COMMUNICATIONS WORKERS OF AMERICA ■ LOCAL 1180 ■ AFL-CIO

SECURITY BENEFITS FUND

SUMMARY PLAN DESCRIPTION

Welcome

October 1, 2018

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

6 Harrison Street, 3rd Floor
New York, NY 10013
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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 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.

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
1-212-966-5353
1-888-966-5353 (out-of-area)

CWA Local 1180 Member's Annuity Benefits Fund
Administrative Services Only, Inc.
303 Merrick Road, Suite 300
Lynbrook, NY 11563-9010
1-718-204-7172 Ext. 5520
1-516-396-5520
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

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
- No out-of-pocket expenses if you use a participating dentist
- 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

Dependents Under Age 19 – No Cost Benefit

Dependents under age nineteen (19) must choose either a Dentcare or a Schedule Dental Plan Participating Dentist. The plan will have no annual dollar cap for medically necessary orthodontia obtained through either a Dentcare Dentist or a Schedule Dental Plan participating provider. However, the lifetime limits will remain in place for orthodontia that is not medically necessary – that is, other than in cases of a cleft palate or other deformities that are part of or the result of a congenital defect or anomaly of the mouth that prevents the usual and normal action of mastication and ingestion of normally solid foods. Otherwise, lifetime frequency limitations in the dental schedules do not apply to those under 19.

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.
- Maximum of four claims per family, per calendar year.
- **Dependents Under Age 19 –**

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, they are only eligible for benefits using an in-network provider — GVS, CPS, Vision Screening, or Vision World — with a selection from a 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 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 $200 per semester for tuition and/or registration fees for a maximum of three terms per year.

Book Reimbursement:

You can be reimbursed up to $25 each semester for books if you are enrolled in a course covered by the College Tuition Reimbursement Program.

Queens College Urban Leadership Program:

Graduate and undergraduate students covered by CWA Local 1180 Education Fund are eligible to participate and for residents of New York State tuition and fees are completely waived for up to eight designated three-credit courses in Urban Studies.

The CUNY/ DCAS Public Administration Program:

The CUNY/DCAS Public Administration Program is offered in collaboration with the NYC Department of Citywide Administrative Services (DCAS), City University of New York's Joseph S. Murphy Institute for Worker Education (JSMI) and Local 1180 on both the undergraduate and graduate level. It is designed to provide an opportunity to earn college credits, improve communication and analytic skills, and provide for expanded knowledge of government agencies, social services, labor relations, and the legislative and budgetary process in the context of deepening the understanding of urban challenges.

New York City Reimbursable Courses

The New York City Reimbursable Courses Program provides reimbursement for tuition for a maximum of 2 courses up to $100 per year, for eligible members who successfully complete courses offered by the New York City Reimbursable Courses Program.

Adult Education Program Tuition Reimbursement

If you successfully complete courses in a job-related area in an Adult Education Program, you can receive full reimbursement of the tuition up to a maximum of $100 per year.

Career Development Conferences

If you attend a conference in a job-related area for Career Development, you can receive reimbursement up to a maximum of $100.

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 examinations for titles covered under the collective bargaining unit or for promotional titles into management.

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, 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 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 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 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, Social Security number 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.

* 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.

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

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 two weeks of age until their 19th birthday

or

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

or

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

or

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

or

- They are the children of your domestic partner two weeks of age until their 19th birthday

When Your Child Reaches Age 19:

Your child's coverage may be continued from his or her 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 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 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 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 card and the Designation of Beneficiary card. Make sure you answer every question carefully, accurately and legibly;
- Submit the Enrollment card and the Designation of Beneficiary card 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 card from the Fund Office or from your Local 1180 Shop Steward and make the proper revisions;
- Submit your revised Enrollment card to the Fund Office.

If you wish to change your beneficiary designation:

- Obtain a new Designation of Beneficiary card from the Fund Office;
- Submit your revised Designation of Beneficiary card 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 Security 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
- 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.

OORDINATING 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 Dependant 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.

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 then 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:

a. Surviving spouse;
b. if no surviving spouse, to the surviving children equally, **or**
c. 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 five 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.

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, Chairman,
Gina Strickland
Gerald Brown
Robin Blair-Batte
Lourdes Acevedo

The Fund Administrator is Damien Arnold.

YOUR CONTINUATION COVERAGE (COBRA)

What is COBRA Continuation Coverage?

Under the Consolidated Omnibus Reconciliation Act of 1985, commonly called COBRA, if you are eligible and choose COBRA Continuation Coverage, you will be entitled to the same health coverage that you had before the event that triggered COBRA (Prescription Drug, General Medical Reimbursement, Dental, Mental Health, Optical, Hearing Aid, Podiatry and Birth/Adoption Benefits), **but you must pay for it**. Federal law requires that most group health plans (including this Fund) give covered members and their families the opportunity to continue their health care coverage when there is a "qualifying event" that resulted in the loss of coverage under the Fund. Depending on the type of qualifying event, "qualified beneficiaries" can include a covered member's spouse (or domestic partner) and eligible dependent children of the covered member. COBRA Continuation Coverage does ***not*** include the Education Benefit, the Legal Services Benefit, Life Insurance or Disability Benefits. COBRA Continuation Coverage is the same coverage that the Fund gives to other participants or beneficiaries under the Fund who are not receiving continuation coverage. If there is a change in the health coverage provided under the Fund to similarly situated active covered members and their families, that same change will be made in your COBRA Continuation Coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Fund as other participants or beneficiaries covered under the Fund.

What Are COBRA Qualifying Events?

COBRA Continuation Coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Fund because of a “qualifying event.” Depending on the type of qualifying event, covered members, spouses of covered members, and dependent children of covered members may be qualified beneficiaries.

You have the right to extend coverage for yourself and your eligible dependents for up to 18 months if coverage ends because:

- of a reduction in your hours of employment; or
- your employment ends for any reason other than gross misconduct.

If you are the **spouse of a covered member**, you will have the right to coverage for up to 36 months if you lose your coverage under the Fund because of any of the following qualifying events:

- Your spouse-covered member dies;
- You become divorced or legally separated from your spouse-covered member.

Covered **dependent children** will have the right to coverage for up to 36 months if they lose their coverage under the Fund because of any of the following qualifying events:

- The parent-covered member dies;
- The parents become divorced or legally separated;
- The child stops being eligible for coverage under the Fund as a "dependent child."

You do not have to show evidence of good health in order to continue coverage. However, you must pay all of the premiums from the date of the event that qualifies you to continue coverage. Future premiums are payable in advance by the first of each month.

