COMMUNICATIONS WORKERS OF AMERICA ■ LOCAL 1180 ■ AFL-CIO

RETIREES BENEFITS FUND

SUMMARY PLAN DESCRIPTION

Welcome

January 2016

Dear Retiree:

The trustees and staff of the CWA Local 1180 Retirees Benefits Fund welcome you and extend our deepest gratitude for your long and dedicated service to the City of New York. We are pleased to provide you with this updated Benefits Summary Plan Description that describes all the benefits provided to you through the Communications Workers of America, Local 1180 Retirees Benefits and Legal Benefits Funds.

To the extent that this booklet describes an insured benefit (e.g., Dentcare), 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 Benefit Summary Plan Description.

Every effort has been made to present this information in clear, straightforward language. Please read this Benefit 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.

Sincerely,

Board of Trustees

CWA Local 1180 Retirees Benefits Fund
CWA Local 1180 Legal Benefits Fund

CWA LOCAL 1180 RETIREES BENEFITS FUND

6 Harrison Street, 3rd Floor
New York, NY 10013
(212) 966-5353, Out-of-area (888) 966-5353
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TABLE OF CONTENTS

YOUR GENERAL MEDICAL REIMBURSEMENT BENEFIT

YOUR MENTAL HEALTH REIMBURSEMENT BENEFIT

YOUR OPTICAL BENEFIT

YOUR HEARING AID REIMBURSEMENT BENEFIT

YOUR PODIATRY BENEFIT

YOUR RETIREE DIVISION BENEFIT

YOUR LEGAL FUND BENEFITS

GENERAL INFORMATION ABOUT THE FUNDS

Introduction

The CWA Local 1180 Retirees Benefits and Legal Benefits Funds are separate trusts maintained for the purpose of providing covered retirees with supplemental health and legal services benefits. The supplemental health benefits provided by the Retirees Benefits Fund are intended to augment basic health insurance and hospitalization benefits administered by employers.

The Funds are separately administered by Boards of Trustees.

The benefits provided by these Funds are the result of collective bargaining agreements between the City of New York and related public employers, the Board of Education of the City of New York, the State of New York and the Communications Workers of America, AFL-CIO on behalf of its Local 1180. These collective bargaining agreements provide for annual contributions to the Funds on behalf of each retired 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 Benefit Summary Plan Description

This Benefit Summary Plan Description was designed to provide our retirees with a description of the benefits made available to you by the CWA Local 1180 Retirees Benefits and Legal 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 Benefit 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 Benefit 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 both the CWA Local 1180 Retirees Benefits Fund and CWA Local 1180 Legal 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 Benefit 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 Summary Plan Description 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 Retirees 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)

BENEFITS FUNDS OVERVIEW

RETIREES BENEFITS FUND

Supplemental Health Benefits:

Dental Benefits (Choose one of the following plans)

Scheduled Dental Plan: or

- 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:

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

S700 Plan Florida Only

- Services at Moderate Fees

Prescription Drug Cost Reimbursement Benefit

- Benefit of up to $1,500 per family, each calendar year towards your prescription drug costs.
- Choose to be reimbursed for the cost of the prescription drug portion of your City Health Plan Optional Drug Rider or receive prescription drug benefits administered by American Health Care
- up to the annual maximum benefit.

General Medical Reimbursement Benefit

- Benefit of up to $1,200 per family per calendar year for covered medical expenses.
- Benefit can be applied towards certain unreimbursed, out-of-pocket medical, prescription drug and Medicare 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 $125 benefit per person, per calendar year.
- Maximum of four claims per family, per calendar year.

Hearing Aid Reimbursement Benefit

- Up to $600 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.

Retiree Division Benefit:

- Services to help you and your dependents achieve good health and well-being in retirement.
- Wide range of activities include exercise programs, computer and language courses, recreational activities, workshops and seminars, individual and group counseling, etc.
- No fees to participate in programs (there may be costs for some activities).

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.

ELIGIBILITY

Eligibility for Retirees:

You are eligible to participate in the CWA Local 1180 Retirees Benefits and the CWA Local 1180 Legal Benefits Funds, if:

- You have retired from employment with the City of New York or other qualified employer*

  and
- You were formerly employed in a title covered by a collective bargaining agreement between CWA Local 1180 and the City of New York or other qualified employer

  and
- Your former employer and CWA Local 1180 have entered into an agreement providing for the payment of contributions to the CWA Local 1180 Retirees Benefits and CWA Local 1180 Legal Benefits Funds

  and
- You are eligible for and receiving a pension from the City of New York or other qualified employer

  and
- You are eligible for and enrolled in a City Health Plan or health plan of a qualified employer.

