COMMUNICATIONS WORKERS OF AMERICA ■ LOCAL 1180 ■ AFL-CIO

SECURITY BENEFITS FUND

SUMMARY PLAN DESCRIPTION

Welcome

March 2022

Dear Member:

I welcome you on behalf of the trustees and staff of the CWA Local 1180 Security Benefits Fund. We are pleased to provide you with this updated Summary Plan Description that describes all the benefits provided to you through the Communications Workers of America, Local 1180 Security Benefits Fund, Legal Benefits Fund, Education Fund, and Members' Annuity Fund.

To the extent that this hand booklet describes an insured benefit (e.g., life insurance/accidental death and dismemberment), the group insurance contract specifies the exact benefits provided and the language of the insurance contract will govern in the event of any inconsistency between it and the language of this Summary Plan Description.

Every effort has been made to present this information in clear, straightforward language. Please read this Summary Plan Description carefully and keep it in a safe place. If you have any questions about your benefits, the Fund Office will be pleased to answer them.

In Unity,

Board of Trustees

CWA Local 1180 Security Benefits Fund
CWA Local 1180 Legal Benefits Fund
CWA Local 1180 Education Benefits Fund
CWA Local 1180 Member's Annuity Fund

CWA LOCAL 1180 SECURITY BENEFITS FUND

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TABLE OF CONTENTS

INTRODUCTION
How to Use this Summary Plan Description 1
How to Contact the Fund Office 2

BENEFITS FUNDS OVERVIEW
SECURITY BENEFITS FUND 3
EDUCATION BENEFITS FUND 5
LEGAL BENEFITS FUND 6
MEMBERS ANNUITY BENEFIT FUND 6

ELIGIBILITY
ELIGIBILITY FOR ACTIVE MEMBERS 7
Who Is Covered? 7
How Do You Enroll? 10
When Does Coverage Begin? 10
When Does Coverage End? 11
Who Is Not Eligible For Coverage? 11

COORDINATING YOUR BENEFITS
What is “Coordinating Benefits”? 12
If You or Your Spouse are Covered by Different Plans 12
If You or Your Spouse are both Eligible Members 12
If You or Your Spouse Both have Dependant Coverage for Your Children 13
What If You Leave Payroll For Any Reason? 13
Recovery of Erroneous Payment 13
Amendment or Termination of Benefits 14
Third-Party Reimbursement/Subrogation 14
When Motor Vehicle or No-Fault Insurance Provides Coverage 15
Benefits Payable On Behalf Of a Deceased Member 15
Additional Coordinating Rules 16
How is the Security Benefits Fund Administered? 16
How Are Contributions Made? 16
How Are Benefits Provided? 17

YOUR CONTINUATION COVERAGE (COBRA)
What is COBRA Continuation Coverage? 18
When is COBRA Continuation Coverage available? 19
How is COBRA Continuation Coverage provided? 20
How Do I Elect COBRA Continuation Coverage? 21
Are There Other Coverage Options Besides COBRA Continuation Coverage? 21
How Do I Add COBRA Coverage for New Dependents? 22
What if My Spouse or Dependents Lose Other Health Insurance Coverage? 23

How Much Does COBRA Continuation Coverage Cost? 23
When And How Must Payment For Continuation Coverage (COBRA) Be Made? 23

YOUR PRIVACY
Section 1: Purpose of This Notice and Effective Date 25
Section 2: Your Protected Health Information 26
Section 3: Your Individual Privacy rights 29
Section 4: The Fund's Duties 32
Section 5: Your Right to File a Complaint 33
Section 6: If You Need More Information 33
Section 7: Conclusion 33

YOUR LIFE & SUPPLEMENTAL HEALTH BENEFITS 34

APPLYING/ CLAIMING YOUR SUPPLEMENTAL HEALTH BENEFITS
When Benefits May Be Withheld or Denied 36

CLAIMS AND APPEALS 37
Request for Review of Denial of Claim 37
Determination of Claims 37
Board Appeal Procedures 40

YOUR LIFE INSURANCE & DISABILITY BENEFITS
What Are The Life Insurance Benefits? 44
How Do You Designate a Beneficiary? 44
How Does Your Beneficiary File A Claim? 45
What If You Become Disabled? 45
What Are The Conversion Privileges? 45
What Are The Accidental Death and Dismemberment Benefits? 45
How Do You File A Claim? 46
What Are The Limitations To Your Accidental Death and Dismemberment Insurance? 46
Are There Conversion Privileges? 47
What Are The Weekly Accident and Sickness Benefits? 47
What Are The Eligibility Requirements? 47
What Serves As Proof of Disability? 48
What Are Successive Periods of Disability? 48
What Is Not Covered? 48
How Do You File A Claim? 48
What Is The Retirement, Pension, and Health Insurance Counseling Benefit? 49

YOUR HOME HEALTH CARE BENEFIT
What is the Home Health Care Benefit? 49
How Do You File A Claim? 49

YOUR BIRTH/ADOPTION BENEFIT
What is the Birth/Adoption Benefit? 50
How Do You File A Claim? 50

YOUR DENTAL BENEFIT PLANS 50
THE SCHEDULED DENTAL BENEFIT PLAN 51
When is Coverage Provided? 51
What Expenses Are Covered By The Scheduled Dental Benefit Plan? 51
Schedule of Dental Benefit Plan 53
What If I Want to Change To A Different Dental Plan 58
What's Not Covered 58

THE DENTCARE BENEFIT PLAN 59
What Coverage Is Provided? 60
How Does The Program Work? 60
What Dental Services Will You Receive? 60
Schedule of Covered Dental Services 62
What If My Request For Dental Services is Denied? 63
What If I Want To Change To A Different Plan? 63
Exclusions and Limitations 64
Medical Necessity 65

MAKING INQUIRES TO DENTCARE 65

THE EMBLEMHEALTH BENEFIT PLANS - PREMIUM OR STANDARD OPTION 66
Covered Dental Services 67

THE EMPIRE BENEFIT PLAN 71
Dental Services 71

YOUR PRESCRIPTION DRUG BENEFIT
What Is The Prescription Drug Benefit? 73
What Kinds of Prescription Drugs Are Covered By the Plan's (Captial Rx) Prescription Drug Cost Reimbursement Benefit Program? 75
How Does The Prescription Drug I.D. Program Card Work? 77
How Do You Get Refills? 77
What Happens If You Use A Non-Participating Pharmacy? 78
The Mail Order Prescription Drug Program 78
Special Rules for Specialty Prescription Drugs 79
Cost Avoidance Program 80
Non-Participating Pharmacies 81
Chemotherapyand Injectible Medication 81

YOUR GENERAL MEDICAL REIMBURSEMENT BENEFIT
What Is The General Medical Reimbursement Benefit 82
When is Coverage Provided? 82
What Expenses Are Covered By the General Medical Reimbursement Benefit? 82
Getting Your Benefit 82

YOUR MENTAL HEALTH REIMBURSEMENT BENEFIT
What Is The Mental Health Benefit? 83
Getting Your Benefit 83
What's Not Covered? 84

YOUR OPTICAL BENEFIT
What Is The Optical Benefit? 84
What Is Excluded From This Plan? 85
How Do You File A Claim? 85
What Is The No-Cost Optical Benefit Option? 85

YOUR HEARING AID REIMBURSEMENT BENEFIT
What Is The Hearing Aid Reimbursement Benefit? 86
What Is Not Covered? 86
How Do You Claim The Hearing Aid Benefit? 87

YOUR PODIATRY BENEFIT
What Is The Podiatry Benefit? 87
How Do You File A Claim? 87
What's Not Covered? 88

YOUR EDUCATION BENEFITS FUND
What Are The Benefits Provided By This Fund? 91
College Tuition Reimbursement 91
Book Reimbursement 91
CUNY School of Labor and Urban Studies 91
Adult Education Program Tuition Reimbursement 93
Career Development Conferences 93
Workplace Literacy Program 93
Exam Prep Courses 93
Who Is Eligible For Benefits? 94
How Do You Apply for Benefits? 94
No Duplication of Benefits 94
Amendment or Termination of Benefits 95
Right to Appeal 95
Other Educational Opportunities Through DCAS 96

YOUR LEGAL BENEFITS FUND
YOUR LEGAL BENEFITS FUND 99
Who's Eligible? 99
When Does Coverage Begin? 99
When Does Coverage End? 99
What Happens When I Retire? 100
How Does The Plan Work? 100

Member vs. Member Disputes? 100
What Does The Plan Cover? 101
Is There A Time Limit On The Legal Services Provided ToYou? 101
Are There Geographical Limitations? 101
What Are The General Matter Benefits? 102
What Are The Civil Matter Benefits? 103
What Are The Criminal Matter Benefits? 106
What Is The Court Cost Disbursement Benefit? 107
What Is The Legal Benefits Program For Out-Of-Area Members? 107
What Is Not Covered By The Plan? 109
Request for Review of Denial of Claim 110

YOUR ANNUITY BENEFITS FUND
ELIGIBILITY AND MEMBERSHIP 114
CONTRIBUTIONS 115
YOUR ACCOUNT 115
BENEFITS UNDER THE PLAN 117
DEATH AND DISABILITY BENEFITS 118
CLAIMS PROCEDURE FOR BENEFITS 119
TAX EFFECTS 120
ADDITIONAL QUESTIONS 122

GENERAL INFORMATION ABOUT THE FUNDS
Getting Information 124

INTRODUCTION

The CWA Local 1180 Security Benefits, Education Benefits, Legal Benefits and Member's Annuity Benefits Funds are separate trusts maintained for the purpose of providing covered members with supplemental health, education benefits, legal services benefits and annuity benefits. The supplemental health benefits provided by the Security Benefits Fund are intended to augment basic health insurance and hospitalization benefits administered by employers. The Funds are separately administered by Boards of Trustees.

The benefits provided by these Funds are the result of collective bargaining agreements between the City Of New York and related public employers, the Board of Education of the City of New York, the State of New York and the Communications Workers of America, AFL-CIO on behalf of its Local 1180.

These collective bargaining agreements provide for annual contributions to the Funds on behalf of each employee in a covered title in accordance with the applicable collective bargaining agreement. The benefits provided by the Funds are made possible by the Funds' assets which are derived from employer contributions. All of the Funds' assets are used to provide your benefits and to defray reasonable administrative expenses.

The Security Benefits Fund is a non-grandfathered plan under the Affordable Care Act.

How to Use this Summary Plan Description

This Summary Plan Description was designed to provide our members with a description of the benefits made available to you by the CWA Local 1180 Security Benefits, Education Benefits, Legal Benefits and Member's Annuity Benefits Funds. It serves as both a Summary Plan Description and Plan Document. Every effort has been made to make the information as clear as possible. To the extent that this Summary Plan Description describes the exact benefits provided and the language of the contract will govern in the event of any inconsistency between it and the language of this Summary Plan Description.

The Board of Trustees reserves the right to amend, modify, discontinue, or terminate all or a part of these Plans of Benefits for any reason and at any time when, in their judgment, it is appropriate to do so.

Furthermore, the Board reserves the complete authority and discretion to construe the terms of the Plans (and any related documents), including, without limitation, the authority to determine the eligibility for, and the amount of, benefits payable under the Plans. These decisions shall be final and binding on all parties affected by such decisions.

The next section, "Eligibility," contains the general eligibility rules you must meet to receive benefits provided by the CWA Local 1180 Security Benefits Fund, the CWA Local 1180 Education Benefits Fund, the Legal Benefits Fund and the Member's Annuity Benefits Fund. Variations in the general eligibility rules for specific benefits are described separately under the sections explaining the benefits provided by each Fund.

This Summary Plan Description and the Funds' staff are your sources of information on the Plans. If you have questions about the benefits described in this Handbook or your eligibility for a benefit, the Funds' staff will gladly assist you.

How to Contact the Fund Office

To reach the Funds' staff for any questions you may have, visit or call the Fund Office at:

CWA Local 1180 Security Benefits, Education Benefits and Legal Benefits Funds
6 Harrison Street
New York, New York 10013-2898
Tel: 1-212-966-5353
Tel: 1-888-966-5353 (out-of-area)
Fax: 1-212-219-2450

CWA Local 1180 Member's Annuity Benefits Fund
Administrative Services Only, Inc.
303 Merrick Road, Suite 300
Lynbrook, NY 11563-9010
1-877-999-3555 (Toll Free)

BENEFITS FUNDS OVERVIEW

SECURITY BENEFITS FUND

Life & Disability Benefits

- Life Insurance $5,000 ($1,000 for part-time)
- Accidental Death & Dismemberment $5,000 ($1,000 for part-time)
- Weekly Accident and Sickness Benefit $250 weekly for up to 13 weeks or $50 a day for partial weeks of disability for up to 65 working days

Supplemental Health Benefits

Dental Benefits:

(Member may choose one of the following plans for the family)

Schedule Dental Plan

- Use a participating dentist or any dentist of your choice
- Maximum benefit of $2,000 per person, per calendar year

Dentcare Plan

- Use Dentcare panel dentist
- Most services covered at no charge
- No annual or lifetime maximum

EmblemHealth

Premium Plan

- Maximum benefit of $2,000 per person, per calendar year
- Emblem will pay 100% for covered services if you see a participating dentist, up to the $2,000 annual maximum
- Monthly premiums of $34.51 are required for family coverage

Standard Plan

- No monthly premium
- Maximum benefit of $2,000 per person, per calendar year
- Deductible of $75 per covered family member or $225 per family and fee schedule for certain dental services

Empire BlueCross BlueShield

- Maximum benefit of $2,000 per person, per calendar year
- Nationwide access to Dentists and Specialists

Dependents Under Age Twenty-Six (26) – No-Cost Benefit

Dependents under age 26 are covered by the Dentcare, Schedule Dental Plan, Empire BlueCross BlueShield and EmblemHealth Plans.

There are limits on coverage for orthodontic services as further described herein.

Prescription Drug Cost Reimbursement Benefit

- There will be no dollar maximum on the amount of money that the SBF will pay for prescription drugs for any member or dependent of the Fund.

General Medical Reimbursement Benefit

- Benefit of up to $150 per family per calendar year for covered medical expenses.
- Benefit can be applied towards certain unreimbursed, out-of-pocket medical expenses.

Mental Health Benefit

- Covers out-patient mental health and substance abuse care.
- Reimbursement of up to a maximum of $300 per person, per calendar year.

Optical Benefit

- One eye exam and one pair of prescription eyeglasses (or contact lenses) per person, per calendar year.
- Maximum $100 benefit per person, per calendar year applicable to both In and Out of Network providers.
- Maximum of four claims per family, per calendar year.

Dependents Under Age Nineteen 19 – No-Cost

Children under the age of 19 are also entitled to one eye exam and one pair of prescription eyeglasses per calendar year and there is no cost or annual dollar limit on benefits the Fund will pay. However, children under age 19 must use an in-network provider — GVS, CPS, Vision Screening, or Vision World — to be eligible for the no-cost benefits. Also, the no-cost eyeglasses benefit only covers a selection from a special pediatric carousel of frames at the in-network providers. A pair of eyeglasses will be provided without charge if the prescription changes within the year. For broken, lost or stolen eyeglasses, the charge for a second pair of eyeglasses in a year will be $50, $75 for a third pair, and $100 for any beyond that.

Hearing Aid Reimbursement Benefit

- Up to $300 toward the cost of covered appliances and services.
- Benefits can be claimed once every two years.

Podiatry Benefit

- Up to $10 per visit four times a calendar year for you and your spouse only.

EDUCATION BENEFITS FUND

The benefits from this Fund cover a wide range of educational programs such as:

The College Tuition Reimbursement Program

- Provides reimbursement of up to $300 per semester for tuition and/or registration fees for a maximum of three terms per year (Spring, Summer, and Fall Semesters).

Book Reimbursement

- You can be reimbursed up to $25 for each of the three semesters (Spring, Summer, and Fall) for books if you are enrolled in a course covered by the College Tuition Reimbursement Program or the CUNY School of Labor and Urban Studies.

CUNY School of Labor and Urban Studies

- Undergraduate and Graduate students covered by CWA Local 1180 Education Fund are eligible to participate and receive Fund benefits as follows:
  - **Undergraduate Students:** Starting with the Fall 2021 Semester, the benefit increases to 30 credits from 24 credits. Undergraduate students may take up to a maximum of two courses per semester for the Spring, Summer, and Fall Semesters. Tuition and Registration Fees will be covered for courses up to 30 credits starting with the Fall 2021 Semester.
  - **Graduate Students:** May take up to a maximum of two courses per semester for the Spring, Summer, and Fall semesters. Tuition and Registration Fees will be covered for courses totaling up to 24 credits.

Adult Education Program Course Reimbursement

- If you successfully complete courses in an Adult Education Program in a job-related or job-advancement area, you can receive reimbursement of course fees up to a maximum of $200 per calendar year.

Career Development Conferences

- If you attend a conference in a job-related or job-advancement area for Career Development, you can receive reimbursement up to a maximum of $200 per calendar year.

NOTE: Combined reimbursement for Adult Education Courses and Career Development Conferences cannot exceed $200 for all such benefits in a calendar year.

Workplace Literacy Program

- The Fund develops and administers courses for Local 1180 members to upgrade and expand their skills in order to function more effectively on their jobs.

Exam Prep Courses

- The Fund develops and administers courses for Local 1180 members to assist them in preparing for civil service promotional examinations which their title promotes.

LEGAL BENEFITS FUND

For a full description of the benefits please refer to the section that covers the Legal Benefits.

- Covers general legal matters such as document review and consultations with a lawyer.
- Covers civil matters such as wills, divorces, adoptions, personal bankruptcy, tenant rights and sale or purchase of a home.
- Covers criminal matters such as representation at a criminal arraignment and bail bond benefit.

MEMBERS′ ANNUITY BENEFIT FUND

For a full description of the benefits please refer to the section that covers the Members' Annuity Benefit.

The purpose of the Plan is to provide you with income for your retirement security.

- Benefits are payable upon your normal retirement age or the later of (i) your actual retirement or (ii) age 70½ if you attained age 70 ½ before 2019, age 72 if you attain age 70 ½ after 2019, or if your employment ceases because of your death, disability, or separation from service.

ELIGIBILITY

ELIGIBILITY FOR ACTIVE MEMBERS

If you are a full-time employee working in a job title represented by CWA Local 1180, AFL-CIO, and funds are received from your employer on your behalf as a result of a collective bargaining agreement between your employer and CWA Local 1180, you are a covered member in the CWA Local 1180 Security Benefits Fund ("Fund"). You can also become a covered member if you are represented by CWA Local 1180, AFL-CIO in a covered job title and work on a part-time, per annum, hourly, per diem, per session or a seasonal basis and are employed on a regular basis at least one-half the regular hours of full-time employees in the same title and a contribution is made in your behalf to this Fund.

Who Is Covered?

Coverage by this Fund is provided for you and your eligible dependents in accordance with the terms of the agreement between your employer and CWA Local 1180, AFL-CIO for your covered job title. A dependent, as defined by the Fund, is your spouse or domestic partner and each child from date of birth who has not attained his or her nineteenth (19th) birthday, or his or her twenty-sixth (26th) birthday and for whom you have Extended Coverage and have affirmed that your dependent child does not have employer provided coverage from another employer, either directly or as a dependent. "Child" includes a natural child, stepchild, legally adopted child (which would include those in the waiting period) or foster child, provided the child is dependent on you for support or maintenance. The Fund may request proof of dependent status through affidavit, income tax returns, court orders, and birth certificates or otherwise.

Your Spouse or Domestic Partner:

Your spouse is eligible for all of the benefits provided by the CWA Local 1180 Security Benefits Fund and some of the benefits provided by the CWA Local 1180 Legal Benefits Fund,* if:

- You and your spouse are legally married.

Your domestic partner is eligible for all of the benefits provided by the CWA Security Benefits Fund and some of the benefits provided by the CWA Legal Benefits Fund,* if:

- Your domestic partner has qualified for and been certified by the City as a domestic partner eligible for City health plan coverage

  or

- You and your domestic partner present proof of certification by the City of domestic partners' health insurance coverage. (If you are an eligible employee of an employer other than the City of New York, your domestic partner must be certified as a domestic partner in accordance with criteria similar to those employed by the City. Please contact the Fund Office for information about the certification process.)

As a general rule, whenever the term "your spouse" is used in this booklet, it is intended to refer to your eligible domestic partner as well, unless otherwise noted or the context indicates that such usage was not intended. References to children, moreover, are also intended to refer to children of your eligible domestic partner.

NOTE: ***The cost of coverage for domestic partners may be taxable as income to the Fund member. Domestic Partnership Registration:***
http://www.cityclerk.nyc.gov/html/marriage/domestic_partnership_reg.shtml

** Consult the eligibility rules of the Legal Benefits Fund for a description of the Legal Services Benefits available to a spouse or domestic partner of a member.*

Your Children:

Your children are eligible for some of the benefits provided by the CWA Local 1180 Security Benefits and CWA Local 1180 Legal Benefits Funds, if:

- They are your biological children from date of birth until their nineteenth (19th) birthday

  or

- They are your legally adopted children from placement until their nineteenth (19th) birthday

  or

- They are your stepchildren from date of marriage until their nineteenth (19th) birthday

  or

- They are your foster children from placement until their nineteenth (19th) birthday

  or

- They are the children of your domestic partner two (2) weeks of age until their nineteenth (19th) birthday.

When Your Child Reaches Age Nineteen (19):

Your child's coverage may be continued from his or her nineteenth (19th) birthday until he or she reaches the age of 26, if

- You have Extended Coverage,
  and
- You have affirmed that your dependent child does not have employer-provided coverage from another employer, either directly or as a dependent

Proposed Adoptive Children:

- Proposed adoptive children (two weeks of age until their 19th birthday) are considered a dependent on the date the Fund Office receives notification of the proposed adoption from you, provided that you have taken the following steps to finalize legal adoption:
- The child must physically be living in your household
- You must have filed a petition for adoption pursuant to Section 115-c of the New York Domestic Relations Law within thirty (30) days of taking physical custody of the child
- No notice of revocation of the adoption must have been filed pursuant to Section 115-b of the New York Domestic Relations Law
- No revocation of consent of the adoption must exist
- No notice of revocation of the adoption is filed pursuant to Section 115-b of the New York Domestic Relations Law
- Consent to the adoption has not yet been revoked.

If the Fund Office does not receive notification from you of the proposed adoption within thirty (30) days of the date the child is in your household, coverage will begin on the date the Fund Office receives notice.

Children with Disabilities:

If your child is physically or mentally disabled, his or her coverage may continue after the age of twenty-six (26), if:

- Your child is unmarried and is dependent on you for his or her support and maintenance
  and
- He or she is incapable of self-support because of mental illness, mental retardation or developmental disability as defined in the New York Mental Hygiene Law, or because of physical disability
  and
- You submit proof of your child's disability within thirty-one (31) days of attaining the age at which coverage would otherwise be terminated.

The Trustees of the CWA Local 1180 Security Benefits Fund have the sole and absolute discretion to decide all issues of eligibility for benefits of your child with a disability. You will be requested by the Fund Office to submit proof of continued disability and to re-certify the disabling condition from time to time.

How Do You Enroll?

When you become eligible for coverage, you must enroll with the Fund Office before benefits become payable.

To enroll, follow these simple steps:

- Complete and sign the Security Benefits Fund Enrollment form and the Designation of Beneficiary form. Make sure you answer every question carefully, accurately and legibly. ***(NOTE: Fund Enrollment is separate from Union member enrollment. Just because you filled out a membership form for CWA Local 1180 Union does not mean you are enrolled for benefits.)***
- Submit the Enrollment form and the Designation of Beneficiary form to the Fund Office.
- Submit birth certificates and Social Security numbers for dependent children and copy of marriage certificate when enrolling your dependents, or such other documentation as requested by the Fund.