The Fund will offer COBRA Continuation Coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred. **When a qualifying event occurs (divorce or legal separation of the covered member and spouse or a dependent child's losing eligibility for coverage as a dependent child or the covered member dies) you must notify the Fund Administrator. The Fund requires you to notify the Fund Administrator IN WRITING within 60 days after the qualifying event occurs.**

Please include the following with your notice:

1. Your name
2. The names of your dependents
3. Your Social Security number and the Social Security numbers of your dependents
4. Your address
5. 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 (Tel: 1-212-966-5353; Fax: 1-212-219-2450).

Once the Fund Administrator receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA Continuation Coverage, COBRA Continuation Coverage will begin on the date that the Fund coverage would otherwise have been lost.

How Long Does COBRA Continuation Coverage Last?

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the covered member, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to 36 months.

COBRA Continuation Coverage will be terminated before the end of the maximum period for any of the following reasons:

- You do not pay the amount for your COBRA Continuation Coverage on time or within certain grace periods;
- The CWA Local 1180 Security Benefits Fund ceases to provide any group health plan for its members;
- You or one of your covered family members becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
- If covered member coverage would be terminated for cause, such as filing a fraudulent claim.

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.

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 September 1 to August 31. All checks must be made payable to the CWA Local 1180 Security Benefits Fund.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment rights at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

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. 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 September 1 to August 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 new 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 http://www.doleta.gov/tradeact/2002act_index.cfm

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 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.

What If I Elect Coverage Under Another Group Health Plan?

If you are or expect to be covered by another employer sponsored health plan (including a plan of your spouse's employer), a federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees you certain rights under that plan, which you should consider when making your decision about COBRA Continuation Coverage. Under HIPAA, the period during which a group health plan may exclude or limit coverage for many pre-existing conditions is reduced or eliminated if the person had previous health coverage under another group health plan. However, credit is not given for earlier coverage if it was allowed to lapse, without replacement, for at least 63 days. If there will be some delay before you can enroll in the new plan, a break in health coverage can be avoided by maintaining COBRA Continuation Coverage in the meantime.

If you need to show a new health plan how long you were covered under this Fund in order to reduce or avoid the new plan's pre-existing condition coverage exclusion, you may request a written statement certifying to the length of your coverage under this Fund, and, if need be, the general categories of benefits that this Fund covers. Please contact the Fund Office at the below address or number to request such a certificate.

Your Rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

When your Fund coverage ends, you and/or your dependents are entitled by law to, and will be provided with a "Certificate of Creditable Coverage." Certificates of Creditable Coverage indicate the period of time you and/or your dependents were covered under the Fund (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under this Fund ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you and/or your dependents under the new group health plan or health insurance policy.

The Certificate of Creditable Coverage will be provided to you:

- on your request, within 24 months after your Fund coverage ends
- when you are entitled to elect COBRA
- when your coverage terminates, even if you are not entitled to COBRA
- when your COBRA coverage ends

Whom to Contact If You Have Questions or to Give Notice of Changes in Your Circumstances

If you have any questions about your COBRA rights, please contact:

Fund Administrator
CWA Local 1180 Security Benefits Fund
6 Harrison Street
New York, NY 10013-2898
Tel: 1-212-966-5353
Fax: 1-212-219-2450

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 ceases to be a "dependent child" as that term is defined by the Fund
- you or your covered dependents, after electing COBRA Continuation Coverage, become entitled to other group health coverage that does not have a pre-existing condition limitation or exclusion, or you or your spouse, or any of your covered dependents, change your address.

For More Information:

The Fund Administrator is responsible for administering COBRA Continuation Coverage, and should be contacted for further information or questions about your rights and obligations under the Fund. The Fund Administrator can be contacted as follows: Fund Administrator, CWA Local 1180 Security Benefits Fund, 6 Harrison Street, New York, NY, 10013-2898 (1-212-966-5353). For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Continuation of Coverage During Leave Under the Family and Medical Leave Act (FMLA)

If your employer has 50 or more employees, you may be eligible for leave under the Family and Medical Leave Act (FMLA). If you take a FMLA leave, your employer must continue to contribute to the Fund on your behalf and certain health-related benefits through the Fund must continue. However, if you do not return to work after your FMLA leave ends, you may be required to repay the amount your employer paid toward your coverage during your leave unless you do not return because of a serious health condition of yourself or a family member other circumstances beyond your control.

If you do not return to work after the end of your FMLA leave, you may be eligible for COBRA continuation coverage.

Contact the Fund Administrator for more information about your rights and your dependents' rights to continuation coverage.

Keep the Fund Informed Of Address Changes

In order to protect your family's rights, you should keep the Fund Administrator informed of 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.

YOUR PRIVACY

The Fund is required by The Health Insurance Portability and Accountability Act of 1996 (HIPAA), which was passed and adopted into federal law on December 28, 2000, 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.

Privacy Notice

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

This Privacy Notice, effective April 14, 2003, describes your rights concerning medical information, known as "Protected Health Information" (PHI), about you and/or your dependents. PHI is information that may identify you and that relates to your past, present, or future physical or mental health condition, or payment for your health care. The PHI includes information maintained by the Fund in oral, written or electronic form. The Fund is required by The Health Insurance Portability and Accountability Act of 1996 (HIPAA), which was passed and adopted into federal law on December 28, 2000, 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.

The Fund reserves the right to change its privacy practices and this Privacy Notice. Any new Privacy Notice may be effective for all PHI that the Fund maintains about you, including PHI created or maintained in the past. Material changes to the Fund's privacy practices will require that the Fund mail copies of revised Privacy Notices to you and to all past and present participants and beneficiaries for whom the Fund still maintain PHI. Any other person, including dependents of named participants, may receive a copy upon request. Any revised version of this Privacy Notice will be distributed within 60 days of the effective date of any material change to the Fund's policies.

Uses and Disclosures of Health Information

Sections I and II contain the circumstances under which the Fund can provide PHI.

SECTION I: Uses and Disclosures of PHI for Treatment, Payment or Administrative Operations

Disclosure of PHI Generally Requires Your Written Authorization.

Under the law, however, the Fund may disclose your PHI without your 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. Your right to this information is detailed later in this Privacy Notice.

- For Treatment, Payment or Health Care Operations:

The Fund and its Business Associates will use PHI in order to carry out treatment, payment, or health care operations.

- For Treatment

Treatment is defined as the provision, coordination, or management of health care and related services. While the Fund is not a health care provider and does not engage in "treatment" of individuals, there are instances when the Fund will disclose treatment information that it receives in support of benefit claims payment. For example, if a dental specialist needs treatment information from your primary dentist, the Fund can provide that information.

- For Payment

The Fund may use and disclose PHI about you in order to allow proper payment of your claims. This can include information regarding eligibility, coverage, pre-authorizations, etc.

- For Health Care Operations

The Fund may use and disclose PHI about you in order to operate business. For example, the Fund may need to use PHI for legal and accounting purposes related to the Fund's operation or administration.