** A qualified employer is an employer which has entered into a collective bargaining agreement with CWA Local 1180, requiring contributions to the CWA Local 1180 Retirees Benefits and CWA Local 1180 Legal Benefits Funds.*

Who is Covered?

Your Spouse or Domestic Partner:

Your spouse is eligible for all of the benefits provided by the CWA Local 1180 Retirees 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 Retirees 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 Retiree.

** If you are an eligible retiree 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.

NOTE:

The cost of coverage for domestic partners may be taxable as income to the Fund retiree.

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 Retirees 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 applied for and are eligible for 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, see extended coverage above) 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 Retirees 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 recertify the disabling condition from time to time.

The Trustees of the CWA Local 1180 Retirees 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 recertify the disabling condition from time to time.

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 Retirees Benefits and Legal Benefits Funds as both a retiree and dependent or as a dependent of more than one retiree.

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

Enrollment in the Fund

- To enroll in the Fund, contact the Fund Office at 1-212-966-5353 and request a Retiree Enrollment Package.
- Complete the Enrollment and Verification form and return to the Fund Office at:

  CWA Local 1180 Retirees Benefits Fund
  6 Harrison Street
  New York, New York 10013-2898

- You will also be requested to provide pertinent information from your personnel department or NYC Retirement System.

- Notify the Fund promptly when any change in status occurs, such as if you move, get married, have a new baby, adopt a child, get divorced or legally separated, when your child reaches the age of 19 or someone covered by the Fund dies.

- If you have any questions about enrollment, please call the Fund Office at 1-212-966-5353.

When Your Coverage Begins

If you meet the eligibility requirements outlined in the section entitled "Who is Covered" above, you can begin receiving benefits from the Fund:

- Starting with your retirement date.
- Provided you have enrolled and completed a verification form which you have filed with the CWA Local 1180 Retirees Benefits Fund.

If you have dependents on the date you become eligible and have enrolled in the Fund, your spouse and/or your children meeting the eligibility requirements outlined in the section entitled "Who is Covered" above, can begin receiving benefits:

- On the day you become eligible.
- Provided you have enrolled them in the Fund.

If you acquire a new dependent after you become eligible and have enrolled them in the Fund because of marriage, birth of a child, adoption of a child, placement of a foster child or certification of a domestic partner, your spouse, children and/or domestic partner meeting the eligibility requirements outlined in the section entitled "Who is Covered" above, can begin receiving benefits:

- On the day they become eligible.
- Provided you have enrolled them in the Fund.

If you and your spouse are both eligible retirees, each of you may enroll yourself individually. If there are eligible children, only <u>ONE</u> parent may enroll them as dependents.

When Your Benefits End

Your benefits end:

- On the date of your death.

- On the date you cease to be eligible for coverage.
- On the date a plan of benefits described in this booklet is cancelled.

- Your spouse and dependent children's coverage end:
- On the date your coverage ends.
- On the date you cease to be eligible for coverage for your spouse and/or dependent children.
- On the date your spouse and/or dependent children no longer qualify for coverage as a spouse or dependent child.
- On the date a plan of benefits described in this booklet ceases covering spouses and/or dependent children.
- On the date a plan of benefits described this booklet covering spouses and/or dependent children is cancelled.

When coverage ends for you, your spouse or dependent children, you may be able to continue your General Medical Reimbursement, Dental, Optical, Prescription Drug, Hearing Aid, Mental Health and Podiatry Benefits under the COBRA option (see "Continuing Your Coverage – COBRA").

COORDINATING YOUR BENEFITS

What is Coordinating Your 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 benefits 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 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 and 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 has been taken.

If You and Your Spouse are Both Eligible Retirees

If you and your spouse are both eligible retirees, each of you may cover yourself only. You cannot each elect individual coverage while also covering each other as dependents. If there are eligible dependent children, only one parent may cover them.

The Fund will not, under any circumstances, make duplicate payments on the same claim.

If You and Your Spouse are Both Have Dependent Coverage for Your Children

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

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

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

- If a court orders one of the parents to provide coverage and that parent's plan covers that 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, the plan that covers the child as a dependent of the parents without custody will be considered to pay benefits first.

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:

When Others Are Responsible for Your Illness or Injury Subrogation, Reimbursement and Recovery:

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

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

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

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

In addition, if you receive payments from or on behalf of the responsible person, you must reimburse the Fund for payments it has made to you or on your behalf. You must reimburse the Fund, regardless of whether the total amount of the recovery is less than the actual loss and even if the third party does not admit liability, itemize the payments, or identify payments as medical expenses. You cannot reduce the amount of the Fund's reimbursement to pay for attorney fees incurred to obtain payments from the responsible person.