When any change occurs in your status, such as marriage, divorce, separation, change of work location, change of address, birth or adoption of a child, or death of an eligible dependent:

- Obtain another Enrollment form from the Fund Office or from your Local 1180 Shop Steward and make the proper revisions.
- Submit your revised Enrollment form to the Fund Office.

If you wish to change your beneficiary designation:

- Obtain a new Designation of Beneficiary form from the Fund Office.
- Submit your revised Designation of Beneficiary form to the Fund Office.

When Does Coverage Begin?

Under this Fund, coverage for you and your eligible dependents begin on the day you are placed on the payroll in a covered job title which is represented by CWA Local 1180, AFL-CIO and a contribution is made by your employer to this Fund on your behalf.

When Does Coverage End?

Coverage for you and your eligible dependents ends on the day you cease to be employed in a covered job title which is represented by CWA Local 1180, AFL-CIO. However, if you are on an approved leave of absence for illness, coverage for you and your dependents can be extended for the period of time during which you are receiving disability benefits from the Fund. If you retire from a position covered by this Fund, you may be eligible for benefits from CWA Local 1180 Retirees Benefits Fund. In addition, under certain qualifying events you and/or your dependents may be entitled to continue coverage (General Medical Reimbursement, Dental, Vision, Prescription Drug, Hearing Aid, Mental Health and Podiatry Benefits) under a self-pay program referred to as "COBRA" ("Your Continuation of Coverage"). Please contact the Fund Office to learn about your benefits.

Who Is Not Eligible For Coverage?

Persons not entitled to coverage include:

- Any child born to your dependent child unless proof of your legal guardianship of such child is provided.
- No one can be covered for benefits provided by the CWA Local 1180 Security Benefits and Legal Benefits Funds as both a member and dependent or as a dependent of more than one member.

The Fund reserves the right to request and be furnished with such proof as may be needed to determine the eligibility status of individuals.

COORDINATING YOUR BENEFITS

What is "Coordinating Benefits"?

Frequently, a person eligible for benefits from the Fund will also be eligible to receive similar benefits from another plan.

If this happens, the two plans will coordinate their benefit payments so that the combined payments of both plans will not be more than the actual expenses that the eligible person has to pay. One plan (the primary plan) will pay its full benefits. The other plan (the secondary plan) will pay any expenses in excess of the primary plan benefits, up to the maximum amount it would pay if the coordination of benefits provisions was not in force, but in no event more than the amount charged.

If You or Your Spouse are Covered by Different Plans

If your spouse is covered by another plan, the Fund will coordinate payment of your benefits with that plan.

For your care:

- The Fund is the primary payer. It makes the first payment on your eligible claim.
- Your spouse's plan is your secondary payer. It may cover any remaining expenses, according to the terms of that plan.

For your spouse's care:

- Your spouse's plan is the primary payer.
- The Fund is your spouse's secondary payer.

When submitting a claim for your spouse's care, you must include a statement from your spouse's plan showing what action they have taken**.**

If You or Your Spouse are Both Eligible Members

If you and your spouse are both eligible members, each of you may cover yourself only. Neither one can elect individual coverage and also cover each other as dependents. If there are eligible

dependent children, only one parent may cover them. The Fund will not, under any circumstance, make duplicate payments on the same claim.

If You or Your Spouse Both have Dependent Coverage for Your Children

If you are covered by the Fund and your spouse is covered by another plan and you both have dependent coverage for your eligible children, benefits for your children are coordinated as follows:

- The primary payer is the plan of the parent whose birthday is earliest in the year.
- If both parents have the same birthday, the plan that has covered a parent longest will be considered primary.
- The other parent's plan is the secondary payer.

In the case of a divorce or separation, the order of payment will be determined as follows:

- If a court orders one of the parents to provide coverage and that parent's plan covers the child as a dependent, and that plan has actual knowledge of the court decree, that plan will be considered to pay first.
- Otherwise, the custodial parent's plan that covers a child as a dependent will be considered to pay before any other dependent coverage.
- If the above rule is inapplicable, the plan that covers the custodial parent's spouse and which also covers the child as a dependent will be considered to pay before any other dependent coverage.
- If neither of the above rules apply then the plan that covers the child as a dependent of the parents without custody will be considered to pay benefits first.

What If You Leave Payroll For Any Reason?

If you have been off payroll for any reason, you must advise the Fund Office when you return to work.

Failure to notify the Fund Office may cause interruption of your benefits. Please refer to the section on Continuation of Coverage Rights (COBRA).

Recovery of Erroneous Payment

If you received benefits from the Fund to which you were not entitled, the Fund has the right to recover the benefits you received in error. This can be accomplished through voluntary restitution by you or through an offset against future benefits or any other means allowed by law.

Amendment or Termination of Benefits

The benefits provided by this Fund may, from time to time, be changed, modified, augmented or discontinued by the Board of Trustees. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this booklet are subject to such rules and regulations and to the Trust Agreement that established the Fund and governs its operations.

Your coverage and your dependent's coverage will stop on the earliest of the following dates:

- When the Fund is terminated
- When you are no longer eligible
- When there is non-payment of the direct pay premiums (COBRA)
- When the Employer ceased to make contributions on your behalf to the Fund.

Your dependents' coverage will also terminate when they are no longer your eligible dependents.

Active member benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees. No person acquires a vested right to such benefits either before or after his or her retirement. The Trustees may expand, modify or cancel the benefits for active members and retirees; change eligibility requirements or the amount of the premiums; and otherwise exercise their prudent discretion at any time without legal right or recourse by an active member, retiree or any other person.

Third-Party Reimbursement/Subrogation

If someone else is legally responsible for your illness or injury, you, your spouse or your eligible children may be able to recover damages from that person, an insurance company, an uninsured motorist fund, or no-fault insurance carrier.

Expenses such as disability, hospital, medical, major medical, prescription drugs or other services, resulting from such an illness or injury caused by the conduct of a third person, are not covered by this Fund.

When another party is legally responsible, the Fund has subrogation rights to recover the full amount it has paid or will pay arising out of, or relating to, any and all of the rights, claims, causes of action, and interest which, you, your spouse or covered children may have against any person, firm, corporation, insurance company, payer, uninsured motorist fund, no-fault insurance carrier, or other entity in regard to such injuries, expenses or losses.

You are required to provide the Fund with any and all information and to execute and deliver all necessary documents as the Fund may require to enforce the Plan's subrogation rights. You (or your spouse or eligible children) may be required to sign a subrogation agreement or a lien before any benefit payments will be made by the Fund.

In addition, if you receive payments from or on behalf of the responsible person, you must reimburse the Fund for payments it has made to you or on your behalf. You must reimburse the Fund, regardless of whether the total amount of the recovery is less than the actual loss and even if the third party does not admit liability, itemize the payments, or identify payments as medical expenses. You cannot reduce the amount of the Fund's reimbursement to pay for attorney fees incurred to obtain payments from the responsible person. If you fail or refuse to reimburse the Fund, or to sign a subrogation lien, then the Fund may suspend future payments to you, or offset future payments to you, or recover from the providers money paid to them until the subrogated portion is reimbursed to the Fund, or take all of the foregoing actions until it is made whole. In addition, the Fund may bring a court action against you to obtain reimbursement. Before entering into a settlement agreement with the third party, or his or her insurance company, you must notify the Fund and obtain written consent. You must obtain consent because the Fund shall have the right to recover the amount if advanced on your behalf for medical care.

When Motor Vehicle or No-Fault Insurance Provides Coverage

This provision is expressly intended to avoid the possibility that this Fund will be primary to coverage that is available under motor vehicle or no-fault insurance.

This plan is secondary to:

- Coverage provided under any "no-fault" provision of any motor vehicle insurance statute or similar statute
  and
- Coverage provided under motor vehicle insurance which provides for health insurance protection, even if you (or your spouse or your eligible children) select coverage under the motor vehicle insurance as secondary

Benefits Payable On Behalf Of a Deceased Member

With respect to any benefits payable to a deceased member upon his/her date of death, or with respect to death benefits payable by virtue of the death of the member where the member's designated beneficiary has predeceased the member and a successor has not been designated, or where a member has not designated a beneficiary, then these benefits will be made payable to the first surviving class of the following classes of successive preference beneficiaries:

The covered member's:

- Surviving spouse;
- If no surviving spouse, to the surviving children equally, **or**
- If no surviving children, to the covered member's estate.

Additional Coordinating Rules

In addition to the coordination rules outlined in this section, the Fund will also apply the following rules in determining the order in which various coverages will pay:

- If a plan has no coordination of benefits rules or has rules which do not comply with applicable law, that plan will be considered to pay its benefits first and the Fund will pay only as if the other plan had paid fully according to its terms.
- A plan that covers a person as an active employee (or dependent of an active employee) will be considered to pay before a plan that covers a person as a laid off or retired employee (or dependent of such an employee). If the other plan does not have this rule, this rule will not apply.
- If the coordination of benefits rules mentioned in this section fail to determine the order of payment of benefits, the plan that has covered the person longest will be considered as paying benefits first.

How is the Security Benefits Fund Administered?

The CWA Local 1180 Security Benefits Fund is administered by a Board of Trustees composed of six Trustees. The address and principal place of business of the Fund is 6 Harrison Street, New York, New York 10013-2898.

The telephone number is 1-212-966-5353. The fax number is 1-212-219-2450.

How Are Contributions Made?

The CWA Local 1180 Security Benefits Fund is maintained through collective bargaining agreements between various public employers and the Communications Workers of America AFL-CIO on behalf of Local 1180. These collective bargaining agreements provide that annual contributions to the Fund be made on behalf of each employee in a covered title.

How Are Benefits Provided?

Benefits are provided from the Fund's assets which are accumulated under the provisions of the collective bargaining agreement and the Trust Agreement for the purpose of providing benefits to covered members and defraying reasonable administrative expenses. Some of the benefits are provided through insurance policies; some are self-insured.

Members of the Board of Trustees include:
Gloria Middleton, Chairperson
Gina Strickland
Gerald Brown
Robin Blair-Batte
Lourdes Acevedo
Arthur Cheliotes

The Fund Administrator is Damien Arnold.

YOUR CONTINUATION COVERAGE (COBRA)

This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the rest of this Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a thirty (30)-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA continuation coverage only covers the Plan's Prescription Drug, General Medical Reimbursement, Dental, Mental Health, Optical, Hearing Aid, Podiatry, and Birth/Adoption Benefits. It does not include the Education Benefit, the Legal Services Benefits, Life Insurance or Disability Benefits.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this document. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the

qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee/member, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee/member, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-member dies;
- The parent-members' hours of employment are reduced;
- The parent-member's employment ends for any reason other than his or her gross misconduct;
- The parent-member becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred**.** The Employer has the responsibility to notify the Fund Office of the Participant's loss of coverage as a result of death, termination of employment, or reduction in hours of employment or Medicare entitlement (under Part A, B or both). For all other qualifying events, **YOU MUST NOTIFY THE FUND WHEN A QUALIFYING EVENT OCCURS WITHIN SIXTY (60) DAYS OF THE EVENT. You must provide this notice to the Fund Administrator <u>in writing.</u>**

Please include the following information with your notice:

- Your name
- The names of your dependents

- Your social security number and the Social Security numbers of your dependents.
- Your address
- The nature and date of occurrence you are reporting to the Fund.

You must send this notice to: Fund Administrator, CWA Local 1180 Security Benefits Fund, 6 Harrison Street, New York NY 10013-2898.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for eighteen (18) months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of thirty-six (36) months of coverage.

There are also ways in which this eighteen (18)-month period of COBRA continuation coverage can be extended:

Disability extension of eighteen (18)-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional eleven (11) months of COBRA continuation coverage, for a maximum of twenty-nine (29) months. The disability would have to have started at some time before the sixtieth (60^{th}) day of COBRA continuation coverage and must last at least until the end of the eighteen (18)-month period of COBRA continuation coverage.

Second qualifying event extension of eighteen (18)-month period of continuation coverage

If your family experiences another qualifying event during the eighteen (18) months of COBRA continuation coverage, the spouse and dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if the Plan is properly notified about the second qualifying event. This

extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

How Do I Elect COBRA Continuation Coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. This means that COBRA Continuation Coverage may be elected for some members of the family but not others (including one or more dependents even if the covered member's spouse does not elect it), as long as those for whom it is chosen were covered by the Fund on the day before the qualifying event (employment ends, death of covered member, divorce, etc.) that led to the loss of regular coverage under the Fund. A parent may elect or reject COBRA coverage on behalf of dependent children living with him or her. If you do not indicate on whose behalf you are electing COBRA Continuation Coverage, the Fund will act as if you have not elected COBRA for all family members who were receiving active coverage. Within 14 days after the Fund Administrator receives notice that a qualifying event has occurred, the Fund Administrator will provide you with a notice of your right to elect continuation coverage.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone

numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

IMPORTANT: ***When electing COBRA Continuation Coverage, you MUST complete the COBRA Continuation of Coverage "ELECTION FORM" by checking off the appropriate boxes following the Election Form instructions and returning the form to the Fund Office. You must mail it to the address shown on the form. The completed form must be mailed no later than 65 days from the post-marked date of the Election Form. If you do not submit a completed Election Form by this date, you will lose your right to elect continuation coverage.***

A check for the first month's payment should be included with the Election Form. You will not be billed separately for the amount due for the period prior to the time your request for COBRA Continuation Coverage is received. ***If the check is not included with the Election Form, you will have 45 days from the date you return your election form to make this payment, but no benefits will be paid or covered services provided until your payment is received. Even though you have 45 days to make your initial payment, it is advisable to include the premium payment together with the Election Form in order to receive prompt payment of claims. You need to remit payment for any complete months for which you have coverage.*** All future payments are due no later than 30 days after the beginning of the month. Remember that you will **not** receive a monthly bill. The premium is subject to change every 12 months. The costs are fixed for the period January 1 to December 31. All checks must be made payable to the CWA Local 1180 Security Benefits Fund.

How Do I Add COBRA Coverage for New Dependents?

If while you are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of your COBRA Continuation Coverage, provided the spouse or child is eligible for coverage under the Fund's rules. You must notify the Fund Office in writing within 30 days of the marriage, birth, adoption or placement for adoption in order to add the child or spouse to your coverage. Adding a child or spouse may cause an increase in the amount you must pay for COBRA Continuation Coverage. If COBRA coverage ceases for you before the end of the maximum 36-month COBRA coverage period, COBRA coverage also will end for your newly added spouse. However, COBRA coverage can continue for your newly added newborn child, adopted child, or child placed for adoption until the end of the maximum COBRA coverage period if the required premiums are paid on time. Check with the Fund for more details on how long COBRA coverage can last.

What If My Spouse or Dependents Lose Other Health Insurance Coverage?

If, while you are enrolled for COBRA Continuation Coverage, your spouse or dependent loses coverage under another group health plan or other health insurance coverage, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible for but not enrolled for coverage under the terms of this Fund. You must notify the Fund Office in writing within 30 days of the termination of the other coverage in order to add your dependents.

How Much Does COBRA Continuation Coverage Cost?

By law, any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated covered members and families plus an additional 2%. The costs are fixed for the period January 1 to December 31, but are likely to change annually.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. More information is also available at https://www.doleta.gov/tradeact/

When And How Must Payment For Continuation Coverage (COBRA) Be Made?

If you elect Continuation Coverage, you do not have to send payment when you apply. However, no benefits will be paid until the initial payment is received. The initial payment for COBRA Continuation Coverage, retroactive to the date your active coverage terminated, is due forty-five (45) days after COBRA Continuation Coverage is actually elected (*i.e.*, the date the Election Form is postmarked, if mailed). If this first payment is not made within that 45-day period, COBRA Continuation Coverage will not take effect and you will lose all Continuation Coverage rights under the plan. Your first payment must cover the cost of Continuation Coverage from the time your coverage under the Plan would otherwise have terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is

enough to cover this entire period. You may call the Fund Office to confirm the correct amount of your first payment. Your first payment for Continuation Coverage should be sent to:

Fund Administrator
CWA Local 1180 Security Benefits Fund
6 Harrison Street
New York, NY 10013-2898

After you make your first payment for Continuation Coverage, you must pay for Continuation Coverage for each subsequent month of coverage. Payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. Payment is considered made when it is postmarked. While payment within the grace period will maintain your coverage, no claims incurred in that month will be paid until the premium is received.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to Continuation Coverage under the Plan.

You must notify the Fund Office immediately *in writing* at the above address and fax number if any of the following events occur while you are receiving COBRA:

- you marry
- you divorce or legally separate
- your spouse or dependent loses other health coverage
- you have a new dependent child
- a dependent cease to be a "dependent child" as that term is defined by the Fund

Keep your Plan informed of address changes

To protect your family's rights, let the Fund Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Administrator.

Plan contact information

Fund Administrator
CWA Local 1180 Security Benefits Fund
6 Harrison Street
New York, NY 10013-2898
T: 212-966-5353
F: 212-219-2450

YOUR PRIVACY

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, the Fund is required to maintain the privacy of PHI about you, provide you with a notice of the Fund's legal duties and privacy practices with respect to PHI, and to comply with the terms of the Fund's current notice of privacy practices.

Section 1: Purpose of This Notice and Effective Date

THIS NOTICE DESCRIBES HOW HEALTH/MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice and any policies, procedures and forms to which it refers, may be obtained on the Fund's web site at https://www.cwa1180.org/benefits.

This Privacy Notice applies to the offices of the CWA Local 1180 Security Benefits Fund (the "Fund") and the medical and prescription drug services that the Fund provides through Capital Rx, optical coverage, and dental coverage and services through other business associates of the Fund.

Effective date: The effective date of this Notice is March 2, 2020.

This Notice is required by law: The Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Fund's uses and disclosures of Protected Health Information (PHI);
- Your rights to privacy with respect to your PHI;
- The Fund's duties with respect to your PHI;
- Your right to file a complaint with the Fund and/or with the Secretary of the United States Department of Health and Human Services (HHS); and
- The person or office you should contact for further information about the Fund's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) means all individually identifiable health information related to an individual's past, present or future physical or mental health condition, or to payment for health care services. PHI includes information maintained by the Fund in oral, written, or electronic form.

When the Fund May Disclose Your PHI

Under the law, the Fund may disclose your PHI without your consent or authorization, or without giving you the opportunity to agree or object, in the following cases:

- ***At your request.*** If you request it, the Fund is required to give you access to certain of your PHI in order to allow you to inspect and/or copy it.
- ***When required by applicable law.***
- ***As required by HHS.*** The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.
- ***Public health purposes***. To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
- ***Health oversight activities***. To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
- ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or court-ordered discovery request.
- ***Law enforcement health purposes***. When required for law enforcement purposes (for example, to report certain types of wounds).
- ***Law enforcement emergency purposes***. For certain law enforcement purposes, including:
  - identifying or locating a suspect, fugitive, material witness or missing person, and
  - disclosing information about an individual who is or is suspected to be a victim of a crime.
- ***Determining cause of death and organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other

authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

- ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.
- ***Research.*** For research, subject to certain conditions.
- ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is to a person reasonably able to prevent or lessen the threat, including to the target of the threat.
- ***Workers' compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- ***For treatment, payment or health care operations.*** The Fund and its business associates will use PHI in order to carry out:
  - Treatment,
  - Payment, and
  - Health care operations.

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Fund may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, Fund reimbursement, and utilization review and pre-authorizations).

For example, the Fund may tell a doctor whether you are eligible for coverage, or what percentage of the bill will be paid by the Fund. If we contract with third parties to help us with payment operations, such as a physician who reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."

Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Fund may use information about your claims to refer you (if appropriate) to a disease management program or to a healthy pregnancy program; or to project future benefit costs or audit the accuracy of our claims processing functions. The Fund does not use or disclose genetic information for any purpose, and it will not under any circumstances use or disclose genetic information for underwriting purposes.

- ***Disclosure to the Fund's Trustees.*** The Fund will also disclose PHI to the Fund Sponsor, which is the Board of Trustees of the CWA Local 1180 Security Benefits Fund, for purposes related to treatment, payment, and health care operations. The Fund has amended its Plan Document to permit this use and disclosure, as required by federal law. For example, the Fund may disclose information to the Board of Trustees to allow them to decide an appeal.

In addition, the Fund may disclose "summary health information" to the Board of Trustees for obtaining premium bids or for modifying, amending or terminating the Fund's group health plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor such as the Board of Trustees has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with federal privacy rules.

Except as otherwise indicated in this Notice, uses and disclosures of your PHI will be made only with your written authorization, which is subject to your right to revoke your authorization.

When the Disclosure of Your PHI Requires Your Written Authorization

Although the Fund does not obtain psychotherapy notes, it must generally obtain your written authorization in order to use or disclose psychotherapy notes about you. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Although the Fund does not sell PHI or use it for marketing purposes, it must obtain your written authorization before it may sell your PHI or use it for marketing purposes.

When You Can Object and Prevent the Fund from Using or Disclosing PHI

The Fund will disclose to your spouse/domestic partner the portion of your PHI that is directly relevant to your spouse or domestic partner's involvement with your care or payment for that care, unless you notify the Fund's Privacy Official in writing (contact information below) that you object to our sharing that information with your spouse or domestic partner. In an emergency, or if you become incapacitated, the Fund may also disclose your PHI to other family members, relatives or close friends under certain circumstances as permitted by the Fund's procedures, unless you have previously notified the Fund's Privacy Official in writing that you do not want your information shared under those circumstances.

If you want the Fund to disclose your PHI routinely to persons other than your spouse or domestic partner (e.g., to your children) then you must complete an authorization form designating that person as authorized to receive your PHI. Any authorization you make can be revoked by you at any time. Authorization and revocation forms are available from the Privacy Official at the Fund Office.

Other Uses or Disclosures

The Fund may contact you to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Section 3: Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

- Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
- Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. The form is available from the Fund's Privacy Official:

Damien Arnold, Fund Administrator
CWA Local 1180, Security Benefit Funds
6 Harrison Street
New York, NY 10013

You May Request Confidential Communications

The Fund will accommodate your reasonable request to receive communications of PHI confidentially by alternative means or solely at alternative locations (e.g., mailing information somewhere other than to your home address) where the request includes a statement that disclosure using the Fund's regular communications procedures could endanger you.

You or your personal representative will be required to complete a form to request confidential communications of your PHI. The form is available from the Fund's Privacy Official.

You May Inspect and Copy Your PHI

You have a right to inspect and to obtain a copy of your PHI contained in a "designated record set," defined below, for as long as the Fund maintains the PHI in a designated record set.

The Fund must provide the requested information within thirty (30) days if the information is maintained on site at the Fund's offices, or within sixty (60) days if the information is maintained offsite. A single thirty (30) day extension is allowed if the Fund is unable to meet the deadline.

You or your personal representative will be required to complete a form to request access to the PHI that the Fund maintains in a designated record set. The Fund may charge a reasonable fee to provide this information to you. Requests for access to PHI should be made to the Fund's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial setting forth the reason for the denial, a description of how you may exercise your review rights, and a description of how you may file a complaint with the Fund and/or HHS.

Designated Record Set: means the enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Fund about you, or other information used in whole or in part by or for the Fund to make decisions about you. Information used by the Fund for quality control or peer review analyses, and not used to make decisions about you, is not part of a designated record set.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set that is maintained by or for the Fund for as long as the PHI is maintained in the designated record set, subject to certain exceptions. See the Fund's "Right to Amend" Policy (available on request from the Fund's Privacy Official) for a list of exceptions.

The Fund has sixty (60) days after receiving your request to act on it. The Fund is allowed a single thirty (30)-day extension if it is unable to meet the sixty (60)-day deadline. If the Fund denies your request in whole or part, the Fund must provide you with this denial in writing and explain in it the reason that your request is not being granted. You or your personal representative may then submit a written statement disagreeing with the denial. Your statement will be included with any future disclosure of the PHI at issue.