- Disclosure to the Fund's Trustees:

The Fund will also disclose PHI to the Board of Trustees of the Fund for purposes related to treatment, payment, and administrative operations. The Board of Trustees has amended the Benefits Handbook to permit this use and disclosure as required by federal law. For example, the Fund's Trustees are permitted to have access to this information for purposes of reviewing claims appeals.

SECTION II Uses and Disclosures in Special Circumstances

These are the following special purposes when the Fund can release PHI about you without your permission:

- Involvement in Individual's Care:

The Fund may disclose PHI about you to a family member, close personal friend or other person identified by you (filed in writing by you on a Fund-approved form) if directly relevant to that person's involvement with your care or payment for that health care unless you notify the Fund's Contact Officer in writing (contact information below) that you object. 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 Contact Officer in writing that you do not want your information shared under those circumstances.

The Fund will provide information to your spouse unless you indicate otherwise by filing the appropriate form with the Contact Officer. If you want the Fund to disclose routinely your PHI to persons other than your spouse then you must complete an authorization form designating that person as authorized to receive your PHI. Authorization forms are available from the Contact Officer at the Fund Office.

- Public Health Activities:

The Fund may disclose PHI about you in order to notify public health authorities of public health risks, such as potential exposure to a communicable disease, or to report child abuse or neglect.

- Health Oversight Activities:

The Fund must disclose PHI about you to a health oversight agency for oversight activities, such as investigations, inspections, licensure or disciplinary actions (for example to investigate complaints against health care providers).

- Judicial and Administrative Proceedings:

The Fund may disclose PHI in a judicial or administrative proceeding. For example, in response to a subpoena or court ordered discovery request. In the case of subpoenas and discovery requests that are not court ordered, the Fund will disclose your PHI only if certain conditions are met.

- Law Enforcement:

The Fund may disclose PHI to law enforcement, for purposes such as reporting a crime.

- Prevention of Serious Harm:

The Fund may use or disclose PHI about you if the Fund believes it is necessary to prevent or lessen serious harm (abuse, neglect, or domestic violence) to you or to other potential victims.

- Serious Threat to Health/Safety:

The Fund may use or disclose PHI when it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

- Specialized Government Functions:

The Fund may use or disclose PHI about you for certain government functions.

- Workers' Compensation:

The Fund may disclose PHI about you in order to comply with Workers‘ Compensation Laws.

Research Organizations:

The Fund may disclose PHI to research organizations if the organization has satisfied certain conditions about protecting the privacy of PHI.

- Related Benefits and Services:

The Fund may contact you to inform you of benefits or services related to your plan that may be of interest to you.

- Decedents:

The Fund may disclose PHI to a coroner, medical examiner, or funeral director to permit them to carry out their legal duties, such as determining a cause of death.

- Donation/Transplantation:

The Fund may use or disclose PHI for the purpose of facilitating organ, eye, or tissue donation and transplantation.

- Business Associates:

The Fund may disclose PHI to business associates. This could include third-party administrators, accountants, or attorneys if those business associates have signed a Letter of Agreement concerning appropriate uses and disclosures of PHI.

- Notification of Location/Condition:

The Fund may use or disclose PHI to give notice or assist in giving notice of your location, general condition or death to a family member, personal representative, or another person responsible for your care.

- Disclosures Required by Law:

The Fund will use and disclose PHI about you when it is required to do so by federal, state, or local law.

Uses and Disclosures of PHI Made Only With Your Written Authorization

Other uses and disclosure of PHI (*i.e.*, psychotherapy notes) about you will be made only with your written authorization, unless otherwise required by law as described in this Privacy Notice.

Your Rights

- Inspection and Copying:

You have the right to access your PHI. The Fund must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30 day extension is allowed if the Fund is unable to comply with the deadline.

If the Fund denies access, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Fund and the U.S. Department of Health and Human Services.

Requesting Restrictions:

You may request the Funds to: (1) Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or (2) Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment of your bills. The Funds, however, are not required to agree to your request unless your request relates to payment or healthcare operations (not treatment), and the PHI relates solely to a product or service which was paid entirely by you as an out-of-pocket expense.

However, if the Fund agrees to your request, the Fund is bound by the agreement except when otherwise required by law, in emergencies, or when the information is necessary for your treatment. Your request must clearly and concisely describe (a) the information you wish restricted; (b) whether you are requesting to limit the Fund's use, disclosure or both; and (c) to whom you want the limits to apply. These restrictions of access to your PHI must be requested on the appropriate Fund form.

- Designated Record Set:

Includes your medical or billing records that are maintained by the Fund. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by the Fund or other information used in whole or in part by or for the Fund to make decisions about you.

Information used for quality control or peer review analyses and not used to make decisions about you is not included.

- Amendment:

You may ask the Fund to amend PHI about you (as long as the information is kept by or for the Fund) if you believe it is incorrect or incomplete. Such requests must be in writing to the Contact Officer and must include a reason for the request. If your request and the reason supporting the request are not submitted in writing, the Fund may deny your request. To apply for an amendment of your PHI you must do so using the appropriate Fund form.

- Alternative Contact Information:

You have the right to receive communications of PHI about yourself from the Fund in a certain manner or at a certain location. The request must be reasonable. For example, you may prefer that the Fund's mailings to you be sent to your work address rather than to your home. Submit requests for an alternative method of contact in writing to the Contact Officer. Such a request must be made on the appropriate Fund form.

- Your Personal Representative:

You may exercise your rights through a personal representative. Except as provided below in connection with parents of unemancipated minor children, 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 without completion of an Appointment of Personal Representative form. For example, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable state law requires otherwise. Unemancipated minors may, however, request that the Fund restrict information that goes to family members. Other documentation that may substitute for this form would include other 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.)

- Accounting:

You have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures that the Fund has made of PHI about you other than disclosures you authorized and other than disclosures made for treatment, payment or administrative operations. The request must be in writing. The first request for an accounting that you make within a 12-month period is free; however, the Fund may charge you for additional requests within the same 12-month period. The Fund will notify you of the costs of the additional requests, and you may withdraw your request before incurring any costs.

The Fund's Duties

Maintaining Your Privacy: The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

Your Right to File a Complaint with the Fund or the HHS Secretary

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Fund or with the U.S. Secretary of Health and Human Services. All complaints must be submitted in writing. The Fund will not penalize you for filing such a complaint. In order to exercise any of your rights as set forth in this Privacy Notice, to obtain forms, or if you have any questions, please write to:

Damien Arnold
HIPAA Contact Officer
CWA Local 1180 Security Benefits Fund
6 Harrison Street, 3rd Floor
New York, NY 10013-2898

In addition to filing a complaint with the Contact Officer listed above, you may also file a complaint with:

Secretary of the U.S. Department of Health and
Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

YOUR LIFE & 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
Gina Strickland
Gerald Brown
Robin Blair-Batte
Lourdes Acevedo

Fund Administrator

Damien Arnold

Counsel

Spivak, Lipton, LLP

Consultants

Policy Research Group, LLC

Certified Public Accountant

Gould, Kobrick & Schlapp, PC

APPLYING FOR 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 described by type of Benefit under the heading "Getting Your Benefit.".