If you fail or refuse to reimburse the Fund, or to sign a subrogation lien, then the Fund may suspend future payments to you, or offset future payments to you, or recover from the providers money paid to them until the subrogated portion is reimbursed to the Fund, or take all of the foregoing actions until it is made whole. In addition, the Fund may bring a court action against you to obtain reimbursement.

Before entering into a settlement agreement with the third party, or his or her insurance company, you must notify the Fund and obtain written consent. You must obtain consent because the Fund shall have the right to recover the amount if advanced on your behalf for medical care.

When Motor Vehicle Or No-Fault Insurance Provides Coverage:
This provision is expressly intended to avoid the possibility that this Fund will be primary to coverage that is available under motor vehicle or no-fault insurance.

This plan is secondary to:

- Coverage provided under any “no-fault” provision of any motor vehicle insurance statute or similar statute

  and

- Coverage provided under motor vehicle insurance which provides for health insurance protection, even if you (or your spouse or your eligible children) select coverage under the motor vehicle insurance as secondary.

Additional Coordination Rules

- If a plan has no coordination of benefits rules or has rules which do not comply with applicable law, then 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.

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 (Dental, Prescription Drug, General Medical Reimbursement, Mental Health, Optical, Hearing Aid and Podiatry Benefits), but you must pay for it. Federal law requires that most group health plans (including this Fund) give covered retirees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under the Fund. Depending on the type of qualifying event, "qualified beneficiaries" can include a covered retiree's spouse (or domestic partner) and dependent children of the covered retiree. COBRA Continuation Coverage does ***not*** include the Retiree Division Benefit or Legal Services Benefit.

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 covered retirees 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.

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

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 retirees, spouses of covered retirees, and dependent children of covered retirees may be qualified beneficiaries.

If you are the **spouse of a covered retiree**, you will become a qualified beneficiary; however, you may lose your coverage under the Fund because of any of the following qualifying events:

1. Your spouse - covered retiree dies;
2. You become divorced or legally separated from your spouse – covered retiree.

Your **dependent children** will become qualified beneficiaries; however, they may lose coverage under the Fund because of any of the following qualifying events:

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

If you are a **covered member who has already retired**, you will become a qualified beneficiary only if you lose your coverage under the Fund because of the bankruptcy of the covered retiree's former employer (see following paragraph for more on your rights in the event of bankruptcy).

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event for covered retirees and their families. If a proceeding in bankruptcy is filed with respect to the covered retiree's former employer and that bankruptcy results in the loss of coverage of any covered retiree under the Fund, the covered retiree is a qualified beneficiary with respect to the bankruptcy. The covered retiree's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Fund. For more information about your rights in respect to bankruptcy of the covered retiree's former employer, contact the Fund Administrator, CWA Local 1180 Retirees Benefits Fund, 6 Harrison Street, New York, NY, 10013-2898 (1-212-966-5353).

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 retiree and spouse or a dependent child's losing eligibility for coverage as a dependent child or the covered retiree 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 Retirees 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 retiree, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to 36 months. For information on the length of COBRA coverage when the qualifying event is a bankruptcy, contact the Fund Office.

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 Retirees Benefits Fund ceases to provide any group health plan for its retirees;
- 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 retiree coverage was terminated for causes, 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 retiree'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 (death of covered retiree, 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 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.***

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 retirees and families plus an additional 2%. The costs 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 1-800-400-7242. TTD/TTY callers may call toll free at 1-866-400-7242. 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 Retirees 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 you 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 to request such a certificate.

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 conditions, 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 if 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 Summary Plan Description 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 for 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 disclosures 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 are 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 is 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 use 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 you 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 with 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:

Dwight R. Kearns
HIPAA Contact Officer
CWA Local 1180 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 SUPPLEMENTAL HEALTH BENEFITS

Dear Retiree:

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

Sincerely,

Board of Trustees
CWA Local 1180 Retirees Benefits Fund

CWA Local 1180 Retirees 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

Arthur Cheliotes
Gina Strickland
Gloria Middleton
Gerald Brown
Lourdes Acevedo

Fund Administrator

Dwight R. Kearns

Counsel

Spivak, Lipton, LLP

Consultants

Policy Research Group, LLC

Certified Public Accountant

Gould, Kobrick & Schlapp, PC

APPLYING FOR YOUR SUPPLEMENTAL HEALTH BENEFITS

When Benefits May Be Withheld or Denied

The procedure for claiming your General Medical Reimbursement, Dental, Optical, 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 Retirees 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 Retiree 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 and 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 DENTAL BENEFIT PLANS