You should make your request to amend PHI to the Fund's Privacy Official. You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of Certain of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of certain disclosures by the Fund of your PHI. We do not have to provide you with an accounting of disclosures related to treatment, payment for treatment, or health care operations, or disclosures made to you or authorized by you in writing.

The Fund has sixty (60) days to provide the accounting. The Fund is allowed an additional thirty (30) days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within any twelve (12)-month period, the Fund will charge a reasonable, cost-based fee for each accounting the Fund provides after the first accounting.

Your Personal Representative

You may exercise your rights under this Policy through a personal representative. Except as provided below in connection with parents of un-emancipated minor children, or in certain emergency medical situations, your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives. For example, the Fund will consider a parent or guardian as the personal representative of an un-emancipated minor, unless applicable state law requires otherwise. Un-emancipated minors may, however, request that the Fund restrict information that goes to family members, as described more fully at the beginning of Section 3 of this Notice. Certain other documentation may be used, including official legal documentation that demonstrates that under relevant state law, the representative is authorized to make health care decisions for you (e.g., appointment as a legal guardian, or a health care power of attorney).

Information that Does Not Identify You

This Notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

Section 4: The Fund's Duties

Maintaining Your Privacy

The Fund is required by law to maintain the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information, and follow the terms of this Notice until such time as it may be amended. We are also required to notify you if your protected health information has been breached.

This Notice is effective beginning on May 8, 2015. However, the Fund reserves the right to change its privacy practices and this Notice, and to apply the changes to all the PHI that the Fund uses or maintains, including PHI that the Fund received prior to the date that it changed its privacy practices.

If a privacy practice is materially changed, a revised version of this Notice will be posted prominently on the Fund's website within sixty (60) days of the effective date of the material change, which may pertain to:

- The uses or disclosures of your PHI;
- Your individual rights;
- The duties of the Fund; or
- Other privacy practices stated in this notice.

A written copy of the most current version of this Notice is available to you at any time upon request from the Fund's Privacy Official. Any other person, including dependents of named participants, may also obtain a copy of this Notice at any time upon request from the Fund's Privacy Official.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI, or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of

PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to you;
- Disclosure or uses made pursuant to an authorization;
- Disclosures made to the Secretary of the United States Department of Health and Human Services, pursuant to its enforcement activities under HIPAA;
- Uses or disclosures required by law; and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

Section 5: Your Right to File a Complaint

If you believe that your privacy rights have been violated, you may file a written complaint with the Fund in care of the Fund's Privacy Official. The Fund will not retaliate against you for filing a complaint.

You may also file a complaint with:

Office for Civil Rights
U.S. Department of Health & Human Services
Jacob Javits Federal Building
26 Federal Plaza, Suite 3312
New York, NY 10278

Section 6: If You Need More Information

If you have any questions regarding this Notice or the subjects addressed in it, please contact the Privacy Official at the Fund Office.

Section 7: Conclusion

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find the HIPAA rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the Fund's obligations under the regulations. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations.

YOUR LIFE AND SUPPLEMENTAL HEALTH BENEFITS

Dear Member,

The life and supplemental health benefits described in this section are provided through the CWA Local 1180 Security Benefits Fund. This Fund is a trust, separate and distinct from the trust maintained for the Legal Benefits Fund, the Retirees Benefits Fund, the Education Fund, and the Members' Annuity Fund.

Sincerely,

Board of Trustees
CWA Local 1180 Security Benefits Fund

CWA Local 1180 Security Benefits Fund

6 Harrison Street, 3rd Floor
New York, NY 10013
(212) 966-5353, Out-of-area (888) 966-5353
www.cwa1180.org

Board of Trustees

Gloria Middleton, Chairperson
Gina Strickland
Gerald Brown
Robin Blair-Batte
Lourdes Acevedo
Arthur Cheliotes

Fund Administrator

Damien Arnold

Counsel

Spivak Lipton LLP

Consultants

Policy Research Group, LLC

Certified Public Accountant

Gould, Kobrick & Schlapp, PC

APPLYING/CLAIMING YOUR SUPPLEMENTAL HEALTH BENEFITS

CLAIMING YOUR SUPPLEMENTAL HEALTH BENEFITS

The procedure for claiming your General Medical Reimbursement, Dental, Vision, Prescription Drug, Hearing Aid, Mental Health and Podiatry Benefits are set forth under the heading "Getting Your Benefit" in each section below describing each type of benefit. The procedures for the determination of claims and appeals for all supplemental health benefits are described below in the "Claims and Appeals" section.

Please pay special attention to the time limits for filing your claims.

IN GENERAL, ALL SUPPLEMENTAL HEALTH BENEFITS MUST BE CLAIMED NO LATER THAN NINETY (90) DAYS AFTER THE SERVICE IS RECEIVED. CLAIMS FILED AFTER THAT DATE WILL BE DENIED.

If you require claim forms, visit or call the Fund Office at:

CWA Local 1180 Security Benefits Fund
6 Harrison Street
New York, NY 10013-2898
1-212-966-5353
1-888-966-5353 (out-of-area)

You can also download Claim Forms by logging into your member portal at: www.cwa1180.org

When Benefits May Be Withheld or Denied

Recovery of Overpayments or Mistaken Payments

If you received benefits from the Fund to which you are not entitled, on your behalf or on behalf of your spouse or children, you are required to make restitution of the overpayment or mistaken payment promptly.

If you fail to do so, the Fund will offset any future benefit payments by the amount of the mistaken payment until full restitution of the amount of the mistaken payment or overpayment is made.

Right To Audit and Verify Claims

Before or after paying any benefits, the Fund reserves the right to audit and verify any claims that are submitted to the Fund.

CLAIMS AND APPEALS

Request for Review of Denial of Claim

If your claim for supplemental health benefits is denied and you disagree with the decision, you may request a review of your claim.

The procedures for claiming each supplemental benefit are set forth under the heading "Getting Your Benefit" in each section below describing each type of benefit. Except where the service provider or the organization administering the benefit submits the claim, all initial claims for benefits by a Member or Beneficiary (hereinafter for purposes of the Section the "Claimant") under the Plan must be in writing and sent to the Fund Office, to the attention of the Trustees.

Determination of Claims

The procedures for determination of claims differ depending on whether it is a post-service claim, a pre-service claim, an urgent care claim, or a concurrent care claim.

Post-Service Claims

A **post-service claim** is a claim for benefits that are not conditioned on advance approval. Typically, a post-service claim is a claim made after you have received the medical care to which the claim relates. In the case of pharmacy and some dental benefits, the organization administering the benefit (Capital Rx, Daniel H. Cook Associates, or Dentcare/Health Plex, for example) and/or the Fund Office will make the decision on the claim and notify you thereof within 30 days. On all other post-service claims, the Fund Office will make a decision on the claim and notify you thereof within 30 days. If the Fund Office determines that matters beyond the Fund's control require an extension of time for processing the claim, the 30-day period may be extended once for up to 15 days, and the Fund Office will notify you in writing prior to the termination of the initial 30-day period. Such notice will include an explanation of the

circumstances requiring an extension of time, and the date by which the Fund expects to render its decision. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed, and you will be have 45 days from receipt of the notice to provide the specified information. Until you supply this additional information, the normal period for making a decision on the claim will be suspended.

Pre-Service Claims

A **pre-service claim** is a claim for a benefit that is conditioned, in whole or in part, on approval of the benefit in advance of obtaining medical care. In the case of pharmacy and some dental benefits, the organization administering the benefit and/or the Fund Office will make the decision on the claim and notify you thereof within 15 days. On all other pre-service claims, the Fund Office will make a decision on the claim and notify you thereof within 15 days. If the Fund Office determines that matters beyond the Fund's control require an extension of time for processing the claim, the 15-day period may be extended once for up to an additional 15 days, and the Fund Office will notify you in writing prior to the termination of the initial 15-day period. Such notice will include an explanation of the circumstances requiring an extension of time, and the date by which the Fund expects to render its decision. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed, and you will be have 45 days from receipt of the notice to provide the specified information. Until you supply this additional information, the normal period for making a decision on the claim will be suspended.

Urgent Care Claims

An **urgent care claim** is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

(A) could seriously jeopardize your life, health, or ability to regain maximum function, or,

(B) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In the case of pharmacy and some dental benefits, the organization administering the benefit and/or the Fund Office will make the decision on the claim and notify you thereof within 72 hours, unless you fail to provide sufficient information to determine whether, and to what extent, benefits are covered or payable under the Plan. On all other urgent care claims, the Fund Office will make a decision and notify you thereof within 72 hours, unless you fail to provide sufficient

information to determine whether, and to what extent, benefits are covered or payable under the Plan. In the event of a failure to provide sufficient information as described above, the Fund Office shall notify you within 24 hours of receipt of the claim of the specific information necessary to complete the claim. You will have not less than 48 hours to provide the specified information. The Fund Office will notify you of its decision on the claim within 48 hours of the earlier of (a) its receipt of the specified information or (b) the deadline it gave you for providing the specified information.

Concurrent Care Claims

A **concurrent care claim** is claim concerning an ongoing course of treatment to be provided over a period of time or number of treatments, where the Fund has already approved that course of treatment. If, after such approval, the Fund decides to reduce or terminate the course of treatment (other through plan amendment or termination), the Fund Office will notify you sufficiently in advance of the reduction or termination to allow you to appeal and obtain a decision on appeal before the reduction or termination takes effect. In the case of dental and pharmacy benefits, the vendor and/or the Fund Office will make the decision on the claim. If you request to extend the course of treatment and the request is an urgent care claim, the Fund Office will notify you of its decision on the request within 24 hours, provided that the request is made at least 24 hours prior to expiration of the prescribed period of time or number of treatments.

If Your Claim Is Denied

You will be provided with written notice if your claim is denied (whether denied in whole or in part). This notice will include:

- information sufficient to identify the claim involved
- the specific reason(s) for the determination
- a description of the Plan's standard, if any, that was used in denying the claim
- reference(s) to the specific Plan provision(s) on which the determination is based
- a description of any additional material or information necessary to perfect the claim and an explanation of why the material or information is necessary
- a description of the appeal procedures and applicable time limits
- a statement of your right to bring a civil action following an adverse benefit determination on appeal.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the claim, you will receive either a copy of such rule or a statement that it will be provided to you on request free of charge.

If the denied claim was an urgent care claim, you will be provided with a description of the expedited review process applicable to such claims. The notice of denial of an urgent care claim may be provided orally within the applicable time frame, followed by written notice within 3 days.

BOARD APPEAL PROCEDURES

These procedures apply to all appeals to the Board of Trustees concerning supplemental health benefits, but they apply in different ways depending on the type of benefit.

For dental benefits, as explained below, your initial appeal must be submitted to the vendor through which the benefits are provided (such as Dentcare or EmblemHealth, for example), and if that appeal is denied, you have the option of submitting an additional, voluntary appeal to the Board of Trustees pursuant to the procedures set forth in this section and subject to the Voluntary Appeal Provisions described below.

For all other supplemental health benefits, the procedures described in this section apply to your initial appeal of a benefit claim, which must be submitted to the Board of Trustees.

The Board appeal process works as follows:

- You must submit your appeal of an adverse benefit determination within 180 days of receiving notice that your claim was denied. You may submit written comments, documents, and other information relating to the claim relating to the claim within the 180-day period following the date of the decision that you are appealing.

- You have the right to review, free of charge, documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Fund Office in making its decision; if it was submitted, considered or generated in connection with your claim (regardless of whether it was relied upon in deciding to deny the claim); or if it demonstrates compliance with the Fund Office's administrative processes for ensuring consistent decision making; or if it constitutes a statement of Plan policy regarding the denied treatment option or benefit for your diagnosis (regardless of whether it was relied upon in deciding to deny the claim).

- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund Office on your claim, without regard to whether their advice was relied upon in deciding your claim.

- Your claim will be reviewed by the Board of Trustees**,** which is not subordinate to (and shall not afford any deference to) the person who originally made the adverse benefit determination. The Board's decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

- You will also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before a claim on appeal is denied based on a new or additional rationale, you will receive a statement of the rationale, free of charge.

- For urgent care claims, you may provide notice of your appeal orally and all necessary information shall be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.

Decision on Appeal

Timing

For post-service claims, a decision on an appeal will ordinarily be made at the next regularly scheduled quarterly meeting of the Board of Trustees following receipt of your appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on your appeal has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

For pre-service claims, the Board shall decide on the appeal and provide notice of its decision to you within 30 days after receipt of your appeal.

For urgent care claims, the Board shall decide on the appeal and provide notice of its decision to you within 72 hours after receipt of your appeal.

For concurrent care claims, an appeal concerning reduction or termination of an approved course of treatment shall be decided, and notice of the decision shall be provided, before the reduction or termination takes effect. Appeals of other concurrent care claim denials shall be governed by the procedures above, depending on whether the claim is post-service, pre-service, or urgent.

Form and Contents of Notice

The decision on any appeal of a claim will be given to you in writing. The notice of a denial of an appeal will include:

- information sufficient to identify the claim involved
- the specific reason(s) for the determination

- a description of the Plan's standard, if any, that was used in denying the claim
- reference(s) to the specific Plan provision(s) on which the determination is based
- a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- a statement of your right to bring a civil action following an appeal
- the statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If an internal rule, guideline or protocol was relied upon by the Plan in denying the appeal, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

Dental Benefit Appeals

If you wish to appeal a dental benefit determination, you must submit the appeal directly to the vendor through which the benefits are provided, pursuant to the following procedures:

If you wish to appeal a benefit determination by **Dentcare**, appeals must be made within 180 calendar days after you receive notice of the adverse determination. If you believe an expedited appeal is warranted due to a problem that seriously affects your health, or any other urgent matter, you may request an expedited appeal by calling Dentcare at 1-800-468-0600. If you wish to appeal the determination with a standard appeal, you may request a standard appeal in person, in writing, or by telephone at 1-800-468-0600 (TTY/TDD: 1-800-662-1220). Written appeals should be sent to:

Dentcare Delivery Systems, Inc.
Attn: Appeals Unit
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553

Expedited appeals will be determined within 72 hours from receipt of the appeal or two business days of receipt of the necessary information to conduct an appeal. Dentcare will acknowledge your standard appeal request within 15 calendar days of receipt. This acknowledgment will include the name, address and telephone number of the person handling your appeal, and indicate what information, if any, must be provided. If your appeal related to a preauthorization request, Dentcare will decide the appeal within 30 days of receipt of the appeal request. If your appeal related to a retrospective claim, Dentcare will decide the appeal within 60 days of receipt of the appeal request. Dentcare's failure to render a determination of your appeal within 60 calendar days of receipt of the necessary information for a standard appeal will be deemed a reversal of the initial adverse determination.

If you wish to appeal a benefit determination on dental benefits administered by **Daniel H. Cook Associates**, appeals must be made within 180 calendar days after you receive notice of the adverse determination. You must fully set forth the basis of your appeal and address your appeal to:

CWA Local 1180 Active
c/o Daniel H. Cook Dental Assoc., Inc.
253 West 35th Street, 12th Floor
New York, NY 10001

If you wish to appeal a decision by **EmblemHealth**, you may appeal it by writing to:

GHI, Complaints and Audits Unit
P.O. Box 2838
New York, NY 10116-2838

You may also call GHI Customer Service at 1-800-624-2414 or visit their offices at 55 Water Street, New York, NY 10041. You must submit your grievance request within 180 days of the notice you are appealing. Emblem will acknowledge your grievance within 15 calendar days. They will respond within 30 calendar days of receiving your grievance.

If you wish to appeal a benefit denial by **Empire BlueCross BlueShield**, you can file a grievance/appeal to Empire by phone at (877) 606-3338 or in writing. You have up to 180 calendar days from when you received the decision you are asking Empire to review to file the grievance. Empire will mail an acknowledgment letter within 15 business days. Empire will notify you of its determination on expedited/urgent grievances within 72 hours of receipt of your grievance. Empire will notify you of its determination on pre-service grievances (a request for a service or treatment that has not yet been provided) within 30 calendar days of receipt of your grievance. Empire will notify you of its determination on post-service grievances (a claim for a service or a treatment that has already been provided) within 60 calendar days of receipt of your grievance.

If your appeal is denied by Dentcare, Daniel H. Cook Associates, EmblemHealth or Empire Blue Cross BlueShield, you **may** submit an appeal of the denial (also known as an "adverse benefit determination") in writing to the Board of Trustees within 180 days of the date of the decision.

This is a voluntary level of appeal, subject to the following Voluntary Appeal Provisions:

- Any statute of limitations or other defense based on timeliness is tolled during the time that any such voluntary appeal is pending;

- The Plan waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to this voluntary level of appeal;
- You may elect to submit a benefit dispute to such voluntary level of appeal only after exhausting the appeal procedures provided by Dentcare, Daniel H. Cook Associates, EmblemHealth or Empire BlueCross BlueShield;
- The Plan will provide upon request, sufficient information relating to the voluntary level of appeal to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that your decision as to whether to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the plan and information about the applicable rules, your right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process; and
- No fees or costs are imposed on you as part of the voluntary level of appeal.

If you choose to submit the voluntary appeal, your appeal will be reviewed and decided by the Board pursuant to the procedures described in the "Board Appeal Procedures" section above.

YOUR LIFE INSURANCE & DISABILITY BENEFITS

What Are The Life Insurance Benefits?

The Fund provides a $5,000 life insurance benefit ($1,000 for covered part-time employees) to your designated beneficiary if you die from any cause either on or off the job – while you are insured. This benefit is underwritten by a life insurance company, Amalgamated Life.

http://www.amalgamatedlife.com
Amalgamated Life
333 Westchester Ave
White Plains, NY 10604
Attention: Life Claims
(914) 367-5000

How Do You Designate A Beneficiary?

You can name anyone you want as a beneficiary by filing a Designation of Beneficiary card with the Fund Office. You may also change your beneficiary at any time by filing a new card with the Fund Office.

How Does Your Beneficiary File A Claim?

Your beneficiary must contact the Fund Office, obtain a claim form from Amalgamated Life and file it within a reasonable period of time. After filling out the form, your beneficiary must return it to Amalgamated Life with one certified copy (with a raised seal) of your death certificate.
If no beneficiary card is on file or if your named beneficiary is not alive, the person claiming the life insurance benefit must complete an affidavit of survivorship form.
If there is no beneficiary, your benefits will be paid to your estate. If your beneficiary is a minor, proof of guardianship of the property of the minor must be submitted before any claim can be paid.

What If You Become Disabled?

If you become totally and permanently disabled before age sixty (60), your insurance will continue at no cost to you for as long as you are disabled. You have to submit proof of your disability to the insurance company periodically in order for your life insurance to continue.

What Are The Conversion Privileges?

If your coverage by the Fund terminates, you may convert the life insurance to an individual policy within thirty-one (31) days without medical examination. The amount of your converted policy cannot be more than the amount provided under the group plan. You may choose any type of individual policy then being written by the insurance company except term insurance. The premium cost to you will be based upon your class of risk and your age at the time of conversion. Applications for conversion are available by contacting Amalgamated Life. If you die within the thirty-one (31) day conversion period, the insurance company will pay the same life insurance benefits as though you were still insured through the Fund.

What Are The Accidental Death and Dismemberment Benefits?

Accidental death and dismemberment benefits are payable to you or your beneficiary if you die or suffer a loss of your hands or feet at or above the wrist of ankle joint or a total and permanent loss of sight.

Benefits are paid only if the loss is the direct result of any injury caused by an accident. The loss must occur within thirty (30) days after the accident.

	Full-time Employees	Part-time Employees
• Loss of life	$5,000	$1,000
• Loss of two limbs, sight of both eyes **or** Loss of one limb **and** sight of one eye	$5,000	$1,000
• Loss of one limb **or** sight of one eye	$2,500	$500

No more than the full benefit amount will be paid for all losses resulting from any one accident.

How Do You File A Claim?

If you suffer dismemberment, you must get a claim form from Amalgamated Life and file it within ninety (90) calendar days of your loss. Claims submitted after the ninety (90) day limit will be denied.

If you die, your beneficiary must contact the Fund Office, obtain a claim form from Amalgamated Life and file it within ninety (90) calendar days of your death or the claim will be denied. After filling out the form, your beneficiary must return it to Amalgamated Life with one certified copy (with raised seal) of your death certificate.

If no beneficiary card is on file or if your named beneficiary is not alive, the person claiming your benefits must complete an affidavit of survivorship form.

If there is no beneficiary card on file and no person is entitled to your benefit, your benefit will be paid to your estate. If your beneficiary is a minor, proof of guardianship of the property of the minor must be submitted before any claim can be paid.

What Are The Limitations To Your Accidental Death And Dismemberment Insurance?

Benefits will not be paid if the loss is the result of:

- Suicide or an intentionally self-inflicted injury;
- Ptomaine poisoning;
- Bacterial infection (except pus-forming infection resulting from an accidental wound);
- Disease, bodily or mental infirmity;
- Participating in the commission of a crime; or

- War or any act of war or service in any military, navel or air force of any country while that country is engaged in war or police action as a member of any military, naval or air organization.

Are There Conversion Privileges?

No. If your coverage terminates, you cannot convert this insurance to an individual policy.

What Are The Weekly Accident and Sickness Benefits?

If you become disabled as a result of a non-occupational accident or sickness and cannot perform your job, you are entitled up to $250 a week for a maximum of thirteen (13) weeks or $50 a day for partial weeks of disability for up to sixty-five (65) working days. The Weekly Accident and Sickness Benefits begin after you have used up all the paid sick leave (including any extensions of paid sick leave granted by your employer) to which you are entitled. Your pay stub showing a zero sick leave balance or your employer's statement showing no remaining sick leave eligibility is sufficient to demonstrate satisfaction of this eligibility requirement.

There is a seven (7) day waiting period for this benefit, unless you are hospitalized. In other words, once you have used up your paid sick leave (including any extensions of paid sick leave granted by your employer), your Weekly Accident and Sickness Benefits will begin no sooner than your eighth (8^{th}) consecutive day of disability or the day you become hospitalized, whichever is earlier. You must provide documentation of the disability from a licensed physician on the eighth (8^{th}) consecutive day of disability or from the hospital on the first (1^{st}) day of disability.

You must see a physician during the first week of your disability to be eligible for Weekly Accident and Sickness Benefits. If you see a physician at a later date, your benefits will begin as of the later date.

NOTE: Weekly accident and sickness benefits are taxable income.

What Are The Eligibility Requirements?

You must meet the following requirements before benefits become payable:

- You are unable to perform the duties of your job;
  and
- You are under the care of a licensed physician or licensed podiatrist

and

- You are not receiving Workers' Compensation.*

** If you have made a claim to the Workers' Compensation Board which claim has been controverted by your employer, the Fund will pay Weekly Accident and Sickness Benefits. However, if the Workers' Compensation Board's decision is in your favor, you must repay the Fund for the period covered by Workers' Compensation during which you received this benefit.*

You do not have to be confined to your home or a hospital to be eligible.

What Serves As Proof Of Disability?

You must submit proof of your disability on a form approved of by the Fund no later than ninety (90) calendar days after the onset of your disability.

What Are Successive Periods Of Disability?

If you recover from a disability and again become disabled from the same or a related accident or illness, after less than two (2) weeks of active full-time work, both disabilities will be considered as one period of disability. You will be entitled to an aggregate maximum of thirteen (13) weeks of payment. However, if your second disability is the result of a totally unrelated accident or illness and you have returned to full-time work for at least one (1) full day, you will be entitled to a new thirteen (13) week payment maximum.

What Is Not Covered?

No benefits are payable for:

- Disabilities covered by Workers' Compensation;
- Periods when you were not in covered employment;
- Periods when you are not under the care of a licensed physician;
- Disabilities resulting from war or acts of war;
- Disabilities resulting from intentional, self-inflicted injuries; **or**
- Disabilities which do not exceed the seven (7) day waiting period, when you are not hospital confined.