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

IN GENERAL, ALL SUPPLEMENTAL HEALTH BENEFITS MUST BE CLAIMED NO LATER THAN 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 at the Fund's website: 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.

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:

- 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.

A decision regarding the claim will be made by the Trustees, or their duly authorized designee, within 90 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 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 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, expect 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 references 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 applicable time limits, as well as a statement of the claimant's right to bring a civil action following and 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/her 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 filled 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 a 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 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 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 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 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 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 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 90 calendar days of your loss. Claims submitted after the 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 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 13 weeks or $50 a day for partial weeks of disability for up to 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.

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 8th consecutive day of disability or the day you become hospitalized, whichever is earlier.

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 90 calendar days after the onset of your disability. The Fund can require you to undergo a medical examination at the Fund's expense.

If an examination is requested and you refuse or do not show for the appointment, benefits will stop or your application will not be processed. If you later attend the examination and are found to be disabled, benefits will resume. Benefits will not be paid for the period between the time they stopped and the examination was had. However, that period of time will count in the 13-week maximum period of payment.

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 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 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 full day, you will be entitled to a new 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 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.

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.

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 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 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 19 or Older

You may use either Dentcare, 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 over the age of 18 chooses Dentcare or uses a Participating Dentist, most services are covered at no charge. There are no out-of-pocket expenses or annual or lifetime maximums when using a Dentcare Dentist. When using a 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.

Dependents Under Age 19

Dependents under age 19 must choose either Dentcare or a Participating Dentist. The plan will have no annual dollar cap for medically necessary orthodontia obtained through either a Dentcare Dentist or a Participating Dentist. However, the lifetime limits will remain in place for orthodontia that is not medically necessary – that is, other than in cases of a cleft palate or other deformities that are part of or the result of a congenital defect or anomaly of the mouth that prevents the usual and normal action of mastication and ingestion of normally solid foods. Otherwise, lifetime frequency limitations in the dental schedules do not apply to those under age 19.

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.

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	Cephalornetric film	15.00

Preventive (once every six months 1110, 1120, 1203, 1204)

1110	Prophylaxis – Adult	25.00
1120	Prophylaxis – Child (to age 12)	20.00
1203	Topical application of fluoride (prophylaxis not included) – Child	15.00
1204	Topical application of fluoride (prophylaxis not included) – Adult	15.00
1351	Sealant – per tooth (once per lifetime)	25.00
1510	Space Maintainer – Fixed – Unilateral	54.50
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*	275.00
2751	Crown – Porcelain fused to predominantly base metal*	275.00
2752	Crown – Porcelain fused to noble metal*	275.00
2790	Crown – Full Cast high noble metal*	250.00
2791	Crown – Full Cast predominantly base metal*	250.00
2792	Crown – Full Cast noble metal*	250.00
2910	Recement inlay, only 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	85.00
2954	Prefabricated post and core in addition to crown	85.00
2970	Temporary crown	36.50
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)	150.00
3320	Bicuspid Root Canal (excluding final restoration)	200.00
3330	Molar Root Canal (excluding final restoration)	275.00
3346	Retreatment of previous RCT – anterior	100.00
3347	Retreatment of previous RCT – bicuspid	150.00
3348	Retreatment of previous RCT – molar	200.00
3410	Apicoectomy - periradicular surgery – anterior	150.00
3421	Apicoectomy – bicuspid periradicular surgery – bicuspid (first root)	200.00
3425	Apicoectomy – molar periradicular surgery – molar (first root)	250.00
3426	Apicoectomy/Periradicular surgery – (each additional root)	125.00
3430	Retrograde filling	60.00

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	275.00
4261	Osseous Surgery – (1-3 teeth per quadrant)	135.00
4263	Bone replacement graft – 1st site in quadrant	125.00
4264	Bone replacement graft – each add'l site in quadrant	100.00
4270	Pedicle soft tissue graft procedure	150.00
4271	Free soft tissue graft procedure (including donor site surgery)	150.00
4320	Provisional splinting – intracoronal	40.00
4321	Provisional splinting – extracoronal	40.00
4341	Perio scaling & root planing – 4 plus teeth per quadrant*	25.00
4342	Perio scaling & root planing – (1-3 teeth per quad)	15.00
4381	Localized delivery of antimicrobial agents*	75.00
4910	Perio maintenance procedures (following active therapy)	35.00

*** Once every three years**

Prosthodontics (removable)

5110	Complete upper dentures*	300.00

5120	Complete lower dentures*	300.00
5130	Immediate upper dentures*	300.00
5140	Immediate lower dentures*	300.00
5211	Maxillary partial denture – resin base*	300.00
5212	Mandibular partial denture – resin base*	300.00
5213	Maxillary partial denture – cast metal frame/resin base*	300.00
5214	Mandibular partial denture – cast metal frame/resin base*	300.00
5281	Removable unilateral partial denture one piece cast metal (including clasps & pontics)*	300.00
5410	Adjust complete denture – maxillary	20.00
5411	Adjust complete denture – mandibular	20.00
5421	Adjust partial denture – maxillary	20.00
5422	Adjust partial denture – mandibular	20.00
5610	Repair resin denture base	30.00
5620	Repair cast framework	30.00
5630	Repair or replace broken clasp	20.00
5640	Replace broken teeth – per tooth	25.00
5650	Add tooth to existing partial denture	40.00
5660	Add clasp to existing partial denture	60.00
5710	Rebase complete maxillary denture	100.00
5711	Rebase complete mandibular denture	100.00
5720	Rebase maxillary partial denture	100.00
5721	Rebase mandibular partial denture	100.00
5730	Reline complete upper denture (chairside)	50.00
5731	Reline complete lower denture (chairside)	50.00
5740	Reline upper partial denture (chairside)	50.00
5741	Reline lower partial denture (chairside)	50.00
5750	Reline complete upper denture (laboratory)	100.00
5751	Reline complete lower denture (laboratory)	100.00
5760	Reline upper partial denture (laboratory)	100.00
5761	Reline lower partial denture (laboratory)	100.00
5862	Precision attachment, by report	50.00

Implant Benefit

6010	Surgical placement of implant body: endosteal implant	**
6040	Surgical placement: eposteal implant	**
6050	Surgical placement: transosteal implant	**

