or legal separation within sixty (60) days of the date of the event on which coverage would end under the Plan because of the event, whichever is later. Your employer has the responsibility to notify the Plan Administrator of your death, termination of employment, reduction in hours of employment or Medicare enrollment.

When the Plan Administrator is notified of one of these events, you will be notified, in writing, that you have the right to choose COBRA coverage within sixty (60) days of other of:

- The date you or your eligible dependent ordinarily would have lost coverage because of one of the events described above, or
- The date you receive notice of your right to elect continuation coverage.

If you do not timely and properly choose COBRA coverage, your group health coverage under the Plan will end.

If you choose COBRA coverage, you are entitled to coverage that is identical to the coverage being provided under the Plan to similarly situated participants or their eligible dependents (with the exception of the Death Benefit). If you lost group coverage because of a termination of employment or a reduction in hours, you can continue coverage for up to eighteen (18) months. In the case of other qualifying events, qualified beneficiaries can continue COBRA coverage for up to thirty-six (36) months.

An 18-month period of COBRA coverage may be extended for up to eleven (11) months (for a total of twenty nine [29] months of COBRA coverage) if the qualified beneficiary has been determined to be disabled (under Title II or XII of the Social Security Act) as of the date of the participant's termination or reduction in hours. The individual must notify the Plan Administrator within sixty (60) days of the determination (and within the initial eighteen [18] month COBRA period). There will be an increase in the cost of such extended coverage.

The eleven (11) month extension also will apply if the qualified beneficiary becomes disabled at any time within the first sixty (60) days of the determination (and within the initial eighteen [18] month COBRA period). There will be an increase in the cost of such extended coverage.

The twenty-nine (29) month extension is also available to a disabled qualified beneficiary's non-disabled family members who are entitled to COBRA coverage.

Additional qualifying events may occur while continuation coverage is in effect. Such events may extend an eighteen (18) month period of COBRA coverage up to a total of thirty-six (36) months, but in no event will coverage extend beyond thirty-six (36) months after the loss of coverage due to the initial qualifying event. You must notify the Plan Administrator if a second qualifying event occurs during your 18 month continuation coverage period.

The law also provides that your COBRA coverage may end before the expiration of the 18, 29 or 36 month period for any of the following five (5) reasons:

- The Plan no longer provides health coverage;
- The payment for your continuation coverage is not timely paid;
- The individual becomes covered under another group health plan (as a participant or otherwise) that (i) does not contain a pre-existing condition exclusion or limitation or (ii) contains a pre-existing condition exclusion or limitation, but it does but it does not apply to the individual because he or she has at least twelve (12) months of creditable coverage (without a sixty three [63] day break in coverage) that counts toward the exclusion or limitation;
- The individual becomes enrolled in Medicare; or
- Coverage has been extended for up to twenty-nine (29) months due to disability and there has been a final determination that the individual is no longer disabled.

In order to continue coverage under the Plan, you must pay the cost of coverage. For coverage during the eleven (11) month extension, there will be an increase in cost. However, you do not have to provide proof of good health.

COBRA coverage is subject to your eligibility for coverage under the Plan. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible. Once your COBRA coverage terminates for any reason, it cannot be reinstated.

If you have any questions about COBRA continuation coverage, please contact the Fund Office.

CLAIM PROCESSING PROCEDURES

When a claim is to be made, the necessary forms should be obtained from Maloney Associates, Inc. You may also submit a claim for benefits on the "universal ADA" claim form. You may either call or write:

MALONEY ASSOCIATES, INC.
211 Broadway
Lynbrook, NY 11563
(800) 334-3680 or (516) 887-2255

Be sure to identify yourself as a Retired SCO member to avoid any delays and to be sure that the proper claim form is sent to you.

Make certain that all required information is completed on the claim form. The completed claim forms and necessary documentation (i.e., death certificates) should be returned to Maloney Associates, Inc. for eligibility certification and benefit processing. All claim payments will be made directly to you, the member, unless you have assigned the payment to the provider for services. **Assignments are only available on Dental and Vision Care benefits.**

If written notice is other than a standard claim form, a standardized claim form will be sent within fifteen (15) days of receipt of notice. The claimant must then submit the claim form within ninety (90) days of receipt.

If a claim form is not furnished to the claimant within fifteen (15) days, the claimant will be deemed to have complied with the requirements as to Proof of Loss provided:

- a) A written proof of the occurrence, character and extent of the loss s submitted; and;
- b) Submission is made within ninety (90) days of the event.

Failure to give Notice of Loss or Proof of Loss within ninety (90) days shall not invalidate or reduce any claim provided.

- a) It was not reasonably possible to do so; and
- b) Notice and proof of loss were given as soon as reasonably possible and within one (1) year from the occurrence of loss upon which the claim is based.

CLAIM APPEALS

If your claim for benefits is denied, in whole or in part, for any reason, the Plan will send you written notice of its decision within ninety (90) days after receipt of claim (180 days in special circumstances). The notice will include the specific reason or reasons for the denial; the special reference to pertinent Plan provisions on which the denial is based; a description of any additional material or information necessary for you to complete your claim, and an explanation of why such material or information is necessary (if applicable); and appropriate information as to the steps to be taken if you wish to appeal the denial of your claim.

If you are not satisfied with the reason or reasons why your claim was denied, then you may appeal to the Board of Trustees. To appeal, you must write to the Trustees at the Fund Office within sixty (60) days after you receive the Security Benefit Fund Plan's denial notice. Your correspondence (or your representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY MY BENEFITS. YOUR DENIAL NOTICE TO ME WAS DATED _____, 20____". If this statement is not included, then the Trustees may not understand that you are making an appeal as opposed to a general inquiry.

If you have chosen someone to represent you, with respect to your appeal, and if your representative writes the appeal to the Trustees, the authorization information must be given and you must sign the statement. Otherwise, the Trustees will not be sure that you have actually authorized someone to represent you. The Trustees will not communicate about your situation to someone other than yourself, unless the Trustees are such the individual is your chosen representative. If you appeal, you or your duly

authorized representative may review pertinent documents concerning your denial and may submit to the Trustees, any issues and/or comments you have in writing. If you do not receive any decision at all from the Plan (regarding a claim for benefits) within ninety (90) days from the date you submitted a claim (180 days in special circumstances), you may appeal to the Trustees in the same manner as previously stated.

The Trustees' decision, with respect to your appeal, will be made promptly, and will not ordinarily be made for more than sixty (60) days after the Plan receives your written appeal. However, if special circumstances require an extension of time for processing, a decision shall be rendered as soon as possible, but no later than 120 days after your appeal is received. If such an extension of time for review is required because of special circumstances, written notice of the extension will be furnished to you (or your representative) prior to the beginning of the extension. The Trustees' decision on review will be in writing and will include specific reasons for their decision, written in a manner calculated to be understood by you, as well as specific references to the Pertinent Plan provisions on which their decision is based.