How Do You File A Claim?

To file a claim, follow these steps:

- Request a Weekly Accident and Sickness Benefits Claim Form from the Fund Office.
- Complete and sign only your portion of the form.

- Your doctor must complete and sign his or her portion of the form.
- You must provide recertification of the disability two weeks before the expected return date stated by your physician.

What is the Retirement, Pension, and Health Insurance Counseling Benefit?

When you are planning to retire, or at any time when you have problems concerning your pension or health insurance coverage, you have the opportunity to benefit from the guidance of professional counselors.

Retirement and Pension counseling is available by appointment only and is held at the Fund Office. You can make an appointment by calling 1-212-966-5353 or via your member portal at www.cwa1180.org.

When you come to the Fund Office for your appointment, it will be helpful to bring with you all necessary information and material pertinent to your problem.

In addition, special group retirement counseling sessions are held for employees who plan to retire. You are urged to register for these sessions if you are planning retirement within the coming year. Registration may be made by telephone by calling the Fund Office at the number listed above.

YOUR HOME HEALTH CARE BENEFIT

What is the Home Health Care Benefit?

This benefit essentially will help defray the cost of care you or your eligible dependent receives in your home as part of a treatment plan approved by your physician for a condition that would otherwise require you to be in a hospital. When you or your eligible dependent require home health care services, the Fund will reimburse you for home health care service expenses to a maximum of $450 per calendar year. The reimbursement is paid at the rate of $150 for each of the first three consecutive 24-hour periods of required home health care.

How Do You File A Claim?

Submit your claim to your basic health plan first. Then, submit the following to the Fund Office within ninety (90) calendar days after the required home health care services are rendered:

- A copy of the Explanation of Benefits from your basic health plan.
- A Home Health Care Claim Form, available from the Fund Office. Complete the form, providing the date or dates you or your eligible dependent received home health care and the charges for the services.
- An itemized bill marked "paid," indicating the date(s) and hours of home health care service as well as the license number of the agency providing the service.
- Evidence in the form of a written statement from the attending physician ordering such care. This statement must also include a brief description of the illness for which you or your dependent required home health care.

Claims submitted after the ninety (90) calendar day limit will be denied.

YOUR BIRTH/ADOPTION BENEFIT

What is the Birth/Adoption Benefit?

This benefit will provide you, the member, with up to $100 toward incidental medical expenses for the birth or adoption of your child.

How Do You File A Claim?

Follow these simple steps to receive benefits from the Fund:

- Obtain a Birth/Adoption Benefit Claim Form from the Fund Office.
- Complete and sign the claim form and submit it to the Fund Office with a copy of the child's birth certificate or Adoption Decree.
- Submit the claim within 90-days after the birth or adoption of the baby/child.

Claims submitted after the 90-day limit will be denied.

YOUR DENTAL BENEFIT PLANS *(You must choose only one plan)*

Age Nineteen (19) or Older

You may use either Dentcare, EmblemHealth, Empire BlueCross BlueShield, or a dentist who participates in the Local 1180 Scheduled Dental Benefit Plan (hereafter, "Participating Dentist"), or go out-of-network. If you or your dependent age nineteen (19) or older chooses Dentcare, EmblemHealth, or Empire or uses a Scheduled Dental Benefit Plan Participating Dentist, most services are covered at no charge. There are no annual or lifetime maximums when using a

Dentcare Dentist. When using a Scheduled Dental Benefit Plan Participating Dentist, the maximum benefit the plan will pay is $2,000 per person, per calendar year, per schedule and there are certain lifetime maximums. The dentist is typically responsible for submitting the claim to Dentcare, EmblemHealth, Empire BlueCross BlueShield, or the Scheduled Dental Benefit Plan. Some dentists may require you to submit the claim form to the dental benefit plan directly.

Dependents Under Age Twenty-Six (26)

Dependents under age 26 are covered by the Dentcare, Schedule Dental Plan, Empire BlueCross BlueShield and EmblemHealth Plans.

There are limits on coverage for orthodontic services as further described below.

THE SCHEDULED DENTAL BENEFIT PLAN

Under this plan, the Fund will pay you, your spouse and your eligible children a set amount for covered dental expenses you incur up to a maximum of $2,000 per eligible person in any calendar year.

When Is Coverage Provided?

Coverage is provided when:

- Services are received in accordance with the procedures described in this Summary Plan Description.
- Services are obtained while you, your spouse or your children are eligible for coverage (See the section entitled “Eligibility”).
- Services are medically necessary and covered hereunder.
- Services are approved by the Fund’s Dental Consultant.
- Services are not otherwise excluded.

What Expenses Are Covered By The Scheduled Dental Benefit Plan?

Covered Services Provided By Participating Dentists

Participating Dentists are dentists who have agreed to provide services covered by the Plan for a fixed fee set by the Plan. If you, your spouse or eligible children use the services of Participating Dentists, the Participating Dentist will accept the fixed fee set by the Plan as payment in full for covered services you receive. There are no out-of-pocket costs to you for covered services provided by The Fund’s Participating Dentists, up to a maximum coverage limit of $2,000 per eligible person in any calendar year.

For services covered by the Scheduled Dental Benefit Plan, please see the Schedule of Dental Allowances below.

Visit www.cwa1180.org/resources or call the Fund Office at 1-212-966-5353 for a current list of Participating Dentists.

Covered Services Provided By Dentists Who Are Not Participating Dentists:

You can go to any dentist you choose, but when you use a dentist who is not a participating dentist, you may incur out-of-pocket expenses for covered services.

Benefits payable under the Scheduled Dental Benefit Plan are based on a Schedule of Dental Allowances; please see the Schedule of Dental Allowances below. If your (non-participating) dentist charges you more than the scheduled allowance, the fees you incur that exceed the Plan's allowance or exceed the maximum benefit of $2,000 per eligible person in any calendar year are your sole responsibility. If your (non-participating) dentist charges you less than the Plan's Scheduled Allowance, you will be reimbursed your dentist's actual fee, up to the maximum benefit of $2,000 per eligible person in any calendar year.

- For example, if your (non-participating) dentist charges $100 for a covered service, but the reimbursement rate for that service under the Schedule of Dental Allowances is $85, the Plan will pay $85 and your unreimbursed, out-of-pocket expense will be $15.

For a list of dental services covered by the Scheduled Dental Benefit Plan, please see the "**Schedule of Dental Allowances**" below.

SCHEDULED DENTAL BENEFIT PLAN

Schedule of Dental Allowances

Diagnostic

0120	Periodic Oral Evaluation (once in 5 months after comprehensive)	20.00
0140	Limited Oral Evaluation	20.00
0150	Comprehensive Oral Evaluation	20.00
0210	Intraoral – completes series incl. Bitewings (once every 3 years)	30.00
0220	Intraoral, Periapical, first film	3.50
0230	Intraoral, Periapical, each additional film	2.00
0270	Bitewings, single film	3.50
0272	Bitewings, two films	7.00
0274	Bitewings, four films	12.00
0290	Posterior-Anterior/lateral skull and facial bone survey film	27.50
0321	Other temporomandibular joint films, by report	36.50
0330	Panoramic film (once every three years)	30.00
0340	Cephalometric film	15.00

Preventive (once every six months)

1110	Prophylaxis – Adult	25.00
1120	Prophylaxis – Child (to age 12)	20.00
1206	Topical application of fluoride varnish (prophy not included) Child	15.00
1208	Topical application of fluoride (prophy not included) – Adult	15.00
1351	Sealant – per tooth	25.00
1510	Space Maintainer – Fixed – Unilateral	54.50
1516	Space Maintainer Fixed Bilateral max	109.00
1517	Space Maintainer Fixed Bilateral Mand	109.00
1520	Space Maintainer – Removable – Unilateral	54.50

Restorative

2140	Amalgam – 1 Surface, Permanent	25.00
2150	Amalgam – 2 Surfaces, Permanent	35.00
2160	Amalgam – 3 Surfaces, Permanent	45.00
2161	Amalgam – 4 or more Surfaces, Permanent	55.00
2330	Resin – 1 Surface, Anterior	35.00
2331	Resin – 2 Surfaces, Anterior	45.00
2332	Resin – 3 Surfaces, Anterior	60.00
2391	Resin – based composite 1 surface, posterior permanent	35.00
2392	Resin – based composite 2 surfaces, posterior permanent	45.00
2393	Resin – based composite 3 surfaces, posterior permanent	60.00
2394	Resin – based composite 4 or more surfaces, posterior permanent	60.00
2510	Inlay - Metallic - 1 Surface*	100.00
2520	Inlay - Metallic - 2 Surfaces*	200.00

2530	Inlay - Metallic - 3 Surfaces*	250.00
2610	Inlay – Porcelain/Ceramic – 1 Surface*	80.50
2710	Crown – Resin – base composite (indirect)*	150.00
2720	Crown – Resin with high noble metal*	175.00
2721	Crown – Resin with predominantly base metal*	175.00
2722	Crown – Resin with noble metal*	175.00
2740	Crown - Porcelain/Ceramic Substrate*	175.00
2750	Crown – Porcelain fused to high noble metal*	500.00
2751	Crown – Porcelain fused to predominantly base metal*	500.00
2752	Crown – Porcelain fused to noble metal*	500.00
2790	Crown – Full Cast high noble metal*	500.00
2791	Crown – Full Cast predominantly base metal*	500.00
2792	Crown – Full Cast noble metal*	500.00
2910	Recement inlay, onlay or partial coverage restoration	15.00
2920	Recement crown	20.00
2930	Prefabricated stainless steel crown - primary tooth	47.50
2940	Sedative filling	25.00
2950	Core build-up	85.00
2952	Cast post and core in addition to crown	110.00
2954	Prefabricated post and core in addition to crown	110.00
2980	Crown repair, by report	30.00

**Prosthetics can only be replaced once every five years.*

Endodontics (including x-rays but exclusive of restoration)

3110	Pulp cap – direct (excluding final restoration)	15.00
3120	Pulp cap – indirect (excluding final restoration)	15.00
3220	Therapeutic pulpotomy (excluding final restoration)	25.00
3310	Anterior Root Canal (excluding final restoration)	400.00
3320	Bicuspid Root Canal (excluding final restoration)	450.00
3330	Molar Root Canal (excluding final restoration)	500.00
3346	Retreatment of previous RCT – anterior	400.00
3347	Retreatment of previous RCT – bicuspid	450.00
3348	Retreatment of previous RCT – molar	500.00
3410	Apicoectomy/Periradicular surgery anterior	400.00
3421	Apicoectomy/Periradicular surgery bicuspid (first root)	450.00
3425	Apicoectomy/Periradicular surgery molar (first root)	500.00
3426	Apicoectomy/Periradicular surgery (each additional root)	200.00
3430	Retrograde filling	100.00

Periodontics

4210	Gingivectomy or Gingivoplasty – 4 plus teeth per quadrant	100.00
4211	Gingivectomy or Gingivoplasty – 1-3 teeth per quadrant	40.00
4240	Gingival flap procedure – 4 plus teeth per quadrant	175.00

4241	Gingival flap procedure – 1-3 teeth per quad	105.00
4249	Clinical crown lengthening	125.00
4260	Osseous Surgery - 4 plus teeth per quadrant	500.00
4261	Osseous Surgery – (1-3 teeth per quadrant)	300.00
4263	Bone replacement graft – 1st site in quadrant	300.00
4264	Bone replacement graft – each add'l site in quadrant	250.00
4270	Pedicle soft tissue graft procedure	300.00
4277	Free soft tissue graft procedure (including donor site surgery)	150.00
4320	Provisional splinting – intracoronal	40.00
4321	Provisional splinting – extracoronal	40.00
4910	Perio maintenance procedures (following active therapy) – once every six months	35.00

Prosthodontics (removable)

5110	Complete upper dentures*	500.00
5120	Complete lower dentures*	500.00
5130	Immediate upper dentures*	500.00
5140	Immediate lower dentures*	500.00
5211	Maxillary partial denture – resin base*	500.00
5212	Mandibular partial denture – resin base*	500.00
5213	Maxillary partial denture – cast metal frame/resin base*	500.00
5214	Mandibular partial denture – cast metal frame/resin base*	500.00
5282	Removable unilateral partial denture- one piece metal maxillary	500.00
5283	Removable unilateral partial denture- one piece metal mandibular	500.00
6210	Pontic – cast high noble metal*	500.00
6211	Pontic – cast predominantly base metal*	500.00
6212	Pontic – cast noble metal*	500.00
6240	Pontic – porcelain fused to high noble metal*	500.00
6241	Pontic – porcelain fused to predominantly base metal*	500.00
6242	Pontic – porcelain fused to noble metal*	500.00
6250	Pontic – resin with high noble metal*	500.00
6251	Pontic – resin with predominantly base metal*	500.00
6252	Pontic – resin with noble metal*	500.00
6545	Retainer – cast metal*	500.00
6720	Crown – resin with high noble metal*	500.00
6721	Crown – resin with predominantly base metal*	500.00
6722	Crown – resin with noble metal*	500.00
6750	Crown – porcelain fused to high noble metal	500.00
6751	Crown – porcelain fused to predominantly base metal*	500.00
6752	Crown – porcelain fused to noble metal*	500.00
6780	Crown – ¾ cast high noble metal*	500.00
6790	Crown – full cast high noble metal*	500.00
6791	Crown – full cast predominantly base metal*	500.00
6792	Crown – full cast noble metal*	500.00

6930	Recement partial dentures	35.00
6792	Precision attachment	100.00
6980	Fixed partial denture repair, by report	50.00

**Prosthetics can only be replaced once every five years.*

Oral Surgery (including local anesthesia and post-operative care)

7111	Extraction, coronal remnants – deciduous tooth	40.00
7140	Extraction - erupted tooth or exposed root	100.00
7210	Surgical removal of erupted tooth requiring elevation mucoperiosteal flap and removal of bone and/or section of tooth	150.00
7220	Removal of impacted tooth – soft tissue	375.00
7230	Removal of impacted tooth – partially bony	425.00
7240	Removal of impacted tooth – completely bony	500.00
7241	Removal of impacted tooth – completely bony w/complications	600.00
7250	Surgical removal of residual roots (cutting procedure)	200.00
7310	Alveoplasty with extraction – per quadrant	250.00
7320	Alveoplasty no extractions – per quadrant	200.00
7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	40.00
7441	Excision of malignant tumor – lesion diameter over 1.25 cm	40.00
7510	Incision & drainage of abscess – intraoral soft tissue	125.00
7520	Incision & drainage of abscess – extraoral soft tissue	20.00
7960	Frenulectomy	75.00

Orthodontics

8080	Comprehensive orthodontic treatment of the adolescent dentition (once per lifetime)	1000.00
8090	Comprehensive orthodontic treatment of the adult dentition (once per lifetime)	1000.00
8660	Pre-orthodontic treatment visit (once per lifetime)	300.00
8670	Periodic orthodontic treatment visit as part of contract (up to 24 consecutive months)	100.00
8680	Orthodontic retainers - limit $400 (200 ea. top & bottom)	400.00

Adjunctive General Services

9110	Palliative (emergency) treatment of dental pain	20.00
9222	Deep Sedation	100.00
9223	Deep sedation each additional 15 minutes	100.00
9239	Intravenous moderate (conscious) sedation	100.00
9243	Intracenous moderate (conscious) sedation	100.00
9310	Consultation	30.00
9951	Occlusal adjustment – limited	80.00
9952	Occlusal adjustment – complete	100.00

When Your Treatment Costs $500 or More

If your dentist expects that your treatment will cost $500 or more, the Fund must approve your treatment ***before*** the work is done. In such case, your dentist must submit for review by the Fund's Dental Consultant:

- The Proposed Treatment Plan
  and
- Supporting X-rays.

After review, you and your dentist will be told:

- What treatment will be covered
- What the Fund estimates it will pay.

The Fund reserves the right to deny claims amounting to $500 or more which have not been reviewed by the Fund's Dental Consultant before treatment begins.

If the Fund is the secondary plan, pre-treatment review by the Fund's Dental Consultant is not required where the primary plan has already performed the pretreatment review.

If the primary plan has not performed a pre-treatment review, then pre-treatment review by the Fund's Dental Consultant is required before the work is done.

Following pre-treatment review, you will receive an estimate of the benefit the Fund will pay. In order to receive payment from the Fund:

- Treatment must be completed
  and
- A Treatment Completion form must be signed by the dentist and submitted to the dental administrator after the work has been performed.

Pre-treatment review is not a guarantee of payment. No payment will be made if the patient is not eligible when services are rendered.

Getting Your Benefit

Follow these simple steps:

- Obtain the official Local 1180 Dental Claim Form from the Fund Office.
- Complete the patient and subscriber/employee sections and sign the form in box #39 after you have discussed the treatment plan and associated fees with your dentist. Only if you wish to assign payment directly to your dentist, also sign box #41.
- If the total charges for the treatment are expected to be $500 or more, have your dentist submit a Pre-Treatment Estimate form and your x-rays to the Fund's Dental Consultant.

When the Pre-Treatment Estimate form is returned to your dentist with information about the benefits payable for your treatment, review these benefits with the dentist before work begins.

- When the treatment is completed, have your dentist complete the dentist's statement of work done. The completed form must be sent within ninety (90) calendar days after the completion of dental treatment to:

CWA Local 1180 Scheduled Dental Benefit Plan
Dental Claim Office
253 West 35th Street, 12th Floor
New York, NY 10001-1907

Claims submitted after the ninety (90) day limit will be denied.

IMPORTANT NOTICE

The Fund does NOT recommend or endorse any particular dentist. You are responsible for selecting the dentist of your choice, whether the dentist is a "participating" or "non-participating" dentist. You should apply the same criteria and care in choosing a participating dentist that you would apply in selecting a non-participating one.

What If I Want To Change To A Different Dental Plan?

The Fund offers four dental plan options. If you are enrolled in the Scheduled Dental Benefit Plan but would like to change to Dentcare, Emblem or Empire, you need to follow these simple steps:

- You can change plans during the open enrollment period.
- Your new selection will become effective on January 1 of the following year.
- You cannot be enrolled in multiple plans at the same time.

What's Not Covered

Benefits are not provided for:

- Treatment from anyone other than a licensed dentist, except routine cleaning of teeth and fluoride application which is performed by a licensed dental hygienist under the direct supervision of, and billed by, a dentist or physician.
- Facings, veneers, or similar material placed on molar crowns or pontics.
- Services performed by a member of you or your spouse's immediate family.
- Services or supplies that are cosmetic in nature or directed towards a cosmetic end.
- Any service or supplies incurred, installed, or delivered before you or your dependent(s) become eligible for benefits from this Fund.
- Replacing a lost, missing or stolen prosthetic appliance.
- A broken appointment.

- Any services received from a medical department, clinic or any facility provided or furnished by your spouse's employer.
- Any service that is not medically necessary or is not normally performed for proper dental care of the condition or any service that is not approved by the attending dentist.
- Services or supplies that do not meet accepted standards of dental practice including experimental or investigational services or supplies.
- Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
- Any duplicate prosthetic appliance except as specifically provided.
- Charges for completing claim forms.
- Oral hygiene, dietary instruction or plaque control programs.
- Wiring or bonding teeth or crowns to act as a splint for any reason.
- An injury arising from your former employment.
- Illness or injury covered by Workers' Compensation.
- Services or supplies for which you are not required to pay.
- Appliances, restorations, or any procedure to alter vertical dimension for cosmetic purposes.
- Services or supplies not specifically listed under the Schedule of Dental Allowances.
- Services for in-patient or out-patient hospital care.
- Services by a provider whose office is attached to, or a dental school which is a part of certain hospitals within New York State (call the Fund Office for a list of such providers).
- Any treatment costing $500 or more which is not submitted for Pre-Treatment Review as required.

THE DENTCARE BENEFIT PLAN

Dentcare Delivery Systems, Inc. is a not-for-profit dental insurance company licensed by the New York State Insurance Department. Their dental plan offers a wide range of dental services to be provided by participating dentists at no cost to you, your spouse and your eligible dependents; a few services require a co-payment by you of a specified amount. There are no annual or lifetime benefit maximums.

Definitions:

Co-payment: An amount the member is required to pay to the dentist for an applicable covered service.

Covered Service: Diagnosis, care, treatment or supplies that are:

- Described in the "**Schedule of Covered Dental Services**" section
- Performed by a Participating Dentist

- Not described as an exclusion or limitations in the Policy

Dental Emergency: Acute pain or a condition that needs immediate treatment but does not produce a definite cure. Includes, but is not limited to procedures to:

- Stop bleeding
- Open and clean an infection
- Relieve pain

Participating Dentist: A dentist who has signed an agreement with Dentcare to provide services to members on a per person basis or other fee basis.

Pre-Certification: A case where prior approval has been obtained from Dentcare for a patient to receive benefits for covered services. Such approval is only valid if treatment is provided during a period of Eligibility.

What Coverage is Provided?

Coverage is provided when:

- Services are received in accordance with the procedures described in this Summary Plan Description.
- Services are obtained while you, your spouse or your children are eligible for coverage (See the section entitled "**Eligibility**").
- Services are medically necessary and covered hereunder.
- Services are not otherwise excluded.

How Does The Program Work?

You may select one participating dentist (per family) from the Comprehensive Panel of Dentcare Providers in a geographical area convenient to you. This general dentist will provide all necessary covered services according to the "**Schedule of Covered Dental Services**". You can change your Dentcare dentist each annual open enrollment period. A request to change your dentist can be submitted to Dentcare in writing or by phone to Member Services.

What Dental Services Will You Receive?

Covered Services Provided By Dentcare Participating Dentists

- Covered benefits include a wide variety of typical dental services. For a list of covered dental services, please see the section titled **"Schedule of Covered Dental Services"** below.

- If you require the services of a specialist, your Dentcare Participating Dentist will refer you to a participating specialist.
- In the event that a Dental Emergency occurs outside of the Dentcare coverage area or if you are unable to visit a Dentcare Participating Dentist, Dentcare will reimburse up to $40 per eligible family member per contract year if you submit copies of the bills for treatment to alleviate the Dental Emergency.
- In the event you are unable to reach your own participating dentist, contact Dentcare's administrator, Healthplex, Inc by calling Member services at (800) 468-0600 or using the find a dentist feature online at www.Healthplex.com.

Dentcare Benefit Plan

Schedule of Covered Dental Services

Procedure	Patient Co-payment
Diagnostic & Preventive Services	
Periodic Oral Examination (once every 6 months)	No Charge
Full Mouth Series X-rays (once every 36 months)	No Charge
Periapical, First Film	No Charge
Bitewings, Four Films	No Charge
Prophylaxis, Adult/Child	No Charge
Fluoride Treatment	No Charge
Basic	
Amalgam, one surface	No Charge
Amalgam, two surfaces	No Charge
Amalgam, three surfaces or more	No Charge
Resin-Based Composite, one surface, Anterior/Posterior	No Charge
Resin-Based Composite, two surfaces, Anterior/Posterior	No Charge
Resin-Based Composite, three surfaces, Anterior/Posterior	No Charge
Resin-Based Composite, four or more surfaces, Anterior/Posterior	No Charge
Pulpotomy	No Charge
Root Canal Therapy – Anterior	No Charge
Root Canal Therapy – Bicuspid	No Charge
Root Canal Therapy – Molar	No Charge
Apicoectomy, Anterior	No Charge
Gingivectomy, per quad	No Charge
Osseous Surgery, per quad	No Charge
Scaling/Root Planing, per quad	No Charge
Pedicle Soft Tissue Graft	$150.00
Free Soft Tissue Graft	$150.00
Routine/Surgical Extraction	No Charge
Soft Tissue Impaction	No Charge
Partial Bony Impaction	No Charge
Full Bony Impactions	No Charge
Alveoloplasty with Extraction, per quad	No Charge
Palliative Treatment	No Charge
Major	
Porcelain with High Noble Metal Crown	$50.00
Full Cast High Noble Metal Crown	$50.00
Post and Core, Casted	No Charge
Recementation Crown/Bridge	No Charge
Stainless Steel Crown (Primary Tooth)	No Charge
Complete Upper/Lower Denture	$50.00

Partial Upper/Lower Denture, Cast Base	$50.00
Denture Repairs	No Charge
Porcelain with High Noble Metal Pontic/Abutment	$50.00
Full Cast High Noble Metal Abutment	$50.00

Orthodontia

Maximum case fee	
Dependent Children*	$300.00
Adult	$300.00

** Dependent children are covered up to the end of the month of their 26th birthday.*

*** Above services represent a partial listing of benefits covered by this plan. Please contact the Fund Office if you have questions, or to request the Dentcare summary of benefits or certificate of coverage for a full list.*

Treatment Options/Materials

Due to the variety of treatment options available to achieve similar results combined with the element of choice involved with many dental services, situations frequently arise where two or more methods of treatment for a particular dental condition could be used, each of which may produce a desirable professional result. Please speak with your dentist to solidify your understanding of the options covered under your dental plan.