** 100% up to $1500 paid per procedure/$2000 Lifetime Benefit Maximum

Implant Supported Prosthetics

6053*, 6054*, 6056*, 6057*	350.00
6058*, 6059*, 6060*, 6061*, 6062*, 6063*, 6064*, 6065*, 6066*, 6067*, 6068*, 6069*, 6070*, 6071*, 6072*, 6073*, 6074*, 6075*, 6076*, 6077*	550.00

Prosthodontics (fixed

6020	Abutment placement or substitution	85.00
6210	Pontic – cast high noble metal*	100.00
6211	Pontic – cast predominantly base metal*	100.00
6212	Pontic – cast noble metal*	100.00
6240	Pontic – porcelain fused to high noble metal*	225.00
6241	Pontic – porcelain fused to predominantly base metal*	225.00
6242	Pontic – porcelain fused to noble metal*	225.00
6250	Pontic – resin with high noble metal*	125.00
6251	Pontic – resin with predominantly base metal*	125.00
6252	Pontic – resin with noble metal*	125.00
6545	Retainer – cast metal*	250.00
6720	Crown – resin with high noble metal*	200.00
6721	Crown – resin with predominantly base metal*	200.00
6722	Crown – resin with noble metal*	200.00
6750	Crown – porcelain fused to high noble metal	275.00
6751	Crown – porcelain fused to predominantly base metal*	275.00
6752	Crown – porcelain fused to noble metal*	275.00
6780	Crown – ¾ cast high noble metal*	175.00
6790	Crown – full cast high noble metal*	275.00
6791	Crown – full cast predominantly base metal*	250.00

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

6792	Crown – full cast noble metal*	250.006930
	Recement fixed partial denture	35.006950
	Precision attachment	100.00
6980	Fixed partial denture repair, by report	50.00

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

** 100% up to $1500 paid per procedure/$2000 Lifetime Benefit Maximum

Oral Surgery (including local anesthesia and post operative care)

7111	Extraction, coronal remnants – deciduous tooth	40.00
7140	Extraction - erupted tooth or exposed root	40.00
7210	Surgical removal of erupted tooth requiring elevation mucoperiosteal flap and removal of bone and/or section of tooth	70.00
7220	Removal of impacted tooth – soft tissue	125.00
7230	Removal of impacted tooth – partially bony	150.00
7240	Removal of impacted tooth – completely bony	200.00
7241	Removal of impacted tooth – completely bony w/complications	225.00
7250	Surgical removal of residual roots (cutting procedure)	35.00
7310	Alveoplasty with extraction – per quadrant	60.00
7320	Alveoplasty no extractions – per quadrant	50.00
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	25.00
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)	500.00
8090	Comprehensive orthodontic treatment of the adult dentition (once per lifetime)	500.00
8660	Pre-orthodontic treatment visit (once per lifetime)	150.00
8670	Periodic orthodontic treatment visit as part of contract (up to 24 consecutive months)	60.00
8680	Orthodontic retention-limit $200 (100 ea. top & bottom)	100.00

Adjunctive General Services

9110	Palliative (emergency) treatment of dental pain	20.00
9220	General anesthesia – first 30 minutes	100.00
9221	General anesthesia – each additional 15 minutes	50.00
9310	Consultation	30.00
9951	Occlusal adjustment – limited	20.00
9952	Occlusal adjustment – complete	50.00

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 90 calendar days after the completion of dental treatment to:

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

Claims submitted after the 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 two dental plan options. If you are enrolled in the Scheduled Dental Benefit Plan but would like to change to Dentcare, 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 the Scheduled Dental Benefit Plan and Dentcare 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 is a pre-paid dental program offered by Dentcare Delivery Systems, Inc., a not-for-profit dental insurance company licensed by the New York State Insurance Department. A wide range of dental services are provided by participating dentists at no cost to you, your spouse and your eligible dependents; a few services require co-payment by you of a specified amount. There are no annual or lifetime benefit maximums.

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 select one participating dentist from a panel of Dentcare dentists in a geographical area convenient to you. You can change your Dentcare dentist each annual open enrollment period. A request to change your dentist must be in writing and only the member can make the change.

What Dental Services Will You Receive?

Covered Services Provided By Dentcare Dentists:

- Covered benefits include a large variety of typical dental services. For a list of covered dental services, please see "Covered Dental Services" on the next page.

- If you require the services of a specialist, your Dentcare dentist will refer you to a participating specialist.
- In cases of emergency, Dentcare covers a maximum of two visits to a Dentcare dentist per member per contract year. However, if the member has had regular checkups or is undergoing treatment, there is no limitation on emergency coverage.
- If the emergency occurs out of the Greater New York City area or if you are unable to visit a Dentcare dentist, Dentcare will reimburse up to $25 per eligible family member per contract year if you submit copies of the bills for emergency treatment.
- In the event you are unable to reach your own participating dentist, DENTCARE provides 24 hour emergency service operators at**:** **(800)-468-0600**

Dentcare Benefit Plan
Covered Dental Services

Procedure	**Patient Co-payment**
Diagnostic & Preventive Services	
Full month x-ray	No Charge
Single Films (periapical or bitewing)	No Charge
Bitewing Series	No Charge
Oral Examination	No Charge
Specialty Consultation	No Charge
Cleaning of Teeth (prophylaxis & polishing)	No Charge
Fluoride Treatment	No Charge
Treatment in case of dental emergency	No Charge
Restorative Dentistry	
Silver amalgam, one surface	No Charge
Silver amalgam, two surfaces	No Charge
Silver amalgam, three surfaces or more	No Charge
Composite filling, one surface	No Charge
Composite filling, two surfaces	No Charge
Composite filling, three surfaces or more	No Charge

Oral Surgery

Routine Extractions – per tooth	No Charge
Surgical extractions	No Charge
Soft tissue impactions	No Charge
Bony impactions	No Charge
Alveolectomy, per quadrant	No Charge

Root Canal Therapy

Pulp Capping, Direct	No Charge
Pulpotomy	No Charge
Root Therapy – anterior	No Charge
Root Therapy – bicuspid	No Charge
Root Therapy – molar	No Charge

Periodontics

Scaling of teeth, per quad	No Charge
Pedicle Soft Tissue Graft	$150.00
Free Soft Tissue Graft	$150.00
Gingivectomy, per quad	No Charge
Osseous surgery, per quad	No Charge

Prosthetics – Crowns

Acrylic with metal crowns	No Charge
Porcelain crowns	No Charge
Porcelain with metal crown	$50.00
Post	No Charge
Recementation, per crown	No Charge

Prosthetics – Fixed Bridges

Acrylic w/ metal bridge crown or pontic	$50.00
Porcelain w/ metal bridge crown or pontic	$50.00
Recementation, bridge	No Charge

Prosthetics – Removable

Full upper denture, w/ adjustments	$50.00
Full lower denture, w/ adjustments	$50.00

Partial lower denture, cast base	$50.00
Partial upper denture, cast base	$50.00
Denture repairs	No Charge
Broken body of denture	No Charge

Orthodontia

Maximum case fee – 24 months

Dependent Children*	$300.00
Adult	$300.00

* Children covered up to age 19, 23 if full-time student.

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 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 two dental plan options. If you are enrolled in Dentcare but would like to change to the Scheduled Dental Benefit Plan, 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 Dentcare and the Scheduled Dental Benefit Plan 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

- If alternate methods of treatment exist, payment will not be made for treatment carrying the greater fee, unless that treatment is the only adequate treatment.
- Crowns and/or bridgework will only be allowed when these services are used to restore tooth structure or replace missing teeth as covered by the Group Contract.
- Reconstruction: Payment will be made toward the cost of procedures necessary to eliminate oral disease and to replace teeth which have been removed subsequent to the effective date of insurance for the covered person.
- When a prophylaxis and gum treatment are both performed on the same day, only the prophylaxis is a covered benefit.

- Benefits for emergency treatment for relief of pain will not be allowed if the service is rendered along with any other service (excluding x-rays).
- Oral exams, bitewing x-rays, prophylaxis, scalings and fluoride treatments – once every six months.
- Full mouth and panoramic x-rays – once every 36 months.
- Crowns, bridges, dentures & periodontal surgery – once every 60 months.
- Orthodontic treatment of Class II/Class III malocclusions – one 24 month case.
- Certain other procedures may have age limitations. A list of such services is available on request.
- Any dental services which were not rendered or approved by a participating dentist except in cases of out-of-area dental emergency.
- A service not furnished 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, Workmen's 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.
- Restorations, crowns or fixed prosthetics when acceptable results can be achieved with alternative methods or materials. In cases where the selection of a more expensive treatment plan is decided upon, the Plan will allow for the least costly alternative and the patient is responsible for all additional fees charged by the dentist.
- 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 cancelled 24 hours in advance, there is a $30 charge.
- Replacement of any existing crown, bridge or denture which can be made serviceable according to common dental standards.
- Procedures, appliances or restorations whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; lengthen crowns or restore occlusion.
- Treatment of unmanageable children and/or unruly patients by general dentists or pedodontists. An attempt will be made to treat all patients. However, if patient is untreatable by virtue of apprehension or any other reason, and is referred to another office for treatment, the responsibility of payment lies with either the patient or with the parents of the patient.

- Services not listed in the "Covered Dental Services" are not covered.

IMPORTANT NOTICE

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.

YOUR PRESCRIPTION DRUG COST REIMBURSEMENT 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 EnvisionRxOptions. With this program, members have two ways of obtaining their medications.

All members receive a prescription drug card issued by EnvisionRxOptions. 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 EnvisionRxOptions' web site (www.envisionrx.com). In many instances, these are antibiotics used to treat infection. Your doctor or prescriber may order up to a 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 (see Mail Order Program description). You can now obtain refills to medications filled at mail order by accessing Costco's web site (www.costco.com) and clicking on the Pharmacy link at the top of the page, or by calling Costco at 1-800-607-6861 for detailed instructions.

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

IMPORTANT INFORMATION

If your covered prescription drug expenses exceed the maximum reimbursement limits allowed under the Prescription Drug Cost Reimbursement you should continue to use your Prescription Drug Card at a participating pharmacy (or the Mail Order Program) to receive discounts for prescription drugs you require.

The cap on prescription drugs is gone on January 1, 2014!

In order to ensure that no one will go bankrupt due to expensive medications the $5,000 per year, per family, maximum prescription drug benefit paid by the SBF had its cap removed on January 1, 2014. There is **no dollar maximum** on the amount of money that the SBF will pay for prescription drugs for any member or dependent of the Fund.

Preventive medications available to you at no cost!

In addition, the following items are paid for by the SBF if you have a doctor's prescription for them **without any copayment on your part**:

- Aspirin, generic only, for men who are age 45-79 and women who are age 55-79.
- Influenza and pneumonia immunizations given outside of a doctor's office or hospital such as at a pharmacy.
- Vitamin D in generic form twice/day for those in an adult community (i.e., a nursing or long term care facility).
- Folic acid in generic form, .4 to .8 mg. once/day for women who may become pregnant.
- Fluoride in generic pill form for children up to age 5.
- Smoking cessation products – generic only. After six (6) months of providing these products, a member will only be eligible thereafter if he/she is in a smoking cessation program.
- FDA approved contraceptives – i) oral - generic only. ii) patch - generic only. iii) vaginal rings if not provided by your City health plan, iv) IUDs if not provided by your City health plan, v) Female condoms if not provided by your City health plan, vi) Emergency contraception – presently, only Plan B is available.
- Iron supplements up to one year of age, generic only.

The following co-payments apply commencing January 1, 2014.

- **The generic 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 90 day supply at the mail order pharmacy.**
- **Brand name copay will be 20% of the cost of a prescription for up to a thirty (30) day supply at retail pharmacy and 20% per prescription for up to a ninety (90) day supply at mail order pharmacy.**
- **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.**
- **The SBF will cover the generic form of proton pump inhibitor only.**
- **There are no changes in the current participating pharmacy network or mail-order pharmacy except for specialty medications (*see below*).**

You should know that Generic drugs are required by the U.S. Food and Drug Administration to be the same as (bioequivalent) 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.

What Kinds of Prescription Drugs Are Covered By the Plan's (EnvisionRxOptions) 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

Covered medications requiring a prior authorization from EnvisionRxOptions: *

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

Excluded medications:

- 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
- Unathorized refills
- Immunization agents, 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

* To obtain a prior authorization, call EnvisionRxOptions. For certain of the above referenced medications, you will need to obtain a physician's letter of medical necessity. Please call American Health Carefor detailed instructions.

** For **Non-Medicare** eligible member, insulin prescriptions and diabetic supplies are covered under your basic NYC Health Insurance Plan. Please call American Health Careat 1-800-361-4542 for detailed instructions.

Generic Drugs vs. Brand Name Medications

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.

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

Step Therapy

Step Therapy Program

Step therapy is an approach to prescription drug therapies intended to control the costs and risks posed by prescription drugs. The practice begins medication for a medical condition with the most cost-effective and safest drug therapy and progresses to other more costly or risky therapies only if necessary. On January 1, 2014, the SBF will institute a step therapy program for:

- angiotensin receptor blockers,
- insomnia agents (a/k/a, sleeping pills),
- osteoporosis medications,
- statins,
- fibric acid derivatives,
- gout medications,
- cox II inhibitors,
- selective serotonin reuptake inhibitors (SSRIs), and
- serotonin and norepinephrine reuptake inhibitors (SNRIs).

If you or your dependent is taking a brand name drug in the step therapy program class of drugs, the SBF will pay only for the generic form of the drug.