What If My Request For Dental Services Is Denied?

If your request for dental services is denied and you disagree with the decision, you may request a review of your claim under Dentcare's procedures for review of such claims.

Please see the "**Dental Benefits Appeals**" section above and/or contact the Fund Office for more information about Dentcare's review procedures.

What If I Want To Change To A Different Plan?

The Fund offers four dental plan options. If you are enrolled in Dentcare but would like to change to the Scheduled Dental Benefit Plan, Empire or Emblem, follow these simple steps:

- You can change plans during the open enrollment period, which occurs once each year.
- Your new selection will become effective on January 1st of the following year.
- You cannot be enrolled in multiple plans at the same time.
- If you move out of the geographical area served by Dentcare Delivery Systems, you may change to the Scheduled Dental Benefit Plan without delay.

Exclusions and Limitations

- Any dental services which were not rendered or approved by a participating dentist except in cases of out-of-area Dental Emergency. In the event that a Dental Emergency occurs outside of the Dentcare coverage area, Dentcare will reimburse up to $40 per eligible family member per contract year if you submit copies of the bills for treatment to alleviate the Dental Emergency.
- A service not performed by a dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or for an x-ray ordered by a dentist.
- Treatment of a disease, defect, or injury covered by a major medical plan, Workers' Compensation Law, occupational disease law, or similar legislation.
- General anesthesia, analgesia and any service rendered in a hospital environment.
- Any dental procedures which are undertaken primarily for cosmetic reasons or dental care to treat accidental injuries, congenital or developmental malformations.
- Services which were started prior to the person becoming covered under this plan.
- Implants, grafts, precision attachments or other personalized restorations or specialized techniques.
- Broken Appointments – If specified by plan dentist for appointments not canceled 24 hours in advance, there is a $30.00 charge.
- Replacement of any existing crown, bridge or denture, which can be made serviceable according to common dental standards.
- Procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension, diagnose or treat conditions or dysfunction of the temporomandibular joint, stabilize periodontally involved teeth, or restore occlusion.
- Treatment of unmanageable children and/or unruly patients. If the assigned dentist is unable to treat a patient by virtue of apprehension or any other reason, and is referred to another office for treatment, the responsibility for payment lies with either the patient or with the parents/guardians of the patient.
- Services not listed in the "**Schedule of Covered Dental Services"** may not be covered. Please visit healthplex.com or submit a pre-certification prior to receiving treatment.
- Oral exams, bitewing x-rays, prophylaxis and fluoride treatments - Once every 6 mos.
    - Full mouth and panoramic x-rays - Once every 36 mos.
    - Crowns, bridges and dentures - Once every 60 mos.
- Orthodontic treatment of Class II/Class III malocclusions - One case per covered individual.

Medical Necessity

Dentcare covers certain benefits described in this Summary Plan Description as long as the service is Medically Necessary. The fact that a dentist has prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that it will be covered.

The decision may be based on a review of:

- Your dental records;
- Dentcare's dental policies and clinical guidelines;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- And the opinion of the attending providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for your illness, injury, or disease.
- They are required for the direct care and treatment or management of that condition.
- Your condition would be adversely affected if the services were not provided.
- They are provided in accordance with generally-accepted standards of dental practice.
- **They are not primarily for the convenience of you, your family, or your dentist.**

MAKING INQUIRIES TO DENTCARE

Customer Service staff members are available to explain policies and procedures. They can also answer questions about benefits and claim determinations. For information or help, a member may call or write Dentcare. The toll-free telephone number for the Customer Service Department is 1-800-468-0600. The address of Dentcare is:

Dentcare Delivery Systems, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608

IMPORTANT NOTICE

The "Schedule of Covered Dental Services" contains a general description of your dental care program for your use as a convenient reference. You will have to pay in full for treatment if an Exclusion and/or Limitation applies to a service otherwise listed as covered. Prior to receiving any treatment, please obtain the Certificate of Insurance for Exclusions and Limitations. A copy of your Certificate of Insurance may also be obtained from the Healthplex website at healthplex.com or by calling Dentcare.

The Fund does NOT recommend or endorse any particular dentist. You are responsible for selecting the Dentcare dentist of your choice. You should apply the same criteria and care in choosing a Dentcare dentist that you would apply in selecting any dentist.

THE EMBLEMHEALTH BENEFIT PLANS – PREMIUM OR STANDARD OPTION

This EmblemHealth Premium or Standard Option plans allow you to choose a network dentist or specialist for services covered under your plans. You don't have to pick a specific primary care dentist.

With both plans, you can cover your children up to age 26 with verification the children are not getting coverage from another employer. Children can be covered for orthodontic services until the end of the year they turn 19.

Predetermination of Benefits: EmblemHealth can let you know, before you go to the dentist, how much you will pay for certain services and materials. You can ask your dentist to send a Treatment Plan to EmblemHealth before you get oral surgery, prosthetics, or appliances. EmblemHealth will review the Treatment Plan and let you and your dentist know what is covered. ***Please note: A Predetermination of Benefits is not required.***

Dental Services Not Covered under the Premium or Standard Plan

- Cosmetic surgery and treatment unless it is reconstructive surgery caused by trauma, infection, or disease of the involved part.
- Prescription drugs and medicines.
- Services and appliances for the treatment of temporomandibular joint (TMJ) dysfunction.
- Transplantations.

Annual Maximum: Both plans have a $2,000 annual maximum per person. This is the most your dental plan will pay toward the cost of dental care during your benefit period. You are responsible for paying costs above the annual maximum. Both plans have a $2,000 lifetime orthodontic maximum per covered family member. Orthodontic benefits are available until the end of the month your covered child turns 19. Adult orthodontia is not covered.

Premium Plan: Under the Premium Plan, Emblem will pay 100% for covered services if you see a participating dentist, up to the $2,000 annual maximum. For family coverage, you must pay a monthly premium of $34.51.

Standard Plan Deductible: Under the Standard Plan**,** there is no monthly premium. There is a deductible of $75 per covered family member or $225 per family and fee schedule for certain dental services.

EMBLEMHEALTH BENEFIT PLANS

Covered Dental Services

Type A – Preventive and Diagnostic Services

Premium Option

In-Network: EmblemHealth will pay 100% of the set dollar amount for covered services when you see a preferred dentist or specialist. You do not have to pay for the following covered services.

Out-of-Network: EmblemHealth will pay 100% of the set dollar amount for covered services. This is the dollar amount your plan has agreed to pay for covered services. You are responsible for paying any costs that are more than the plan's agreed-upon amount. You may have to pay some of your bill for the following covered services.

Standard Option

In-Network: Emblem Health will pay 100% of the set dollar amount for covered services when you see a preferred dentist or specialist. You do not have to pay for the following covered services.

Out-of-Network: EmblemHealth will pay 100% of the set dollar amount for covered services. This is the dollar amount your plan has agreed to pay for covered services. You are responsible for paying any costs that are more than the plan's agreed-upon amount. You may have to pay some of your bill for the following covered services:

- **Examinations** – 2 periodic exams per each person on the plan per calendar year. 1 comprehensive examination per dentist, per lifetime.
- **Prophylaxes (Cleanings)** – 2 per person on the plan per calendar year.
- **X-rays** – 4 bitewing x-rays per person on the plan per calendar year.
  - 1 full-mouth series of x-rays or 1 panoramic film per person on the plan once every 3 years.
- **Fluoride Treatments** – 1 per child on the plan per calendar year. Coverage provided until the end of the year the child turns 19.
- **Space Maintainers** – 1 per child on the plan. Coverage provided until the end of the year the child turns 19.

- **Athletic Mouth Guards** – 1 per child on the plan. Coverage provided until the end of the year the child turns 19.

Type B – Basic Services

Premium Option

In-Network: EmblemHealth will pay 100% of the set dollar amount for covered services when you see a preferred dentist or specialist. You do not have to pay for the following covered services.

Out-of-Network: EmblemHealth will pay 80% of the set dollar amount for covered services. This is the dollar amount your plan has agreed to pay for covered services. You are responsible for paying any costs that are more than the plan's agreed-upon amount. You may have to pay some of your bill for the following covered services.

Standard Option

In-Network: After you meet the deductible, EmblemHealth pays 80% of set dollar amount for covered services with a preferred dentist or specialist. You pay 20% of the cost of covered services after the $75 per covered family member, or $225 per family deductible.

Out-of-Network: After you meet the deductible, EmblemHealth pays 50% of set dollar amount for covered services. You are responsible for paying any costs that are more than this amount that an out-of-network provider may bill for. $75 per covered family member, or $225 per family deductible applies.

- **Simple Extractions**
- **Basic Restorations (Fillings)**
  - Posterior composite fillings on molars are reimbursed at the fee paid for amalgam (metal) fillings. If you or someone on your plan chooses composite restorations on molars, you are responsible for the difference between what EmblemHealth pays and what your dentist charges. Discuss these additional fees with your dentist when reviewing the treatment and payment plans.
- **Endodontics (Root canal therapy)**
  - Pulpotomy covered once per tooth, per lifetime. Not covered if root canal is done on same tooth by same dentist within 3 months of the pulpotomy.
- **Periodontics (Treatment of diseases of the gum and jaw)**
  - 5 periodontal treatments per person on the plan per calendar year.
  - 1 type of periodontal surgery and/or 1 graft per quadrant.
- **Oral Surgery (Surgical removal of an erupted tooth)**
  - Your plan will pay for x-rays taken for surgery, local anesthesia, and post-operative care.

  - Your plan will pay for surgery on fractured jaws, impactions, lesions in and around the mouth, and reimplantations.
  - Some types of oral surgery may be covered under your medical plan, but not this dental plan.

- **Anesthesia & IV Sedation** – Your plan will pay for general anesthesia and IV sedation for covered services. Charges for local anesthesia are included in the allowance for the dental procedure. No separate allowance for local anesthesia. Analgesia and monitoring devices will not be paid for by your plan.
- **Palliative Services (Relief of pain)**
  - 1 service per person on the plan per calendar year. This is for emergencies only.
- **Repair of Appliances**
  - Replacement of broken teeth or clasps. Recementation of inlays, crowns, bridges, and space maintainers. Replacement of broken facings.
- **Tests and Laboratory Exams** – Biopsy and examination of oral tissue.

Type C – Major Services

Premium Option

In-Network: Emblem Health will pay 100% of the set dollar amount for covered services when you see a preferred dentist or specialist. You do not have to pay for the following covered services.

Out-of-Network: EmblemHealth will pay 80% of the set dollar amount for covered services. This is the dollar amount your plan has agreed to pay for covered services. You are responsible for paying any costs that are more than the plan's agreed-upon amount. You may have to pay some of your bill for the following covered services.

Standard Option

In-Network: After you meet the deductible, EmblemHealth pays 50% of set dollar amount for covered services with a preferred dentist or specialist. You pay 50% of the cost of covered services after the $75 per covered family member, or $225 per family deductible.

Out-of-Network: After you meet the deductible, EmblemHealth pays 50% of set dollar amount for covered services. You are responsible for paying any costs that are more than this amount that an out-of-network provider may bill for. $75 per covered family member, or $225 per family deductible applies.

- **Fixed and Removable Prosthetics –** Temporary services are not covered. Dentures (full or partial), repair, and crowns over implants.
- **Major Restoration –** Includes crowns, related post and core procedures, and inlays.

- Your plan will pay for replacement or substitution of appliances only after 5 years have passed since appliance was inserted.
- EmblemHealth reimburses crowns, single abutment crowns, and pontics other than porcelain fused to base metal at the allowance for predominantly base metal. If you or someone on your plan chooses crowns other than porcelain fused to base metal, you will be responsible for the differences between what EmblemHealth pays and what your dentist charges. Discuss these additional fees with your dentist when reviewing the treatment and payment plans.
- Your plan will pay for crowns or pontics for attachment or clasp purposes only if tooth cannot be restored by fillings.
- When a fixed bridge and partial denture are inserted in the same arch, your plan will only pay for the partial denture unless 5 years have passed since prior insertion of the fixed bridge or partial denture.
- No separate allowance for temporary service or appliance.
- Your plan will pay for posts only if there is evidence of root canal on the tooth.
- Charges for cementation of crown/inlay are included in allowance for the crown/inlay.

Type D – Orthodontics

Premium Option

In-Network: Emblem Health will pay 100% of the agreed-upon dollar amount when you see a preferred dentist or specialist. You do not have to pay for the following covered services.

Out-of-Network: EmblemHealth has agreed to pay 50% of the agreed-upon dollar amount for these services. This is the most amount of money your plan will pay. You are personally responsible to pay for any costs that are more than the plan's agreed-upon amount. You may have to pay some of your bill for the following covered services.

Standard Option

In-Network: EmblemHealth will issue an initial payment of 50% of the agreed-upon dollar amount when you see a preferred dentist or specialist upon receipt of a claim confirming the initiation of comprehensive orthodontic treatment. The balance of the available orthodontia benefit due will be issued in subsequent monthly or quarterly payments.

Out-of-Network: EmblemHealth has agreed to pay 50% of the agreed-upon dollar amount for these services. This is the most amount of money your plan will pay. You are personally responsible to pay for any costs that are more than the plan's agreed-upon amount. You may have to pay some of your bill for the following covered services.

- **Orthodontic Base Coverage Level –** This benefit is available until the end of the month your child turns 19. Your child must have 20 continuous months of treatment to qualify. This

does not include charges for missed appointments or additional cosmetic banding options. You will be responsible for these charges.

This is not a complete benefit comparison or contract. A detailed benefits description, including limitations and exclusions, is contained within the Certificate of Insurance. Please contact the Fund Office if you have questions, or to request the EmblemHealth summary of benefits or certificate of coverage for a full list.

THE EMPIRE BENEFIT PLAN

Under the Empire BlueCross BlueShield Plan, the coverage year maximum (calendar year) is $2,000 per member for participating or nonparticipating dentist. The orthodontic services benefit maximum per eligible insured child is $2,000 per member for participating or nonparticipating dentist. The annual deductible (contract year) is $75 per member, with family maximum of 3x single member deductible for participating or nonparticipating dentist. The deductible is waived for diagnostic/preventive services for participating dentists. The deductible is not waived for diagnostic/preventive services for nonparticipating dentists.

Dental Services

Diagnostic and Preventive Services: In-Network Empire pays 100% co-insurance. Out-of-network Empire pays 50% coinsurance.

- Periodic oral exam $16-$35 In-Network, $16-$18 Out-of-Network
- Teeth cleaning (prophylaxis) $27-$90 INN, $27-$45 OON
- Bitewing X-rays (once in 12 mos. For all ages) $9-$50INN, $9-$25 OON
- Periapical X-rays $7-$25 INN, $7-$12 OON

Basic Services: In-Network Empire pays 80% co-insurance. Out-of-network Empire pays 50% coinsurance.

- Amalgam (silver-colored) filling $41-$150 INN, $41-$89 OON
- Front composite (tooth colored) filling $92-$200 INN, $92-$106 OON
- Back composite (tooth colored) filling, alternated to amalgam allowance $41-$150 INN, $41-$74 OON
- Simple extractions $52-$150 INN, $52-$60 OON

Endodontics: In-Network Empire pays 50% co-insurance. Out-of-network Empire pays 50% coinsurance.

- Root canal $80-$900 INN, $80-$474 OON

Periodontics: In-Network Empire pays 50% co-insurance. Out-of-network Empire pays 50% coinsurance.

- Scaling and root planing $75-200 INN, $75-$90 OON

Oral Surgery: In-Network Empire pays 50% co-insurance. Out-of-network Empire pays 50% coinsurance.

- Surgical extractions $100-$230 INN, $100-$115 OON

Major Services: In-Network Empire pays 50% co-insurance. Out-of-network Empire pays 50% coinsurance.

- Crowns $312-$900 INN, $312-$460 OON

Prosthodontics: In-Network Empire pays 50% co-insurance. Out-of-network Empire pays 50% coinsurance.

- Dentures $92-$604 INN, $92-$1,000 OON
- Bridges $250-$900 INN, $250-$461 OON
- Dental implants (covered) $410-$2,500 INN, $410-$1,350 OON

Prosthetic Repairs/Adjustments: In-Network Empire pays 50% co-insurance. Out-of-network Empire pays 50% coinsurance.

Orthodontic Services: In-Network Empire pays 50% co-insurance. Out-of-network Empire pays 50% coinsurance.

- $1,900-$7,688

This is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your certificate of coverage. Please contact the Fund Office if you have questions, or to request the Empire BlueCross Blue Shield summary of benefits or certificate of coverage for a full list.

YOUR PRESCRIPTION DRUG BENEFIT

What Is The Prescription Drug Benefit?

The Fund's prescription drug benefits are designed to help you and your eligible dependents meet the high cost of prescription drugs. The CWA Local 1180 prescription drug benefit for active members and their eligible dependents is administered by Capital Rx. With this program, members have two ways of obtaining their medications.

All members receive a prescription drug card issued by Capital Rx. Members and dependents requiring acute medications should take their prescription and the member identification card to the pharmacy. An "acute" medication is a medication you need to take immediately and for a short period of time. You may also obtain information concerning participating pharmacies by accessing the Capital Rx's website www.cap-rx.com.

In many instances, these are antibiotics used to treat infection. Your doctor or prescriber may order up to a thirty (30) day supply and up to a ninety (90) day supply at mail order pharmacy.

For medications you need to take repeatedly, you should use the mail order provider. You can now obtain refills for medications filled at mail order by accessing the GeniusRx through **www.cap-rx.com** or by calling 1-844-227-7962.

If employment terminates or you retire, you must return the I.D. card to the Fund Office immediately.

Preventive Medications available to you at no cost!

The following items are paid for by the SBF if you have a doctor's prescription for them **without any copayment on your part** except for members who are covered by:

EMBLEM/GHI CBP

As mandated under the Affordable Care Act, preventative medications listed below will be provided by your **Emblem/GHI CBP** coverage as of July 1, 2016 **without charge to you**.

- Aspirin, generic only, for men who are age forty-five (45) through seventy-nine (79) and women who are age fifty-five (55) through seventy-nine (79).
- Influenza and pneumonia immunizations given outside of a doctor's office or hospital such as at a pharmacy.
- Fluoride in generic pill form for children up to age five (5).
- Smoking cessation products – generic only. After six (6) months of providing these products, a member will only be eligible thereafter if they are in a smoking cessation program.

- FDA approved contraceptives if not approved by your City Health plan – 1) oral contraceptives - generic only* (e.g.: combined pill, progestin only, extended/continuous use); 2) patch - generic only*; 3) vaginal contraceptive ring if not provided by your City health plan; 4) IUDs if not provided by your City health plan; 5) Female condoms if not provided by your City health plan; 6) emergency contraception - (Plan B/Plan B One Step/Next Choice/Ella) 7) cervical cap; 8) spermicide; 9) diaphragm; 10) sponge.
- Iron supplements up to one year of age, generic only.
- Bowel Preps: Ages 50 through 75; generic only; limit two prescriptions per 365 days.
- Primary Prevention of breast cancer: Roloxiphene (generic only version of the brand name Evista) is only covered for the Primary Prevention of Breast Cancer in women age 35 and older. All other drugs for the primary prevention of breast cancer are covered through New York City PICA Program, not through GHI.

** The Fund will accommodate any individual for whom a generic drug would be medically inappropriate, as determined by the individual's health care provider. Please contact the Fund Office for instructions on requesting a waiver of the generic-only provision.*

The following co-payments apply:

- The **generic drug** copay will be $5 per prescription for up to a thirty (30) day supply at a participating retail pharmacy and $10 per prescription for up to a ninety (90) day supply at the mail order pharmacy.

- **Brand name drug without a generic equivalent** have a copay of 20% of the cost of a prescription for up to a thirty (30) day supply or (for non-Specialty brand drugs) a ninety (90) day supply.

- The copay for a **brand name drug with a generic equivalent** will be the difference between the price of the brand name drug and the price of the generic drug for both retail and mail order.

- Unless they are obtained through the Cost Avoidance Program (described below), **Specialty Drugs** have a copay of 20% of the cost of a prescription and are limited to a thirty (30) day supply. Specialty Drugs are not available as generic drugs.

- The SBF will cover the generic form of proton pump inhibitor only.

Please contact Capital Rx if you have a question about which of these copay categories applies to your prescription.

What Kinds of Prescription Drugs Are Covered By the Plan's (Capital Rx) Prescription Drug Cost Reimbursement Benefit Program?

Covered medications include:

- Federal legend drugs, preventative medications with the exception of vitamins or dietary supplements, even if these are legend drugs
- State restricted drugs
- Compound prescriptions, when one ingredient is a federal legend medication
- Federal legend oral contraceptives
- Smoking cessation medications, limited to two cycles or therapy per lifetime
- Topical acne agents, limited to participants 23 years of age and under (see excluded medications)

Examples of medications requiring a prior authorization from Capital Rx include: *

- Specialty prescription drugs
- Smoking cessation medications
- Erectile dysfunction medications
- Enbrel
- Chemotherapy drugs
- Topical acne agents for participants over 23 years of age.

Some Excluded medications (for a full list, please contact the Fund Office):

- Retin-A, Renova, Avita and any generic equivalent of Retin-A, Renova or Avita (regardless of the Participant's age).
- Fertility drugs
- Drugs used for baldness
- Vitamins and dietary supplements
- Drugs for cosmetic purposes
- Insulin on prescription **
- Syringes and needles on prescription
- Federal legend vitamins and dietary supplements
- Items lawfully obtainable without a prescription
- Devices and appliances
- Prescriptions covered without charge under federal, state, or local programs, including Workers' Compensation
- Any charge for the administration of a drug or insulin
- Investigational or experimental drugs
- Unauthorized refills
- Immunization age nts, biological sera, blood or plasma

- Medication for an eligible member confined to a rest home, nursing home, sanitarium, extended care are facility, hospital, or similar entity
- No coverage is provided for O.T.C (over the counter) drugs, vitamins, diet supplements, etc., which, even though prescribed by a physician, can be legally purchased without a prescription (exceptions may be made from time to time; contact the Fund Office for a list of covered, prescribed, O.T.C. drugs)
- Drugs covered by this Plan must be prescribed by a duly licensed medical practitioner
- All prescriptions must be dispensed in registered pharmacies
- Coverage does not include drugs administered to in-patients of any hospital, nursing home, or in-patient facility
- Olysio, Sovaldi, Truvada and Viekira Pak.
- All new to market drugs unless the Trustees have approved them.