If, prior to January 1, 2014, you or your dependent are taking a brand name drug in the step therapy program class of drugs that has no exact generic equivalent, you or your dependent will be "grandfathered" and will be eligible to continue to receive that drug with a copay of 20% for a 12 month period (i.e., until December 31, 2014).

Thereafter, you or your dependent will be required to follow the regular step therapy program and 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 clearing you for a step 2 drug.

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.

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 EnvisionRxOptions' web site (http://www.envisionrx.com/pdfs/dmr.pdf).

- 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 90 calendar days following the date the prescription or refill was filled. Claims submitted after the 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:

EnvisionRxOptions, Inc. **1-800-361-4542**
2181 E. Aurora Road, Suite 201
Twinsburg, Ohio 44087

The Mail Order Prescription Drug Program

This program, which is administered by **American Health Carethrough Costco Mail Order Pharmacy**, offers you the convenience of ordering from your home and of having your prescriptions refilled less often.

There is a $10.00 co-payment on mail-order prescriptions for up to a 90 day supply, unless you order a brand name drug where a generic equivalent is available the co-payment 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.

- If you, your spouse or eligible children require covered medications on an on-going basis, you can order a 90-day supply through the mail.
- Using the Mail Order Program offers the convenience of ordering from your home and having your prescriptions filled less often. The Mail Order Program can also reduce the costs of your prescription drugs, allowing you to purchase more of your maintenance medications with your $5,000 annual Prescription Drug Cost Reimbursement Benefit.
- Your doctor can prescribe up to a 90-day supply. When you place your first order, you will be asked to complete a Mail Order Patient Profile which you will receive from EnvisionRxOptions. Enclose the doctor's prescription(s) in the pre-addressed, postage paid business reply envelope. You can obtain a Mail Order enrollment brochure by calling American Health Careat 1-800-361-4542 or Costco Mail Order at 1-800-607-6861. ***Do not send your CWA Local 1180 Prescription Drug I.D. card with your claim.***

If you are enrolled in the CWA local 1180 Prescription Drug Benefit program, you or your pharmacist may call or write American Health Carewith any questions regarding the program as follow:

EnvisionRxOptions, Inc.
2181 E. Aurora Road, Suite 201
Twinsburg, Ohio 44087
1-800-361-4542
www.envisionrx.com

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:

Effective July 1, 2010, there will no longer be an annual deductible for 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 and Retirees 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 ~~34~~ 30 day supply)	(up to 90 day supply)
$5 Generic	$10 Generic
20% of the cost of Brand Name	20% per Brand Name prescription

Chemotherapy and Injectable Medication:

Non-Medicare Eligible Members, employed or retired 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.

NOTE: If you have an optional rider for prescription drugs with your health plan all Chemotherapy, Injectable and Asthma prescriptions will be included in the optional rider. Follow the procedures of your health plan's prescription drug program.

Co-payments and deductibles for all Chemotherapy, Injectable and Asthma category drugs are not reimbursable under the Funds' benefits.

Medicare Eligible Members with Three or More Eligible Dependants

As of October 24, 2005, the benefit plan was amended to provide that in every family where the member is Medicare-eligible or has a Medicare-eligible beneficiary (or where both are Medicare eligible) and the family consists of three or more individuals eligible for benefits from the Fund, the following annual prescription drug caps shall apply:

- If the Medicare-eligible individual is the member, the participant shall have a $5,000 annual cap and the remaining beneficiaries shall have their own combined cap of $5,000 annually;
- If the Medicare-eligible individual is the spouse of the member, the spouse shall have a $5,000 annual cap and the remaining members of the family, including the participant, shall have their own combined cap of $5,000 annually;
- If both the member and spouse are Medicare-eligible and they have one or more dependent children, the member and spouse shall have a combined $5,000 annual cap and their dependent children shall have their own combined cap of $5,000 annually.

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 medical expenses, 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. Mental health, podiatry, dental and optical expenses 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 up to a maximum of $300 per calendar year for each covered member of your family.

These benefits will be paid for out-of-hospital mental health or substance abuse care only. These benefits will be paid for out-of-hospital mental health 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 1997, 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. Please contact the Fund Office for a list of Providers

Getting Your Benefit

- Obtain a Mental Health Benefit Claim Form from the Fund Office or the Local 1180 website 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 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 over the age of 18 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.

Dependents Under Age 19

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, 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.

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.
- 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 90 calendar days after the expense is incurred. Claims submitted after the 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.

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 90 calendar days after the date the hearing appliance was purchased. Claims submitted beyond the 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.

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 90 calendar days following the date of treatment. *Claims submitted after the 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
www.cwa1180.org

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Fund Administrator

Damien Arnold

Counsel

Spivak, Lipton, LLP

Consultants

Policy Research Group, LLC

Certified Public Accountant

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 $200 per semester 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.

Book Reimbursement

If you are enrolled in a course covered by the College Tuition Reimbursement Program, you can be reimbursed up to $25 each semester for books related to the courses you are taking.

Queens College Urban Leadership Program

Graduate and Undergraduate students covered by CWA Local 1180 Education Fund are eligible to participate.

A major advantage of this program is that for New York State resident tuition and fees are completely waived for up to eight designated three-credit courses in Urban Studies. One or two courses each semester may be taken on a tuition-waived basis. This benefit is in addition to the College Tuition Reimbursement Benefit.

Undergraduate Study

Requirements for a Bachelor of Arts degree include courses in the humanities, arts, sciences, and social sciences. These are designed to improve the student's writing and critical thinking skills and to provide students with a well-rounded liberal arts background.

In addition, students are expected to major in a department or program. A total of 128 credits are necessary to complete the Bachelor's degree.

Undergraduates may take two Urban Leadership courses on a tuition-waived basis in a semester if they:

1. Have completed at least 64 credits, whether at Queens College or transferred from other colleges;
2. Have completed at least one semester at Queens College; and
3. Do not have any incomplete or absent grades pending in any Urban Leadership course.

Admission: Applicants must submit a completed application form; a copy of their high school diploma or GED certificate and an official high school transcript; and official transcripts from all accredited colleges they may have attended.

Graduate Study

Urban Leadership graduate students enter the Masters of Arts in Urban Affairs program of the Urban Studies department. The college can waive New York State resident tuition and fees for up to 24 of the 30 credits required for the Masters degree of the designated courses in such areas as public policy, public administration, and specific topics.

Graduate students may take two Urban Leadership courses on a tuition-waived basis in a semester if they:

1. Have completed at least 6 credits as a graduate student at Queens College; and
2. Have at least a 3.0 grade point average; and
3. Do not have any incomplete or absent grades pending in any Urban Leadership course.