** To obtain a prior authorization, please call Capital Rx.*

******* *For **Non-Medicare** eligible members, insulin prescriptions and diabetic supplies are covered under your basic NYC Health Insurance Plan. Please call Capital Rx at 844-227-7962 for detailed instructions.*

Generic Drugs vs. Brand Name Drugs

Generic drugs are the same as brand name drugs. The major difference is cost. Because brand name drugs are heavily advertised, they cost considerably more than generic drugs.

By law, generic drugs must contain the **same active ingredients** in the **same quantities** and be the **same strength** as the corresponding brand name drug. Furthermore, they must meet the same FDA standards for safety and effectiveness. More specifically, generic drugs are required by the FDA "bioequivalent" to the brand name drug and have the same active ingredient, strength, dosage form, and route of administration as the brand name product. Through review of bioequivalence data, FDA ensures that the generic product performs the same as its respective brand name drug.

When your doctor prescribes a generic drug, both your costs and the Fund's costs are reduced.

If you or your dependent is taking a medication that is available as **both a brand and generic** equivalent/alternative, you will be required to pay your brand copay plus the cost difference between the brand drug and generic drug. The SBF will only pay for the generic form of the drug, even if not an exact replica, unless you or your dependent provide a letter of medical necessity, and the 20% brand name copay as described above will apply.

Step Therapy

Step Therapy is a program designed to have a patient begin therapy for a medical condition with the most cost-effective medication first and then progressing to other more costly therapy only if necessary. The aim is to control costs and minimize risks.

The following drugs require Step Therapy:

Category	Step One Drug(s)	Step Two Drug
Angiotensin Receptor Blockers (ARBs)	Losartan/HCT, Valsartan/HCT, Irbesartan/HCT, nebivolol	Teveten/HCT, Byvalson (nebivolol)
Diabetes	Linaglitan, Lantus, adlyxin, metformin	Jentadueto/XR (linagliptan), Soliqua (lantus and / or adlyxin), Adlyxin (metformin and/ or basal insulin)
Acne	Other topical acne medications	Aczone
Cholesterol Medications	Generics	Lovaza, Niaspan

See **www.cap-rx.com/** for further information.

How Does The Prescription Drug I.D. Program Card Work?

A plastic CWA Local 1180 Security Benefits Fund Prescription Drug Program ID Card is issued to each covered member provided the Fund Office has on file both your Enrollment Card and your Designation of Beneficiary Card. ***Your I.D. card is valid only while you are employed by an employer who contributes to the Fund on your behalf.*** If you lose your card you must notify the Fund Office immediately.

If employment terminates or you retire, you must return the I.D. card to the Fund Office immediately. ***If employment terminates or you change title, you are no longer eligible for benefits. You will be responsible for all charges you incur after you are no longer eligible for benefits***.

When you or one of your eligible dependents need prescribed medicine:

- Have your doctor write the prescription on his or her prescription form.
- Take the prescription form and your I.D. card to your pharmacist. You will receive your prescription by paying the appropriate co-payment. Your pharmacist will be reimbursed by the Fund.

How Do You Get Refills?

If the original prescription written by your doctor specifies that it may be refilled, and if you require a refill, you can obtain a refill at the same pharmacy where the prescription was first filled by showing your I.D. card.

What Happens If You Use A Non-Participating Pharmacy?

You will be eligible for reimbursement from the Fund if for any reason you have a covered prescription filled at a pharmacy which is not a participant in the CWA Local 1180 Prescription Drug Program. In order to obtain this benefit, you must follow these procedures:

- Obtain a Prescription Drug Benefit Reimbursement Form from the Fund Office or from Capital Rx's website www.cap-rx.com .
- Pay the pharmacist the full cost of the prescription.
- Sign and complete the form, be sure to attach pharmacy receipt where indicated and return it to the address shown on the reverse side of the reimbursement form.
- The Fund will reimburse you the cost of the prescription at the same rate that would be payable for that drug at a participating pharmacy, less that appropriate co-payment.

Claims for prescription drugs filled by a non-participating pharmacy must be received by the Fund Office within ninety (90) calendar days following the date the prescription or refill was filled. Claims submitted after the ninety (90) calendar day limit will be denied.

NOTE: If your pharmacist has any question regarding the Fund's Prescription Drug Benefit Program ask him or her to call or write to the following:

Capital Rx
228 Park Ave South, Suite 87234
New York, NY 10003
Member Service: 844-227-7962
www.cap-rx.com

The Mail Order Prescription Drug Program

This program, which is administered by GeniusRx, offers you the convenience of ordering from your home and of having your prescriptions refilled less often. If you, your spouse or eligible children require covered medications on an on-going basis, you can order a ninety (90) day supply through the mail.

For a 90-day supply of prescription drugs obtained through mail order (other than Specialty Prescription Drugs, which are subject to special rules described in the next section), the following copayments apply:

- For generic drugs, the copayment is $10.00
- For brand name drugs with a generic equivalent , the copayment is the difference between the price of the brand name drug and the price of the generic drug
- For brand name drugs with no generic equivalent, the copayment is 20% of the cost of the prescription
- Please note the following:
  - Prior to your first fill by mail order, you will need to set up an account with GeniusRx Mail Order Pharmacy.
  - **Online:** Go to **www.cap-rx.com** and register.
  - **Phone:** Call **1-844-227-7962** to request your prescription and provide complete patient and payment information.
- Choose one of the following options to complete setup and submit your prescription:
  - **E-prescribe:** After you setup an account with GeniusRx Mail Order Pharmacy at www.cap-rx.com, have your prescriber e-prescribe your prescription to GeniusRx at https://www.geniusrx.com/.
  - **Fax:** After you set up an account with GeniusRx Mail Order Pharmacy, have your prescriber fax your prescription to 1-833-308-0115. Faxed prescriptions may only be sent by a doctor's office and must include patient information and diagnosis for timely processing.

** There is special mail order for Specialty Prescription Drugs. See below for details.*

Special Rules for Specialty Prescription Drugs

Specialty Drugs include biologic drugs, orphan drugs and, for purposes of the Cost Avoidance Program, drugs covered by that Program. You may submit a first fill Specialty Drug prescription to any in-network pharmacy and, unless the drug is covered by the Cost Avoidance Program (described below), you may obtain a 30-day first fill of the Specialty Drug from the in-network pharmacy. Otherwise, Specialty Drug prescriptions must be submitted to GeniusRx. Unless the drug is obtained through the Cost Avoidance Program, the copay for a Specialty Drug will be 20%.

To fill a specialty medication through GeniusRx Mail Order Pharmacy, follow these easy steps:

Step 1: Have your prescriber e-prescribe to Genius Rx Mail Order Pharmacy, https://www.geniusrx.com/, or fax your prescription to 1-833-308-0115. Make sure your prescriber includes your contact information. If prior authorization is required, your prescriber may need to take extra steps to submit your prescription.

Step 2: A representative from GeniusRx will call you to get more information and schedule your first delivery.

Step 3: If you have any questions regarding your specialty medication, please contact 1-844-227-7962.

Cost Avoidance Program

- The Plan has a cost avoidance program, coordinated through Payer Matrix, for some specialty drugs. A complete listing of drugs that are subject to the Cost Avoidance program can be found at https://www.payermatrix.com/1180. If you are currently taking or are prescribed a specialty drug covered by the Cost Avoidance Program, Payer Matrix will help you enroll in any applicable alternate funding programs for your eligible drug therapy, with the goal of helping you avoid any out-of-pocket expense for specialty medications.
- If you are taking or are prescribed a specialty drug, you must submit your prescription first to either a participating pharmacy (for a first fill only) or GeniusRx Mail Order Pharmacy as described above. You will then receive a telephone call to your current telephone number on file with the Fund office, outlining the enrollment process. If you do not receive a call from and believe your therapy is part of the Cost Avoidance Program you may call 877-305-6202. Capital RX conducts the clinical prior authorization to ensure the medication is medically necessary for you, and then Payer Matrix conducts an administrative review to locate a payer for the specific specialty medication you need. If the prior authorization process determines that the drug is medically necessary and Payer Matrix locates a payer, Payer Matrix and/or your Plan will assist you throughout the Cost Avoidance process, from enrollment through your receipt and use of your medication.
- If you are not eligible for any alternate funding program through Payer Matrix or opt out of the Payer Matrix program, any Specialty Drug prescriptions covered by the Plan will be processed by Capital RX according to the otherwise applicable terms of the Plan.
- For more information on how to access the specialty drug program, you may contact Payer Matrix at:

  Payer Matrix
  407 Elmwood Ave
  Sharon Hill PA 19079
  Phone number: 877-305-6202
  M-F 8am-6pm EST.
  Email: customerservice@payermatrix.com

Any Specialty Prescription Drugs covered upon opt out or ineligibility for payment through Payer Matrix may only be obtained through GeniusRx Mail Order Pharmacy.

Non-Participating Pharmacies

If for any reason you have a covered prescription filled at a pharmacy that is not a participant in the CWA Local 1180 Prescription Drug Benefit Program, you are eligible for a reimbursement from the Fund for the cost of the prescription drug at the same rate that would be payable for that drug at a participating pharmacy. You are responsible for the difference.

About PICA Drugs

Psychotropic Drugs: Psychotropic medication prescriptions, and co-payments will be subject to the same co-payment schedule as required for the general prescription drug benefit.

Asthma Medication: Eligible Employees receive these medications through the CWA Local 1180 Prescription Drug Program.

There is an annual deductible of $100 per person.

Co-payments are as follows:

Retail Pharmacy	**Mail Order**
(up to thirty(30) day supply)	(up to ninety (90) day supply)
$10 Generic	$20 Generic
$25 per Brand Name prescription	$50 per Brand Name prescription

Chemotherapy and Injectable Medication: Non-Medicare Eligible Members, employed from the City of New York, receive these medications through the City Health Insurance Program (NPA/Express Scripts Card).

CHEMOTHERAPY AND INJECTABLE medications are covered under CWA Local 1180 Prescription Drug Plan ONLY for Medicare Eligible Members, New York City Transit and Javits Convention Center members. These medications are subject to the same schedule of co-pays and deductibles (described above) which affect all Chemotherapy, Injectable and Asthma drugs.

YOUR GENERAL MEDICAL REIMBURSEMENT BENEFIT

What Is The General Medical Reimbursement Benefit?

The Fund will provide you, your spouse and eligible children up to a maximum benefit of $150 per family, per calendar year for certain unreimbursed medical expenses. You can apply the reimbursement toward un-reimbursed, out-of-pocket, health plan premium payments, deductibles and co-payments under any medical insurance covering you, your spouse and your eligible dependents. This benefit is for reimbursement of medical expenses only. Expenses for podiatry, dental, optical, and mental health services covered by the Mental Health Reimbursement Benefit are not eligible for reimbursement under this benefit.

When Is Coverage Provided?

Coverage is provided when:

- Services are received in accordance with the procedures described in this Summary Plan Description.
- Services are obtained while you, your spouse or your children are eligible for coverage (See the section entitled “Eligibility”).
- Services are medically necessary.
- Services are not otherwise excluded.

What Expenses Are Covered By the General Medical Reimbursement Benefit?

The Fund will reimburse your out-of-pocket expenses, not otherwise reimbursed under any plan of insurance or other benefit plan provided by this Fund, up to the maximum annual family limit, for:

- Unreimbursed premium payments, deductibles and co-payments under any medical insurance plan covering you, your spouse and eligible children.

Getting Your Benefit

Follow these simple steps: If you are submitting claims for unreimbursed premium payments, deductibles or co-payments under your City Health Plan or any other medical plan covering you, your spouse and your eligible children:

- Save your health plan statements showing that you have met your deductibles, co-payment expenses, and incurred premium payments for which you have not been reimbursed and had co-payment expenses for covered medical procedures.
- Obtain a claim form from the Fund Office.
- Submit photocopies of your health plan statements to the Fund Office **once each calendar year no later than June 30th** following the end of the prior year. *Claims submitted after that date will be denied.*

YOUR MENTAL HEALTH REIMBURSEMENT BENEFIT

What Is The Mental Health Benefit?

If you or your eligible dependent is under the care of a duly licensed psychiatrist, psychotherapist or psychologist, or certified social worker, the Fund will reimburse you for the actual expenses you incur for such care up to a maximum of $300 per calendar year for each covered member of your family. You should check with your employer provided health plan to determine if services of licensed psychiatrist, psychotherapist or psychologist, or certified social worker, are covered by their plan.

These benefits will be paid only for out-of-hospital mental health or substance abuse care by a provider who is not part of a hospital or outpatient facility. In New York State, under the provisions of the Health Care Reform Act of 1996, if a doctor or covered provider's practice is part of a certain hospital or outpatient facility, benefits will not be paid for their services.

Getting Your Benefit

Obtain a Mental Health Benefit Claim Form from the Fund Office or logging into your member portal at: www.cwa1180.org

- Visit any duly licensed psychiatrist, psychotherapist, psychologist, or certified social worker of your choice.
- After the testing and/or your session(s) and after you have paid for services, obtain an itemized bill marked "paid."
- Submit your claim to your basic health plan first.
- Submit a copy of the Explanation of Benefits from your basic health plan,* the paid bill and the completed claim form to the Fund Office within 90 calendar days after the services were provided. *Claims submitted after the ninety (90) day limit will be denied.*

What's Not Covered?

Benefits are not provided for Services by a provider whose office is attached to certain hospitals with New York State (call the Fund Office for a list of such providers).

YOUR OPTICAL BENEFIT

What Is The Optical Benefit?

You and your eligible dependents are entitled to one claim for optical services per individual, per calendar year, but not more than four claims per family, per calendar year. Optical services for:

Age 19 or Older:

Every eligible person age 19 or older is entitled to one eye exam and one pair of prescription eyeglasses per person, per calendar year, up to four pairs of glasses or contact lenses per family, per year. The maximum benefit is $100 per eligible person.

- Eye examinations (for vision correction only). Treatment of illness or injury is not covered.
- Prescription eyeglasses (lenses and frames, including prescription sunglasses or contact lenses).
- Replacement of lenses and/or frames.
- You will be reimbursed up to a maximum of $100 per eligible claim.

VDT glasses are covered by the City. Eligibility verification can be requested by contacting the Benefits Department at benefits@cwa1180.org or 212-966-5353.

Dependents Under Age Nineteen (19):

Children under the age of nineteen (19) are also entitled to one eye exam and one pair of prescription eyeglasses per calendar year and there is no cost or annual dollar limit on benefits the Fund will pay, however, they are only eligible for benefits using an in-network provider- GVS, CPS, Vision, Screening, or Vision World – with a selection of special pediatric carousel of frames covered by the plan. A pair of eyeglasses will be provided without charge if the prescription changes within the year. For broken, lost or stolen eyeglasses, the charge for a second pair of eyeglasses in a year will be $50, $75 or a third pair, and $100 for any beyond that.

What Is Excluded From This Plan?

- Non-prescription sunglasses are not covered.
- Repairs to eyeglasses are not covered.
- Treatment of illness or injury is not covered.
- Services not leading to the purchase of glasses will not be honored.

How Do You File A Claim?

Follow these simple steps to receive the optical benefits:

- Obtain a claim form from the Fund Office.
- Visit **any in-network** ophthalmologist, optometrist or optician of your choice.
- You should check with your employer provided health plan to determine if services of an ophthalmologist, optometrist or optician are covered by their plan.
- You may also visit an out-of-network ophthalmologist, optometrist or optician. However, please note that the cost of services may be greater than the costs for the in-network provider and the same maximum benefit of $100 still applies. If you wish, you may opt out of this out-of-network optical benefit. Please contact the Fund office if you wish to do so.
- After your optical service is completed and you pay for the service, obtain an itemized bill,
- marked "paid" which indicates the name of patient and services rendered.
- Submit your paid bill and the completed claim form to the Fund Office within ninety (90) calendar days after the expense is incurred. Claims submitted after the ninety (90) day limit will be denied.
- You will be reimbursed up to a maximum of $100 per claim for you or your eligible dependents.

What Is The No-Cost Optical Benefit Option?

The Fund has arranged with certain participating providers to make covered vision benefits available to you, your spouse and eligible children. If you choose the no-cost option, you, your spouse and eligible children will receive **at no out-of-pocket expense**. (No claim forms or vouchers are required.)

- A comprehensive eye exam.
- A wide choice of eyeglass frames.
- A choice of lenses, tinting and UV coating.
- Instead of eyeglasses, choose contact lenses (standard soft, spherical contacts, or disposable lenses).

To obtain these benefits:

- Contact the Fund Office for a list of participating providers and their locations, as well as the pan description.
- To avoid out-of-pocket costs, ask the participating provider to show you the lenses, frames and services covered by the program.
- Plan limitations apply. If the costs of the eye examination, eyeglasses or contact lenses exceed $100, you must pay the difference.

Benefits are not provided for:

- Non-prescription sunglasses.
- Repairs to eyeglasses.
- Treatment of illness or injury.
- Expenses for which benefits are payable under any Workers' Compensation Law.
- Upgraded lenses, frames and services.
- Services by a provider whose office is attached to certain hospitals within New York State (call the Fund Office for a list of such providers).

YOUR HEARING AID REIMBURSEMENT BENEFIT

What Is The Hearing Aid Reimbursement Benefit?

The plan pays up to a maximum of $300 towards the cost of a hearing aid. This benefit is provided no more than once in every two consecutive year period for each covered member and eligible dependent. You should check with your employer provided health plan to determine if hearing analysis, tests and evaluation are covered by their plan.

Covered Hearing Aid expenses include the charges that an individual is required to pay for hearing aid appliances, hearing analysis, tests or evaluations by a physician, otologist or audiologist. **Hearing analysis, tests and evaluation that do not result in the purchase of a hearing aid will not be covered by the Fund.** Covered expenses also include charges for the cost and installation of a Hearing Aid that was provided after the date of a written recommendation by a physician, otologist, or audiologist.

What Is Not Covered?

No benefits are provided for:

- Expenses not recommended or approved by a physician, otologist, or audiologist.

- Expenses for which benefits are payable under any Workers' Compensation law.
- Non-durable equipment, such as batteries.
- Special procedures or training such as lip reading courses, schooling or institutional expenses.
- Medical or surgical treatment of the ear or ears.
- Charges for services or supplies which are covered in whole or in part under any other benefit plan of the Fund.
- Repairs or adjustments of hearing aids.
- Hearing tests and evaluations that do not result in the purchase of a hearing aid appliance prescribed by a physician, otologist or audiologist.
- Services by a provider whose office is attached to certain hospitals within New York State.* (call the Fund Office for a list of such providers).

**under the provisions of the Health Care Reform Act 1997.*

How Do You Claim The Hearing Aid Benefit?

Follow these simple steps to receive the benefit:

- Obtain a Hearing Aid Benefit claim form from the Fund Office.
- Have the form completed at the time the services are rendered.
- Pay for the services or appliance.
- Return the claim form to the Fund Office together with an itemized paid bill describing the services rendered the date services were provided and the appliance purchased, the amount charged and the name of the person who required the hearing appliance. The claim form must be submitted to the Fund Office within ninety (90) calendar days after the date the hearing appliance was purchased. Claims submitted beyond the ninety (90) calendar day limit will be denied.

YOUR PODIATRY BENEFIT

What Is The Podiatry Benefit?

When you or your spouse needs podiatry care, the Fund provides benefits of up to $10 per visit for a maximum of four visits to a podiatrist during each calendar year. You should check with your employer provided health plan to determine if podiatry care is covered by their plan.

How Do You File A Claim?

- Obtain a Podiatry Claim Form from the Fund Office. After you visit your podiatrist and you pay your bill, obtain a copy of the bill marked "paid."
- Your provider must complete and sign the podiatrists section of the form.

- Complete and sign the employee section of claim form, and submit it to the Fund Office along with the bill.
- Podiatry Benefit claims must be submitted to the Fund Office within ninety (90) calendar days following the date of treatment.

Claims submitted after the ninety (90) *day limit will be denied.*

What's Not Covered

Benefits are not provided for:

- Charges for services covered in whole or in part by any other benefit plan.
- Expenses for which benefits are payable under any Workers' Compensation law.
- Services by a provider whose office is attached to certain hospitals within New York State (call the Fund Office for a list of such providers).

YOUR EDUCATION BENEFITS FUND

Dear Member:

The Education Benefits described in this section are provided through the CWA Local 1180 Education Fund. This Fund is maintained through a trust, separate and distinct from the trust maintained for the Security Benefits Fund, the Legal Benefits Fund, and the Members' Annuity Fund.

The information contained in this section provides a description of the benefits provided by the Education Fund.

Sincerely,

Board of Trustees
CWA Local 1180 Education Fund

CWA Local 1180 Education Benefits Fund

6 Harrison Street, 3rd Floor
New York, NY 10013
(212) 966-5353, Out-of-area (888) 966-5353
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Gould, Kobrick & Schlapp, PC

YOUR EDUCATION BENEFITS FUND

What Are The Benefits Provided By This Fund?

The benefits from this Fund cover the wide range of educational programs described below.

College Tuition Reimbursement

The College Tuition Reimbursement Program provides reimbursement of up to $300 per semester beginning Fall Semester 2021, for tuition and/or registration fees if you successfully complete courses for which you earn college credit at any accredited college or for remediation courses given at a college or university. If you complete your course(s) with a passing mark and submit the required claim form, you will be reimbursed at the end of the term. The program will pay benefits for a maximum of three terms per year: Spring, Summer and Fall.

Book Reimbursement

If you are enrolled in a course covered by the College Tuition Reimbursement Program or CUNY School of Labor and Urban Studies, you can be reimbursed up to $25 each of the three semesters (Spring, Summer, and Fall) for books related to the courses you are taking.

The CUNY School of Labor and Urban Studies (SLU) serves working adults who seek to improve their professional skills, upgrade their qualifications, advance their careers, and deepen their understanding of the world. Established as a partnership between The City University of New York and New York City labor unions, SLU provides working adults increased opportunities to earn a college degree or certificate.

The School of Labor and Urban Studies Offers:

- Application assistance.
- Free tutoring and college preparation classes.
- Assistance with transfer credits and Life Experience credits.
- Convenient locations and Evening and weekend classes.
- Counseling services and Assistance with union tuition support and financial aid.
- Academic support and advisement.

The Urban Leadership Program is a special series of college courses subsidized by CWA Local 1180 Fund participants who are interested in advancing their careers and taking on leadership roles in their union, workplace and/or community. The program offers courses in Urban Studies, Public Administration and Policy, Community Leadership, Healthcare Administration, Labor Relations, and Labor Studies. All courses in the series are offered for college credit and lead to either a certificate or college degree from the CUNY School of Labor and Urban Studies or Queens College.

Benefits for 1180 Fund Participants:

- 30 credits and most student fees towards undergraduate study and 24 credits and most student fees for graduate study in Urban Studies, Labor Studies, Public Administration and Health Care Administration.
- $300 tuition reimbursement per semester that can be applied to cover the additional credits needed to complete your degree. However, you cannot receive the tuition reimbursement for a course which is being paid for under the CUNY SLU program.
- SLU Offers: MA in Labor Studies Scholarship at the CUNY School of Labor and Urban Studies.
- Diversity Scholarships in Labor Studies are available, and you must apply through CUNY SLU.
- Need and merit-based scholarships and Financial aid application assistance.

Local 1180 Fund Participants will:

- Earn higher education credits and credentials.
- Deepen their understanding of urban problems and issues.
- Improve their analytical skills.
- Expand their knowledge of government agencies, labor relations, urban planning, and the legislative and budgetary processes.

Courses are designed to:

- Engage Fund participants in generating new ideas for solving the City's most pressing challenges.
- Offer Fund participants the unique opportunity to participate in task forces on a wide range of public policy topics including social welfare, housing, health care, criminal justice, economic development, and education.
- Apply their experience as a public service professional to examining and challenging government policy and procedures and developing alternative policy recommendations.
- Prepare Fund participants for a leadership role in their workplace, union, and community.

For More Information:

- School of Labor and Urban Studies Manhattan Campus: 212.827.0200, slu.cuny.edu/1180
- Queens College Campus: 718.997.3060, https://slu.cuny.edu/worker-education/murphy-queens/

Adult Education Program Tuition Reimbursement

If you successfully complete courses in a job-related or job-advancement area in an Adult Education Program, you can receive reimbursement of the course fees up to a maximum of $200 per year. The reimbursement will be made at the conclusion of the term .

Career Development Conferences

If you attend a conference in a job-related or job-advancement area for Career Development, you can receive reimbursement up to a maximum of $200 per year. The reimbursement will be made at the conclusion of the conference.

NOTE: Combined reimbursement for Adult Education Courses and Career Development Conferences cannot exceed $200 for all such benefits in a calendar year.

Workplace Literacy Program

The Fund develops and administers courses for Local 1180 members to upgrade and expand their skills in order to function more effectively on their jobs.

These courses are designed to assist the member in improving workplace skills in such areas as management, supervision, communications, computers, and personal development.

Program offerings are announced through the *Communiqué* and registration is done online at www.cwa1180.org.

Exam Prep Courses

The Fund develops and administers courses for Local 1180 bargaining unit members to assist them in preparing for civil service promotional examinations for titles in the bargaining unit.

Program offerings are announced through the *Communiqué* and registration is done online at www.cwa1180.org.

Who Is Eligible For Benefits?

Education Fund Benefits are available to you if you meet the following requirements:

- You are employed in a covered title on the first day of class.
- You are an active, full-time, per annum employee. Part-time employees and employees on leaves of absence are not eligible.
- You work for an employer whose contract with CWA Local 1180 provides for contributions to the Local 1180 Education Fund.

How Do You Apply For Benefits?

If you want to take advantage of any of the benefits provided by the CWA Local 1180 Education Fund, contact our office for a claim form:

CWA Local 1180 Education Fund
6 Harrison Street, 3rd Floor
New York, NY 10013-2893
1-212-966-5353
benefits@cwa1180.org

You must submit:

- A separate claim form for each semester.
- Your bursar's receipt and/or financial statement showing tuition and registration fees paid.
- For reimbursement claims for Adult Education Courses and Adult Education Conferences, you must submit a paid receipt, a course or conference completion statement and complete the registration form following instructions on the form no later than 90 days after the completion of the Course or Conference.
- For Book Reimbursement Program, you must submit a paid receipt and complete the book reimbursement form no later than 90 days after the last day of class.
- The Fund shall determine, based on the certification and any other information provided, whether a course or conference qualifies for coverage on the basis that it is job related or will improve your opportunity for job advancement by enhancing your skills.

No Duplication of Benefits

You cannot receive duplicate benefits from the Education Fund. For example, you cannot receive tuition reimbursement from the College Tuition Reimbursement Program and the Adult Education Program for the same expense.

Amendment or Termination of Benefits

The benefits provided by this Fund may, from time to time, be changed, modified, augmented or discontinued by the Board of Trustees. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this Supplemental Plan Description are subject to such rules and regulations and to the Trust Agreement that established the Fund and governs its operations.

Your coverage will stop on the earliest of the following dates:

- When the Fund is terminated.
- When you are no longer eligible.
- When the Employer ceases to make contributions on your behalf to the Fund.

Benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees. No person acquires a vested right to such benefits either before or after his or her retirement. The Trustees may expand, modify or cancel the benefits for active members; change eligibility requirements; and otherwise exercise their prudent discretion at any time without legal right or recourse by an active member or any other person.

Right to Appeal

The Board of Trustees may change the benefits provided by this Fund. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this Supplemental Plan Description are subject to such rules and regulations and to the Trust Agreement that established and governs the Fund operations.

The Fund Office uniformly applies all rules. The action of the Fund Office is subject only to review by the Board of Trustees.

A member may request a review of action by submitting notice in writing to the Board of Trustees, CWA Local 1180 Education Fund, 6 Harrison Street, New York, New York, 10013. The Trustees shall act on the appeal within a reasonable period of time and render their decision in writing, which shall be final and conclusive and binding on all persons.

Other Educational Opportunities through DCAS

In addition to the Education Fund benefits described above, the Trustees wish to inform you about other educational opportunities that are available through DCAS. For further information see https://slu.cuny.edu/about/labor-community-employer-partners/dcas/.

YOUR LEGAL BENEFITS FUND

Dear Member:

The legal benefits described in this section are provided through the CWA Local 1180 Legal Benefits Fund. This Fund is a trust, separate and distinct from the trust maintained for the Security Benefits Fund, the Retirees Benefits Fund, the Education Fund, and the Members' Annuity Fund.

Sincerely,

Board of Trustees
CWA Local 1180 Legal Benefits Funds

CWA Local 1180 Legal Benefits Fund

6 Harrison Street, 3rd Floor
New York, NY 10013
(212) 966-5353, Out-of-area (888) 966-5353
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YOUR LEGAL BENEFITS FUND

Who's Eligible?

You are eligible to participate in the benefits provided by the Legal Benefits Fund if:

- You are in a job title represented by CWA Local 1180, AFL-CIO.
- Contributions are received by the Legal Benefits Fund on your behalf pursuant to a collective bargaining agreement between your employer and Local 1180.

In certain instances, your spouse, certified domestic partner and your eligible children (as defined by the Fund) are entitled to benefits provided by the Legal Benefits Fund. Please refer to each specific benefit for more information.

Your eligible dependents: A dependent, as defined by the Fund, is your spouse or domestic partner and each child 2 weeks or more of age who has not attained his or her 19th birthday, or his or her 26th birthday and for whom you have requested annually for Extended Coverage. "Child" includes a natural child, stepchild, legally adopted child (which would include those in the waiting period) or foster child, provided the child is dependent on you for support or maintenance. The Fund may request proof of dependent status through affidavit, income tax returns, court orders, and birth certificates or otherwise.

When Does Coverage Begin?

Coverage for you and your eligible dependents begins on the day you are placed on the payroll in a job title represented by CWA Local 1180, AFL-CIO and for which contributions are made.

When Does Coverage End?

Your coverage ends when you cease to be employed in a job title that is represented by CWA Local 1180, AFL-CIO and/or for which contributions are made. However, if you are on an approved leave of absence for illness, coverage may be extended for the period of time during which you are receiving disability benefits from the Security Benefits Fund. You should promptly contact the Fund Office if you are on such a leave to find out how to obtain such extended coverage.

What Happens When I Retire?

Retirees are eligible to continue the legal services benefits from this Fund. Please consult the separate Retirees Benefits Supplemental Plan Description for further details.

How Does The Plan Work?

If you need a lawyer for any of the services listed in this Summary Plan Description, follow this procedure. Call the CWA Local 1180 Legal Benefits Fund Office at 1-212-966-5353, or come to the office located at 6 Harrison Street, New York, New York 10013-2898, and tell the office that you want to see a panel attorney.

Once the Fund Office determines that you are eligible for benefits, an appointment will be scheduled for you. From that point on, all contact will be directly between you and the panel attorney. This assures you of a confidential relationship between you and your lawyer.

If you cannot be present for your scheduled appointment, you should notify the Fund Office and cancel the appointment as soon as possible. If you fail to appear for a scheduled appointment without having notified the Fund Office, the Fund will deduct a half-hour from your General Consultation Benefit of three one-half hour sessions for that calendar year.

During your first visit with the panel attorney, you and the attorney will complete a claim form for legal benefits.

You are not, of course, required to use the benefits provided by the Legal Benefits Fund. You are free at all times to hire your own attorney but the Plan will not cover the fees charged by anyone other than a panel attorney or an outside attorney designated by the Fund. **(See Member vs. Member Disputes below.)**

Under exceptional circumstances, the Panel Attorney or Plan designated outside attorney may either refuse to represent or discontinue representing you or your eligible dependents. You may appeal such a decision, as explained in the section on "Request for Review of Denial of Claim."

You are not required to pay any subscription or enrollment fee in order to be entitled to benefits from the Fund. However, due to Internal Revenue Service regulations, the value of this benefit will be reported as income on your year-end W-2 statement of earnings.

Member vs. Member Disputes

In cases where two covered members are involved on opposite sides of the same controversy or proceeding, and both members are entitled to Fund benefits in the matter, each member will be

provided with an attorney. This will insure that each party to the dispute will receive the same high quality of legal service.

What Does The Plan Cover?

The legal services benefits of the Legal Benefits Fund are divided into three categories:

- General Matters
- Civil Matters
- Criminal Matters

There is also a Court Cost Disbursement Benefit, which covers court costs that may be charged to you if you receive certain covered legal services.

Is There A Time Limit On The Legal Services Provided To You?

There is no overall time limit on your legal services. However, certain benefits do have restrictions. Please read the descriptions of the benefits to determine these restrictions.

Are There Geographical Limitations?

Yes. No benefit will be provided by this Plan that cannot be resolved within New York, Bronx, Kings, Queens, Richmond, Nassau, Suffolk, Rockland, Putnam, Westchester, Dutchess, Orange and Ulster Counties in the State of New York and Bergen, Hudson, Essex, Union, Middlesex, Passaic, Morris, Somerset, Mercer and Monmouth Counties in New Jersey. For members residing outside this geographical area, the Legal Benefits Fund will provide reimbursement according to the Out-of-Area Reimbursement schedule of fees (see "Table of Contents").

IMPORTANT NOTE:

You are entitled to legal services benefits from a Panel Attorney or, for members residing outside the geographical area referred to above, Out-of-Area legal services benefits in accordance with the Out-of-Area Reimbursement Schedule, but NOT BOTH. The determination of your benefit provider i.e., panel attorney or out-of-area legal services, depends on your address on file with the Fund Office.

What Are The General Matter Benefits?

- **General Consultation Benefit**

  You are entitled to a maximum of three one-half hour consultations each calendar year with a panel attorney. These consultations may be about any legal matter.

- **Document Review Benefit**

  You can consult with a panel attorney to review legal documents, such as warranties, guarantees, installment purchase agreements, loans, leases, insurance policies, and court papers, but not including tax returns or work being prepared by other attorneys at the time of your document review appointment. There is also coverage for consultations and document reviews for your unemancipated children.

  You are entitled to use the Document Review Benefit as many times as you feel it is necessary during the calendar year.

- **Identity Theft Protection Benefit**

  Who is Eligible?

  Any member who wishes legal consultation in connection with an identity or personal information theft issue is covered by this benefit.

  What is the Benefit?

  The Fund provides coverage through the panel law firm for a member to consult with an attorney if the member believes he/she has been the victim of an act of identity or personal information theft including but not limited to the following examples:

  - using or opening of a credit card account in the member's name, fraudulently;
  - opening telecommunications or utility accounts in the member's name, fraudulently;
  - passing bad checks or opening a new bank account in the member's name, without authorization; and
  - obtaining a loan in the member's name, fraudulently.

  The panel law firm will provide consultation and assistance* to a member in connection with their contacting and reporting an act of identity theft to the three major credit bureaus, the security departments of the appropriate creditors or financial institutions, the police and the Federal Trade Commission.

  The Fund makes this benefit available at no charge to member.

  How is the Identity Theft Benefit Obtained?

  To obtain the Identity Theft Benefit, simply contact the Fund to request an appointment. At the time of your appointment, you and an attorney from the panel law firm will complete the appropriate forms.

  ** The Identity Theft Benefit does not include representation in litigation other than that already provided in the Consumer Protection Benefit.*

What Are The Civil Matters Benefits?

You are to use no more than three Civil Matter Benefits each calendar year. The Last Will and Testament Benefit will not count towards reaching this annual maximum.

- **Last Will and Testament Benefit**

  You and your spouse are entitled to have a Last Will and Testament prepared and executed under supervision of a panel attorney. This benefit is provided once every two years.

- **Living Will/Health Care Proxy**

  You and your spouse are entitled to a Living Will and/or Health Care Proxy at no cost to you. A Living Will/Health Care Proxy serves as a clear, documented expression of an individual's carefully considered intention to have life-sustaining procedures withheld or withdrawn in the event he/she were to suffer from a catastrophic illness, disease or injury from which there is little likelihood that he/she would recover to enjoy a meaningful quality of life. Your adult children are also entitled to a Health Care Proxy, power of attorney and HIPAA authorization provided the adult child appoints you as his/her representative/proxy.

- **Designation of Person in Parental Relation**

  You are entitled to have a Designation of Person in Parental Relation prepared for you.

- **Legal Defense Benefit**

  You are entitled to the services of a panel attorney for the defense of a lawsuit or proceeding against you in a court or administrative agency.

- **Appeals Benefit**

  You will be provided with the services of a panel attorney if you wish to appeal the decision of a court of law or administrative agency regarding a civil action. Because of the very high cost of initiating appeals, the panel attorney will provide services only when an appeal is appropriate and would have a likelihood of success. This benefit is available to you whether or not you used a panel attorney in the original action.

  This benefit provides legal representation for appeals to the following courts:

  - Appellate Term
  - Appellate Division, First and Second Departments of the Supreme Court of the State of New York
  - New York State Court of Appeals
  - Appellate Division of the Superior Court of New Jersey
  - United States Court of Appeals for the Second Circuit
  - United States Supreme Court

When an appeal is filed on your behalf, the court will charge you for the costs of printing a Record of Appeal. You must pay 25% (to a maximum of $150) of these costs. The Plan will pay the balance.

- **Legal Separation Benefit**

  You are entitled to the services of a panel attorney if you are seeking a mutually agreed upon separation agreement between yourself and your spouse or if you are a plaintiff or a defendant in a legal separation action.

- **Pre-Nuptial Agreement Benefit**

  You are entitled to the services of a panel attorney for the preparation of pre-nuptial agreements.

- **Divorce Proceeding Benefit**

  A panel attorney will provide services if you are a defendant or a plaintiff in contested or uncontested divorce proceedings.

- **Annulment Proceeding Benefit**

  You are entitled to the services of a panel attorney if you are a defendant or a plaintiff in contested or uncontested annulment proceedings.

- **Family Court Benefit**

  You are entitled to the services of a panel attorney if you are a Petitioner or Respondent in a Family Court action. This benefit covers actions and proceedings involving maternity, paternity, and non-support cases.

- **Custody Benefit**

  A panel attorney will provide services if you are a Respondent or a Petitioner in custody dispute, whether or not it goes to court.

- **Adoption Benefit**

  A panel attorney will represent you in adoption proceedings. This benefit is limited to the services normally rendered by an attorney in formalizing an adoption; it does not cover fees or expenses to adoption agencies or any other agencies.

- **Personal Bankruptcy Benefit**

  You are entitled to a panel attorney's services involving the preparation of a petition to file for personal bankruptcy.

- **Veteran and Service Affairs Benefit**

  You are entitled to the services of a panel attorney if you feel that a military board or an agency of the United States Government has denied your rights as a veteran.

- **Estates and Administration Benefit**

  If you, your spouse, certified domestic partner, or your eligible dependent is named an executor in a Will, or if there is no Will, to qualify under the laws of intestacy as an administrator of an estate (An "intestate" is a person who dies without leaving a valid will. The laws of intestacy sets forth the rules for administration of an intestate's estate, including who is qualified and must be granted "Letters of Administration" to see to the distribution of the assets of such an estate.), a Panel Attorney will provide services required in all phases in the handling of the estate. You pay nothing for a consultation with the attorney. As for the other phases in the handling of the estate, you pay nothing if the estate is classified as a "small estate" (valued at $30,000 or less).

  or

  In the instances where the estate is not classified as a "small estate", the panel law firm has also agreed to provide legal representation with a 25% reduction in its current hourly rate, which for 2020 is $450. This hourly rate is subject to change.

  or

  The panel attorney will also provide legal representation if you or your eligible dependent is, or claims a right to be, named a beneficiary, heir, or next of kin.

  This benefit will also cover your eligible dependent if you die and the dependent qualifies to be appointed the executor or administrator of your estate.

- **Homeowner Rights Benefit**

  A covered member who owns a house, a condominium or a cooperative or is in the process of buying such a residence will be provided with the services of a panel attorney for:

  - The sale or purchase of the residence in which the member primarily resides.
  - Problems relating to a Board of Management or a similar group that governs certain aspects of a private dwelling, condominium or cooperative in which the member primarily resides.
  - Mortgage foreclosures of any of the above-stated primary residences.
  - This benefit does not cover situations involving a title search, title insurance, appraisal value, or seller misrepresentation.

  Plan participants must receive preauthorization from the Fund Trustees when requesting legal services for more than two house closings in a calendar year for their primary residence.

- **Tenant Rights Benefit**

  If you are a residential tenant or you are in the process of entering into a residential lease, you will be provided with the services of a panel attorney for:

- Matters involving the lease or sublease of the residence where you primarily reside or intend to primarily reside.
- Problems with your landlord or management company.
- Proceedings involving your right to sublet your primary residence, your right to possession of the premises, or a suit against you for damages resulting from your possession of the premises.

This benefit does not cover your rights as a landlord or sublessor except for your right to sublet your residence.

What Are The Criminal Matter Benefits?

- **A "Public Officer's Benefit" For Members**

  This means that a panel attorney will defend you, the member, if you are sued as a result of actions arising out of your duties as a public employee by one other than your employer.

- **Criminal Arraignment Benefit**

  If you are arrested for a criminal offense, whether it be a felony, misdemeanor or violation, a panel attorney will:

  - Represent you if you have been arrested and you are being interrogated by law enforcement official.
  - Counsel you before the arraignment on the application for bail and on possible negotiations of the charges against you.
  - Appear in court to enter a plea on your behalf, issue an application for bail, and when possible, seek a disposition of the charges against you.

  This benefit does not include any aspects of post-arraignment legal practice, such as investigation of the charges, pre-trial motions, or trial or appellate representation. It also does not cover appearances for Vehicle and Traffic Law violations, including driving while intoxicated or impaired.

- **Criminal "Hotline" Benefit**

  If you are arrested, you or anyone on your behalf should call the Fund Office at 1-212-966-5353 to arrange an appointment with a panel attorney. If the office is closed, or if the arrest occurs after working hours, on a weekend, or on a holiday, call the Fund's 24-Hour Answering Service at 1-212-484-9756, and a panel attorney will assist you as soon as possible.

- **Bail Bond Benefit**

  If you are arrested in a non-work-related situation on a civil or criminal charge, the Fund affords you a bail bond of up to $2,500. To obtain this benefit, you or someone on your behalf should call the Fund Office at 1-212-966-5353. If the office is closed, or if the arrest occurs after working hours, on a weekend, or on a holiday, call the Fund's 24-Hour Answering Service at 1-212-484-9756, and a panel attorney will assist you as soon as possible.

What Is The Court Cost Disbursement Benefit?

The Fund will pay court costs, to a maximum of $100 per calendar year, in any legal matter in which you are using a panel attorney or an outside attorney designated by the Plan. Court costs include filing fees, deposition fees, and costs relating to investigations. **The Fund will not pay any fines, penalties or other amounts that you are required to pay as a result of a judgment against you.**

The panel attorney will prepare all forms, bills, and other papers relating to court costs. You are not required to file a claim form for this benefit.

What Is The Legal Benefits Program For Out-Of-Area Members?

The Legal Benefits Program provides for payment of a stipend for each covered service listed below. If you **live outside the geographical area** served by the Plan attorney, (please refer to the Geographical Limitations describe in "What Does the Plan Cover" section), you are entitled to a maximum reimbursement up to $1,000 per year, per family in accordance with the schedule below. In order to receive benefits, you must pay the attorney and then submit a claim form together with a copy of the Attorney's bill marked "Paid" to the Fund office. All claims must be submitted to the Fund Office no later than ninety days following the date on which the service is provided. Claims submitted after the ninety-day limit will be denied.

Covered Out-of-Area Legal Services And Schedule of Reimbursable Allowances

- *SIMPLE WILL* – entitles you and your spouse, or certified domestic partner, to each have simple wills prepared and executed (once every two calendar years). ($65)
- *GENERAL CONSULTATION BENEFIT* – entitles you to consult an attorney and seek professional advice concerning any legal problems whatsoever (three one-half hour consultations per calendar year). ($35 per visit)

- *DOCUMENT REVIEW BENEFIT* – entitles you to have an attorney review and interpret legal documents such as guarantees, lease, loan and installment of sale, etc. (three times per calendar year). ($35 per visit)
- *DIVORCE PROCEEDINGS BENEFIT* – entitles you to representation in an action for divorce whether you are the plaintiff or defendant. ($500)
- *LEGAL SEPARATION BENEFIT* – entitles you to legal representation in seeking a separation from your spouse, by means of a separation agreement or relief through the court by an action for legal separation. ($500)
- *ANNULMENT PROCEEDINGS BENEFIT* – entitles you to legal representation in an annulment proceeding. ($500)
- *ADOPTION BENEFIT* - entitles you to legal representation in formal adoption proceedings (limited to those services normally rendered by an attorney to formalize an adoption). ($500)
- *PERSONAL BANKRUPTCY BENEFIT* – entitles you to the legal services necessary to file a petition for personal bankruptcy. ($350)
- *CHANGE OF NAME BENEFIT* – entitles you to the legal services necessary to file all appropriate papers and represent you in the change of name process. ($350)
- *CUSTODY BENEFIT* – entitles you to legal representation when you are named a plaintiff or defendant in a custody dispute. ($350)
- *APPEALS BENEFIT* – entitles you to legal representation in appealing the decision of a court or administrative agency, regarding a civil action ($500)
- *FAMILY COURT BENEFIT* – entitles you to legal representation where you are a defendant or plaintiff in Family Court action involving maternity, paternity or non-support. ($300)
- *VETERANS AND SERVICE AFFAIRS BENEFIT* – entitles you to legal representation in seeking remedial action in relation to a denial or the pursuit of your rights before a military board or agency of the U.S. Government. ($500)
- *HOMEOWNER RIGHTS BENEFIT* – entitles you to legal representation in the purchase or sale of any home, condominium or co-operative you intend to live in as your primary residence, or the purchase of any unimproved property on which you intend to build your primary residence or co-operative, or the refinancing of a mortgage on a primary residence (one sale/purchase/refinance per calendar year). (Sale/purchase/refinance - $600; Mortgage Foreclosure - $500)
- *ARRAIGNMENT BENEFIT* – entitles you, when a defendant in a criminal proceeding outside the metropolitan area, to the appearance by an attorney before the court where you are charged as the defendant in a criminal matter. Excluded from this benefit is the cost of legal representation for Vehicle and Traffic Law infractions and representation beyond the arraignment state (one per calendar year). ($250)
- *TENANT RIGHTS BENEFIT* – entitles you to legal representation for matters involving the lease or sublease of your primary residence. (Consultation regarding lease - $35; consultation

regarding problem with landlord or management company - $35; legal proceedings against you - $300)

- *PLANNING FOR THE ELDERLY* – entitles you and your spouse, or certified domestic partner, the opportunity to consult with an attorney on matters involving placement of elderly parent(s) in nursing homes, available Medicare entitlements and health planning for the elderly, including preparation of powers of attorney (three per calendar year). ($35 per visit)
- *ESTATES AND ADMINISTRATION BENEFIT* – entitles the covered member or eligible dependent to all legal services required in connection with the handling of an estate from its inception (probate of a Will or Petition for Letters of Administration). ($350)
- *COURT COST DISBURSEMENT BENEFIT* – entitles you to reimbursement of court costs for covered legal matters including filing fees, deposition fees and costs relating to investigations, but does NOT include fines, penalties or other amounts that you are required to pay as a result of a judgment against you ($100 per calendar year).

What Is Not Covered By The Plan?