Admission: Depending on their previous academic record, applicants may be admitted either on a matriculated or non-matriculated basis. Those applying for matriculated status must submit a completed application, letters of recommendation, an official transcript, and an essay. Applicants for non-matriculated status must complete a shorter application and submit proof of a college degree.

For further information call:
Queens College LEAP Office at 1-718-997-3060 or
The Murphy Institute at 1-212-827-0200

The CUNY/ DCAS Public Administration Program

The CUNY/DCAS Public Administration Program is offered in collaboration with the NYC Department of Citywide Administrative Services (DCAS), City University of New York's Joseph S. Murphy Institute for Worker Education (JSMI) and Local 1180 on both the undergraduate and graduate level. It is designed to provide an opportunity to earn college credits, improve communication and analytic skills, and provide for expanded knowledge of government agencies, social services, labor relations, and the legislative and budgetary process in the context of deepening the understanding of urban challenges.

1180 members may enroll at the undergraduate, graduate or post MA level.

Students may attend classes at DCAS on released time (with supervisory approval) or at CUNY during the evening. Students earn a Certificate in Public Administration and Public Policy from the City University of New York and the NYC Department of Citywide Administrative Services. Students may have their tuition waived (except for the post MA level certification) under the Urban Leadership Program and may apply credits toward a bachelor's or master's degree at Queens College, CUNY.

Courses of Study:

Undergraduate Certificate in Public Administration and Public Policy

This undergraduate certificate program provides you with a solid background in government, the policy-making process, and public administration. The interdisciplinary approach taken in this program focuses on public agencies and the problems they face in the delivery of social services. You can apply the 16 credits you earn in this program to a bachelor's degree in Urban Studies.

Advanced Certificate in Public Administration and Public Policy: Level I (Graduate)

If you have already earned a bachelor's degree, this certificate program will provide you with a deeper understanding of such topics as public management, the

administrative decision-making process, training and staff development, and union-management relations. You will also learn how to analyze data and research on public policy and its implementation. You can apply the 12 credits you earn in this program towards a Master's degree in Urban Studies.

Advanced Certificate in Public Administration and Public Policy: Level II (Post-MA)

If you already hold a Master's degree in Urban Studies or a related field, this 9 credit certificate program provides you with an opportunity to practice decision and policy making skills through field based projects. You will also use the advanced research skills you develop in the program to analyze and evaluate public policy, produce policy reports, and generate policy recommendations.

For further information call:

The Murphy Institute at 1-212-827-0200 or DCAS at 1-212- 669-3630

New York City Reimbursable Courses

The New York City Reimbursable Courses Program provides reimbursement for tuition for a maximum of 2 courses up to $100 per year, for eligible members who successfully complete courses offered by the New York City Reimbursable Courses Program. Reimbursement will be made at the conclusion of the term to each eligible member who has applied to the program and has completed the course(s) and received a certificate.

New York City Reimbursable Courses Program is provided by the CWA Local 1180 Education Fund for full-time municipal employees in covered titles.

Adult Education Program Tuition Reimbursement

If you successfully complete courses in a job-related area in an Adult Education Program, you can receive full reimbursement of the tuition up to a maximum of $100 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 area for Career Development, you can receive reimbursement up to a maximum of $100.

NOTE: Combined reimbursement for New York City Reimbursable Courses, Adult Education Courses and Career Development Conferences can not exceed $100 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 members to assist them in preparing for civil service examinations for titles covered under the collective bargaining unit or for promotional titles into management.

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 before the first day of class and you remain employed in a covered title for the term.
- 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, call or write to the following address for a claim form:

CWA Local 1180 Education Fund
6 Harrison Street
New York, NY 10013-2893
1-212-966-5353

You must submit:

- A separate claim form for each semester,
- your bursar's receipt and/or financial statement showing tuition and registration fees paid,
- a letter from your supervisor verifying that the course is job-related, in the case of Adult Education Program Tuition Reimbursement claims or career development conferences,
- your grade and credits on college stationary report,
- receipt from other educational benefits you received (e.g., a financial aid statement such as TAP, Pell, etc.).

These items must be submitted to the Fund within 90 calendar days after your course ends.

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.

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
www.cwa1180.org

Board of Trustees

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Counsel

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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 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.

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.

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 Matter 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 in 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.

- **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.

➢ **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 in these matters with a 25% reduction in its current hourly rate, which for 2009 is $350.

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.

➢ **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 a 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 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 Communications Workers of America, AFL-CIO, or its Locals or any of their affiliated bodies, or any of the officers, agents or attorneys of the above groups
- 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 90 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 90 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 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 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 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, 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:	Chairman, Gloria Middleton Gina Strickland Gerald Brown Robin Blair-Batte Lourdes Acevado
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 1-718-204-7172 Ext. 5520 1-516-396-5520 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. 350 Fifth Avenue New York, NY 10118

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 $5,000 or less, and you terminate employment and have not attained age 55 (Normal Retirement Age), you may not elect to defer receiving a distribution of your account. Instead, your account balance will be paid to you in a lump sum as soon as administratively feasible following your termination of employment.

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 you reach age 70½, 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 or any other termination. 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 $5,000. If the value of your account at that time is less than $5,000, 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 upon reaching age 70½ 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, the Plan Administrator will make payment to you as required by federal law.

If you continue to work beyond age 70½, you may continue to defer payment of your Plan benefit until you terminate your employment.

How Do I Apply For My Benefits?

You must file an application when you want to receive your benefit. 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.

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, 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 90 days after receipt of the notification of the claim denial. The Trustees, or a person or committee designated by them, will receive your appeal and issue a final decision within 90 days after the receipt of your appeal.

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 another employer's qualified retirement plan that accepts rollover contributions or into an individual retirement arrangement (e.g. IRA, but not Roth IRAs).

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 60 days of receiving that distribution roll over into another employer's qualified 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 enlist 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. A summary of the Annual Report which provides details of the financial information of the Fund operation will be furnished free of charge to all covered members.

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 reserve the right to amend, modify or discontinue part or all these Plans whenever, in their 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
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 Plans
Make all factual determinations required to administer, apply, construe and interpret the Plans (and all related documents).

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

Board of Trustees

Gloria Middleton,

President, CWA Local 1180

Gina Strickland

1st Vice President. CWA Local 1180

Gerald Brown

2nd Vice President, CWA Local 1180

Robin Blaire-Batte,

Secretary-Treasurer, CWA Local 1180

Lourdes Acevedo

Recording Secretary, CWA Local 1180

Funds Administrator

Damien Arnold

6 Harrison Street

New York, NY 10013-2898

1-212-966-5353

1-888-966-5353

Counsel

Spivak, Lipton, LLP

Consultant

Policy Research Group, LLP

Certified Public Accountant

Gould, Kobrick & Schlapp, P.C

CWA LOCAL 1180 SECURITY BENEFITS FUNDS OFFICES

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OPEIU153