The CWA Local 1180 Legal Benefits Fund will not provide legal services for the following matters:

- Cases against your employer or your employer's agents or officers.
- Cases against any of the CWA Local 1180 Benefits Funds, their Trustees, agents or Attorneys or CWA Local 1180 or its officers or agents.
- Cases for which the Fund is prohibited by law to defray the cost of Legal Services.
- Any controversy, action or proceeding in which representation on a contingent fee basis is normally or customarily available or where the fee is payable by virtue of statute or by order of court.
- Class actions or interventions or amicus curiae activities; two or more covered persons involved in the same legal matter may not combine their benefits from this Plan.
- Any matter concerning the payment of income tax, including preparation or filing of income tax returns.
- Cases for which legal services are available through insurance or through any government agency or government attorney.
- Cases in which you have already retained a private attorney.
- Cases that began before you became eligible for benefits from this Plan.
- Cases for which you retained legal counsel before you became eligible for benefits from this Plan.
- Proceedings under NYS Alcoholic Beverage and Control Law.
- Proceedings before the City Parking Violations Bureau or the State Department of Motor Vehicles.
- Any controversy, dispute, proceedings or matter which involves a member's business, commercial or investment interest.

If you have any questions about coverage and exclusions, contact the Fund Office at 1-212- 966-5353.

Request for Review of Denial of Claim

If your claim for Legal Services Benefits is denied and you disagree with the decision, you may request a review of your claim:

- All initial claims for benefits by a Member or Beneficiary (hereinafter for purposes of this Section, the "Claimant") under the Plan must be in writing and sent to the Fund Office, to the attention of the Trustees within sixty (60) days of receiving notification of a denial or any other decision with which you disagree. A decision regarding the claim will be made by the Trustees, or their duly authorized designee, within sixty (60) days from the date the claim is received by the Fund Office, unless it is determined that special circumstances require an extension of time for processing the claim, not to exceed an additional ninety (90) days. If such an extension is required, written notice of the extension will be furnished to the Claimant prior to expiration of the initial ninety (90) day period. The notice of extension will indicate the special circumstances requiring the extension of time and the date by which the Trustees, or their duly authorized designee, expects to make a determination with respect to the claim. If the extension is required due to the Claimant's failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to the Claimant until the date on which the Claimant responds to the Fund Office's request for information.
- A Claimant whose application for benefits under the Plan has been denied, in whole or in part, will be provided with written notice of the determination, setting forth: (I) the specific reason(s) for the adverse benefit determination, with reference to the specific Plan provisions on which the determination is based; (ii) a description of any additional material or information necessary for the claimant to perfect the claim (including an explanation as to why such material or information is necessary); and (iii) a description of the Fund's review procedures and the applicable time limits, as well as a statement of the claimant's right to bring a civil action following an adverse benefit determination on review.
- If an adverse benefit determination is made by the Trustees, or their duly authorized designee, the Claimant (or his/her authorized representative) may request a review of the determination. All requests for review must be sent in writing to the Trustees within sixty (60) days after receipt of the notice of denial or other adverse benefit determination. In connection with the request for review, the Claimant (or his duly authorized representative) may submit written comments, documents, records, and other information relating to the claim. In addition, the Claimant will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records, and other information relevant to the claim. The review by the Trustees will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim.

- A decision on review will be made by the Trustees (or a committee designated by the Board of Trustees) at their next regularly scheduled meeting following receipt of the request for review, unless the request is filed less than thirty (30) days prior to the next regularly scheduled meeting, in which case a decision will be made by no later than the date of the second regularly scheduled meeting following receipt of such request for review. If special circumstances require an extension of time for processing the request for review, the decision may be made at the third meeting following receipt of such request. The Claimant will be notified in advance of any such extension. The notice will describe the special circumstances requiring the extension and will inform the Claimant of the date as of which the determination will be made. If the extension is required due to the Claimant's failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to the Claimant until the date on which the Claimant responds to the Fund Office's request for information.
- The Claimant will be noticed in writing of the determination on review within five (5) days after the determination is made. If an adverse benefit determination is made on review, the notice will include: (I) the specific reason(s) for the adverse benefit determination, with references to the specific Plan provisions on which the determination is based; (ii) a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to (and copies of) all documents, records and other information relevant to the claim; and (iii) a statement of the Claimant's right to bring a civil action. The decision of the Trustees (or their designated committee) on review shall be final and binding on all parties.
- In the event the Trustees, or their duly authorized designee, fail to respond to an initial claim for benefits or an appeal thereof within the time frames applicable thereto, the claim or appeal shall be deemed denied for all purposes of this section as of the date on which the Trustees, or their duly authorized designee, would otherwise be required to respond to the claim or appeal.

YOUR ANNUITY BENEFITS FUND

INTRODUCTION

The Plan of the CWA Local 1180 Members' Annuity Fund (the "Plan") was established effective July 1, 1999 by the Board of Trustees of the CWA Local 1180 Members' Annuity Fund. It is financed by contributions from the City of New York and related public employers (the "Employers") pursuant to a collective bargaining agreement between Local 1180 of the Communications Workers of America (the "Union") and the Employer.

The purpose of the Plan is to provide you with income for your retirement security. Benefits are payable upon your normal retirement age or the later of (i) your actual retirement or (ii) age 70½, if you attain age 70 ½ before 2019, age 72 if you attain age 70 ½ after 2019, or if your employment ceases because of your death, disability, or separation from service.

This **Summary Plan Description is only a summary** of the basic terms and provisions of the Plan; it is not a substitute for the Plan document. If there is a discrepancy between the Plan document and the Summary Plan Description, the language of the Plan document will control. The Plan document is available for your review at the Fund Office during regular business hours, where you may direct any questions you have about the Plan or your rights and benefits.

A copy of the pertinent collective bargaining agreements may be obtained upon written request to the Trustees and is available for your review at the Fund Office.

MEMBERS' ANNUITY FUND INFORMATION:

Name of Plan:	CWA Local 1180 Members' Annuity Fund
Employer:	The City of New York and Related Public Employers
Tax I.D. Number:	13-4068007
Plan Number:	001
Type of Plan:	Defined Contribution Benefit Plan
Trustees' Names:	Chairperson, Gloria Middleton Gina Strickland Gerald Brown Robin Blair-Batte Lourdes Acevedo Arthur Cheliotes
Trustees' Business Address:	6 Harrison Street, 3rd Floor New York, NY 10013-2898
Third Party Administrator:	Administrative Services Only, Inc. 303 Merrick Road Suite 300 Lynbrook, NY 11563-9010 1-877-999-3555 (Toll Free)
Fund Counsel:	Spivak, Lipton, LLP 1700 Broadway New York, NY 10019
Fund Auditor:	Gould, Kobrick and Schlapp, P.C. 3 Park Avenue, 14th Floor New York, N.Y. 10016 (212) 564-9451

Legal Process may be served on a Trustee or the Third Party Administrator.

ELIGIBILITY AND MEMBERSHIP

How Do I Become Eligible For Membership In The Plan?

You are eligible to become a Member of the Plan if you are employed by the City of New York or related public employer in a position represented by CWA Local 1180 (the "Union") under which retirement benefits are the subject of good faith bargaining between the City or related public employers and the Union and for which the employer is obligated to make contributions to the Fund on your behalf.

When Do I Become A Member Of The Plan?

You become a Member on the first date for which contributions are required to be made on an Individual Account established on your behalf in accordance with the terms of the applicable collective bargaining agreement.

How Long Do I Remain A Member Of The Plan?

Your membership in the Plan will continue as long as you are employed in a position covered by the Plan and contributions are made on your behalf to the Fund.

Your membership in the Plan will terminate upon your retirement, resignation, transfer to a position not covered under the Plan, death or dismissal. You may withdraw your account balance at that time. Alternatively, if you choose to defer receiving a distribution of your account, you continue as an Affiliated Member of the Plan. Notwithstanding the preceding, if your account balance is $1,000 or less, and you either (a) terminate employment and have not attained age 55 (Normal Retirement Age) or (b) have not terminated employment, have had any contributions for two years, and no contributions have been paid on your behalf for two years, you may not elect to defer receiving a distribution of your account. Instead, your benefit will be paid to you in a lump sum as soon as administratively feasible following your termination of employment or the expiration of the two-year period when no contributions have been made on your behalf, as the case may be. In the event of termination of employment, your entire account balance will be paid. In the event of a payment after two years without contributions, the amount paid will be the amount of your account balance at the last valuation date preceding the start of the two-year period.

Transfers

If you are promoted, demoted or transferred from a title not covered by this Plan to a title eligible to participate in the Plan, any account balance in a prior plan funded by your employer may be transferred into this Plan. No transfer will be accepted, however, if federal qualification requirements are not met.

In the event you are promoted, demoted or transferred to a title not represented by the Union and (a) remain an employee of the same Employer and (b) the title into which you are promoted, demoted or transferred maintains a qualified Annuity Fund, the Trustees may directly transfer your Individual Account Balance in the CWA Local 1180 Members' Annuity Fund to the Trustees of the Annuity Fund for the title to which you are promoted, demoted or transferred.

CONTRIBUTIONS

Who Makes Contributions To The Fund?

The City of New York and related employers make contributions for each Member. You are not required, nor are you allowed, to make contributions.

After your employment is terminated you may elect to defer receipt of your Plan distribution until the April 1 of the calendar year following the year in which you reach age 70½ if you attained age 70 ½ before 2019, or age 72 if you attain age 70 ½ after 2019, as an Affiliated Member. Once you become an Affiliated Member, no further contributions are made to your Individual Account.

YOUR ACCOUNT

How Much Will My Employer Contribute?

The amount to be contributed is determined by the latest collective bargaining agreement.

How Does The Plan Work?

A separate account, known as an Individual Account, is established for each Member. A contribution in the amount specified by the applicable collective bargaining agreement is credited to this account on a regular basis.

What Happens To The Contributions?

All of the contributions are placed in a Trust Fund. A separate record is kept of your share of the Trust Fund. The contributions in the Trust Fund are invested to make additional money for you. However, some investments may result in a loss.

How Does My Account Share In The Earnings Or Losses Of The Fund?

Four times a year a valuation is made of the investment earnings and/or losses. As of each Valuation Date, the amount in your Individual Account is determined by adding together:

The Amount in your Individual Account as of the last Valuation Date,

plus

Employer contributions received on your behalf since the last Valuation Date,

plus

Your share of the investment return – determined as the earnings on investments, realized gains and losses and unrealized appreciation or depreciation in the fair market value of investments as of the Valuation Date, after deducting expenses of the Fund.

The Plan's four Valuation Dates are March 31, June 30, September 30, and December 31. The amount in your Individual Account as of a Valuation Date is known as your "Accumulated Share Value."

Risk And Return

All investments involve some risk. The Plan's investment philosophy is designed to provide positive returns in the long run. ***The Fund makes no guarantee about investment results. Contributions to your Individual Account are invested in diverse vehicles to balance risk and return. However, the Fund may experience losses, as well as gains, subject to the ups and downs of the financial markets.***

When Do I Receive A Statement Of My Account?

At the end of each year, you will receive a statement that shows your opening balance as of the beginning of the year, the current year's contribution and the investment earnings (or losses) added to (or subtracted from) your account.

BENEFITS UNDER THE PLAN

When Do I Receive My Benefits?

Your benefits are payable as soon as administratively feasible following your retirement, death, resignation, dismissal, transfer, any other termination, or the expiration of a two-year period in which no contributions have been payable on your behalf. However, you must file an application to apply for your benefits. To receive an application please contact Administrative Services Only, Inc., our third-party administrator.

Normal Retirement Age

The Normal Retirement Age under this Plan is age 55.

If you separate from service before reaching age 55, you may defer receiving a lump sum distribution of your Individual Account until you reach Normal Retirement Age, provided the value of your account (your "Accumulated Share Value") is greater than $1,000. If the value of your account at that time is $1,000 or less it will be paid to you as soon as administratively feasible following your termination of employment.

Federal tax law requires that you begin receiving distributions no later than the April 1 of the calendar year following the year in which you reach age 70½ (if you attained age 70 ½ before 2019), or age 72 (if you attain age 70 ½ after 2019), if you separated from service. You may want to consult with a tax advisor to determine when to receive your Plan distribution.

If you do not apply to receive your lump sum distribution from the Plan after termination of your employment and attaining age 70½ (if you attained age 70 ½ before 2019), or age 72 (if you attain age 70 ½ after 2019), the Plan Administrator will make payment to you as required by federal law.[1]

If you continue to work beyond age 70½ or 72 (whichever is applicable as indicated above), you may continue to defer payment of your Plan benefit until you terminate your employment.

[1] Due to the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act"), distributions that would otherwise have been made on or before April 1, 2021 based on a required beginning date occurring in 2020 were not made. Additionally, distributions that would otherwise have been made on or before December 31, 2020 based on a required beginning date occurring before 2020 were not made.

How Do I Apply For My Benefits?

You must file an application when you want to receive your benefit, except when the Fund is required to distribute your benefits after you reach age 70 ½. Administrative Services Only, Inc., the Plan's third-party administrator, will furnish you with the necessary forms, income tax withholding requirements and instructions.

How Much Will My Benefit Be?

You will receive 100% of the total value of your account (your "Accumulated Share Value") as of the Valuation Date following or coincident with the date an application is made after your retirement, death, resignation, dismissal, transfer or any other termination. If you are still employed by the employer and apply for a distribution based on the lack of contributions on your behalf within the last two years (or more), the amount distributed will be the amount of your account balance prior to that two-year period. Please note that all distributions are subject to applicable tax withholdings.

How Will My Benefits Be Paid?

All benefits are paid in a lump sum. (See "Tax Effects" for a description of the income tax implications of benefit distributions.)

For Additional Information regarding cash-out, roll-over, transfers, and in-service distributions, please see the Plan Document and/or contact the Fund Party Administrator, Administrators Services Only, Inc.

DEATH AND DISABILITY BENEFITS

What Benefits Are Payable If I Die Before I Receive My Account Balance?

In the event you die before receiving your benefit, your beneficiary will receive 100% of your Accumulated Share Value as of the Valuation Date coincident with or next following your death.

To Whom Are Benefits Payable If I Die Before I Receive My Benefits?

Your beneficiary will receive the full value of your account if you die while you are an active employee.

If you die after leaving your job and you elected to leave your account balance invested in the Plan, your beneficiary will receive any payment you were entitled to receive once a final distribution form has been completed and processed.

How Do I Designate A Beneficiary?

When you become a Member of the Plan, you are given a Beneficiary Designation Form on which you designate the person who is to receive any Plan benefits payable on account of your death. *It is important that you update this beneficiary form as your life circumstances change, such as marriage, divorce, or death of beneficiary.*

What If I Become Disabled?

If you are determined by the Social Security Administration or the public retirement system to which you belong to be permanently and totally disabled, you are eligible to receive your Accumulated Share Value.

CLAIMS PROCEDURE FOR BENEFITS

What Are The Plan's Claim Procedures?

You must apply for your benefit by filing an application for benefits with the Fund. The Trustees endeavor to administer the Plan fairly and consistently and to pay all benefits to which you or your beneficiaries are entitled. However, failure to properly file an application or provide requested information may result in a denied or delayed benefit payment.

What If My Claim Is Denied?

If your claim for benefits is denied, you will be notified in writing of the specific reason why your claim was denied, a description of any additional information you must provide and an explanation of the procedure you may follow to appeal the denial of your claim.

You may request a review by the Trustees of the denied claim by filing a written notice with the Trustees within sixty (60) days after receipt of the notification of the claim denial. The Trustees, or a person or committee designated by them, will make a final decision at their next regularly scheduled meeting following receipt of the request for review, unless the request is filed less than thirty (30) days prior to the next regularly scheduled meeting, in which case a decision will be made by no later than the date of the second regularly scheduled meeting following receipt of such request for review. If special circumstances require an extension of time for processing the request for review, the decision may be made at the third meeting following receipt of such request. The Claimant will be notified in advance of any such extension. The notice will describe the special circumstances requiring the extension, and will inform the Claimant of the date as of which the determination will be made. If the extension is required due to the Claimant's failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to the Claimant until the date on which the Claimant responds to the Fund Office's request for information. The Claimant will be notified in writing of the determination on review within 25 days after the determination is made.

TAX EFFECTS

What Are The Tax Effects Of Plan Distributions?

The following is only a general description of the income tax implications of benefit distributions under this Plan. The laws are complex and subject to frequent change.

You should not rely on this information and should consult the Internal Revenue Service or your tax advisor when considering a distribution under the Plan to determine the most appropriate tax planning for your circumstances. The contributions and all investment earnings are currently income tax free while held on your behalf.

Income taxes will be payable when these funds are actually distributed to you in the future. Such taxes may be less if distribution is deferred until your retirement when your total taxable income is generally reduced.

Rollovers

To continue deferring taxes and avoid withholdings on your payment, you can make a direct rollover. In this case, the Plan makes your check payable to the name of the IRA or other employer’s plan. Alternatively, you have 60 days to complete a rollover on your own, but current federal law requires the Plan to withhold 20% for income taxes.

Current tax law also requires you to pay an additional 10% penalty tax if you receive a taxable distribution from the Plan before age 59½.

The Internal Revenue Code permits you to avoid current taxation on any portion of the taxable amount of an eligible distribution by rolling over that portion into an eligible employer retirement plan or individual retirement arrangement (e.g. IRA) that accepts rollover contributions.

If your account balance is $200 or more and you make a rollover election and provide the required information, the Trustees will directly rollover all or a portion of your account balance either to:

1. The trustee of an Individual Retirement Account ("IRA"),
   or
2. The trustee of another employer's qualified retirement plan that accepts such rollover, and, if applicable, distribute the remaining amount directly to you.

Amounts rolled over directly to either of the trustees mentioned in (1) or (2) above will not be subject to federal income tax in the year of distribution nor to federal income tax withholding. If you choose to receive a portion of your account in cash while requesting the Trustees to directly roll over the remainder, the amount you elect to have rolled over must equal at least $500.

Please note that current federal law requires that the Trustees withhold for federal income tax 20% of the amount of a distribution which is actually received by you. In addition, the amount which is not rolled over into an IRA or another qualified plan is subject to federal income tax in the year in which the distribution is received and, if you are subject to the 10% early distribution penalty (described below), it will apply to the amount of the distribution that you actually receive.

If you elect to have all or a portion of your account distributed to you in cash, you may within sixty (60) days of receiving that distribution roll over into an IRA or another eligible employer plan that accepts such rollovers:

1. All or a portion of the amount received and, thus, avoid federal income tax on the portion rolled over in the year in which the distribution was received and, if otherwise applicable, also avoid the 10% early distribution penalty on the amount rolled over; or
2. All of the amount received plus an additional amount from your own funds, up to, but not exceeding, the 20% that was withheld for federal income tax and, thus, avoid federal income tax (but not the withholding requirement) on the amount rolled over in the year in which the distribution was received and, if otherwise applicable, also avoid the 10% early distribution penalty on the amount that was rolled over.

There are specific and technical qualifications and requirements set forth in the Internal Revenue Code that must be satisfied in order for your plan distribution to be eligible to be rolled over. If

interested, you may obtain additional information on the establishment and maintenance of an IRA from the nearest Internal Revenue Service District Director's office.

10-Year Averaging

You may qualify for 10-year averaging under certain circumstances.
Please consult your tax advisor.

Early Distribution Penalty

Distributions from the plan prior to age 59½ may be subject to an additional 10% income tax to the extent the distribution is includable income (amounts in excess of after-tax contributions which are not rolled over to an IRA or other qualified plan). Distributions are exempt from the tax if paid on account of (a) death, (b) disability, or (c) termination of employment after age 55. Exemptions are also permitted for annuity distributions, payments to alternate payees under qualified domestic relations orders and amounts not in excess of certain deductible medical expenses, and some other exceptions under the Internal Revenue Code.

ADDITIONAL QUESTIONS

Who Administers The Plan?

The Plan is administered by the Board of Trustees. The Plan Administrator's duties are the control and administration of the Plan and the interpretation and implementation of the Plan's provisions. The Board of Trustees enlists the services of other professionals to carry out the day-to-day record keeping and other functions. The Trustees have appointed a Third-Party Administrator to oversee the operations of the Fund**.**

Who Holds The Plan's Assets and Manages The Trust Fund?

All assets of the Plan are held in a Trust Fund by the Board of Trustees of the CWA Local 1180 Members' Annuity Fund. All benefits are paid directly from the Trust Fund. The assets in the Trust Fund are managed, invested and safeguarded by the Trustees who are responsible for investing the Trust Fund in a prudent manner. The Trustees enlist the services of an Investment Manager, attorneys, accountants, and advisors as they deem necessary to assist in the performance of their duties.

What Is The Plan's Fiscal Year?

The Plan's Fiscal Year is the Plan year, which begins on January 1 and ends on December 31st. All Plan records are kept on the basis of the Fiscal Year.

May The Plan Be Amended Or Terminated?

While the Trustees expect to continue the Plan indefinitely, the Trustees will have the right to amend or terminate the Plan, subject to the terms of the Trust Agreement. In the event the Plan is amended or terminated, the Trustees will advise all Members accordingly. Upon Plan termination, all assets, after providing for the expenses of the Plan and any prior approved payments, will be proportionally distributed to the Members.

Is The Plan A Contract Of Employment?

No. The Plan does not create or affect any contract of employment between you and the Employer. In addition, the Plan does not create or affect any tenure or seniority that you may have with the Employer.

GENERAL INFORMATION ABOUT THE FUNDS

Getting Information

You may examine the following documents at the Fund Office during regular business hours, Monday through Friday, except holidays:

- Collective Bargaining Agreement.
- Contracts and all Amendments.
- Form 5500 or full Annual Report filed with the Internal Revenue Service and the Department of Labor.

You may also obtain copies of any of the documents by writing for them and paying the reasonable cost of duplication. You should find out what charges will be before requesting copies. If you prefer, you can arrange to examine a document during business hours at the CWA Local 1180 Union or the Benefits Funds Office.

Nothing in this Summary Plan Description is meant to interpret, extend or change in any way the provisions expressed in the Plan documents or contracts. The Board of Trustees reserves the right to amend, modify or discontinue part or all these Plans whenever, in its judgment, conditions so warrant.

The benefits provided by the Funds are made possible by the Funds' assets which are derived from employer contributions. All of the Funds' assets are used to provide your benefits and to defray reasonable administrative expenses.

Authority of the Fund Administrator

Notwithstanding any other provision in the Plans, the Board of Trustees shall have the exclusive right, power and authority, in its sole and absolute discretion to:

- Administer, apply, construe and interpret the Plans and any related Plan documents
- Make all factual determinations required to administer, apply, construe and interpret the Plan (and all related documents)
- Decide all matters arising in connection with entitlement to benefits, the nature, type, form, amount and duration of benefits and the operation or administration of the Plan.

- Without limiting the generality of the statements above, the Board of Trustees shall have the ultimate discretionary authority to:
- Determine whether an individual is eligible for any benefits under these Plans
- Determine the amount of benefits, if any, an individual is entitled to under these Plans
- Interpret all of the terms used in these Plans
- Interpret all of the provisions of these Plans (and all related Plan documents)
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Plans in accordance with its terms
- Decide questions, including legal or factual questions, relating to the eligibility for, or calculation and payment of, benefits under the Plans
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plans or other related Plan documents
- Process and approve or deny benefit claims and rule on any benefit exclusions
- All determinations made by the Board of Trustees (or any duly authorized designee thereof) with respect to any matter arising under the Plans and any other Plan documents shall be final and binding on all parties.

Plan Amendment and Modification

The Board of Trustees reserves the right, within its sole discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of these Plans (including any related documents and underlying policies), at any time and for any reason.

Fund Information

Communications Workers of America, AFL-CIO,

Local 1180 Security Benefits Fund

Communications Workers of America, AFL-CIO,

Local 1180 Education Benefits Fund

Communications Workers of America, AFL-CIO,

Local 1180 Legal Benefits Fund

Communications Workers of America, AFL-CIO,

Local 1180 Members' Annuity Fund

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Gina Strickland
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