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 Benefit 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)	225.00
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	225.00
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*	85.00
6058*, 6059*, 6060*, 6061*, 6062*, 6063*, 6064*, 6065*, 6066*, 6067*, 6068*, 6069*, 6070*, 6071*, 6072*, 6073*, 6074*, 6075*, 6076*, 6077*	275.00

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

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

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

6792	Crown – full cast noble metal*	250.00
6930	Recement fixed partial denture	35.00
6950	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 Fund 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 Benefit 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 retiree 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 retiree per contract year. However, if the retiree 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

Diagnostic & Preventive Services	**Patient Co-payment**
Oral Examination	No Charge
Full Mouth X-Ray	No Charge
Single Films (periapical or bitewing)	No Charge
Bitewing Series	No Charge
Cleaning of Teeth (prophylaxis & polishing)	No Charge
Fluoride Treatment	No Charge
Specialty Consultation	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 Crown	No Charge
Porcelain Crown	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 or Lower Denture, w/adjustments	50.00
Partial Upper or Lower 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, 26 if waiver filed.

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 Cost Reimbursement Benefit?

The Fund will provide you, your spouse and eligible children up to a maximum benefit of $1, 500 per family, per calendar year for your family's covered prescription drug costs.

When Is Coverage Provided?

Coverage is provided when:

- Services are received in accordance with the procedures described in this Benefit 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.

What Expenses Are Covered By The Prescription Drug Cost Reimbursement?

For Retirees who have the City Health Plan Optional Drug Rider:

- If you have chosen the Optional Drug Rider with your City Health Plan, the Fund will reimburse the cost of the prescription drug portion of your City Health Plan Optional Drug Rider and any deductibles and out-of-pocket co-payment expenses you incur for covered prescription drugs, up to the annual maximum of $1,500 per calendar year
- If the cost of your Optional Drug Rider, deductibles and out-of-pocket co-payment expenses for covered prescription drugs exceed the annual maximum of $1,500 per calendar year, your out-of-pocket expenses may be covered by the Fund's "General Medical Reimbursement Benefit." (See "Your General Medical Reimbursement Benefit.")

For Retirees Who Do Not Have the City Health Plan Optional Drug Rider:

- If you do not have the Optional Drug Rider with your City Health Plan, you, your spouse and eligible children will be eligible for the Prescription Drug Cost Reimbursement Benefit administered by American Health Care. Upon presentation of your prescription card, participating pharmacists will provide covered prescription drug benefits at no out-of-pocket cost up to the $1,500 per family annual maximum.
- If you reach the $1,500 per family annual maximum, your additional covered prescription drug costs will automatically continue to be covered by the Fund's "General Medical Reimbursement Benefit" until you have exhausted the maximum benefit allowed. (See "Your General Medical Reimbursement Benefit.")

IMPORTANT INFORMATION

If your covered prescription drug expenses exceed the maximum reimbursement limits allowed under the Prescription Drug Cost Reimbursement and General Medical Reimbursement Benefits, 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.

What Kinds of Prescription Drugs Are Covered By the Plan's American Health Care Prescription Drug Cost Reimbursement Benefit Program?

Covered medications include:

- Federal legend drugs, with the exception of vitamins or dietary supplements, even if these are legend drugs
- State restricted drugs
- Compound prescription, when one ingredient is a federal legend medication
- Insulin on prescription * **(Only for Medicare eligible retirees aged 65 and over)**
- Syringes and needles on prescription
- Federal legend oral contraceptives
- Smoking cessation medications
- Topical acne agents, limited to participants 23 years of age and under

***** For **Non-Medicare** eligible retirees, insulin prescriptions and diabetic supplies are covered under your basic NYC Health Insurance Plan. Please call American Health Care at 800-872-8276 for detailed instructions.

Covered medications requiring a prior authorization from American Health Care: **

- Erectile dysfunction medications
- Gleevac
- Topical acne agents for participants over 23 years of age.

*******To obtain a prior authorization, call* **American Health Care** at 800-872-8276. *You will need to obtain a physician's letter of medical necessity for certain of the above referenced medications. Please call* **American Health Care** *for detailed instructions.*

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
- Items lawfully obtainable without 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 on prescription *****
- Investigational or experimental drugs
- Unauthorized refills
- Immunization agents, biological sera, blood or plasma
- Medication for an retiree confined to a rest home, nursing home, sanitarium, extended care 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 Program 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.

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. If you are enrolled in the Prescription Drug Benefit program which has a $1,500 annual family maximum per year, you can have more of your prescribed medications covered by the Fund's benefit by using generic drugs instead of the more costly brand name equivalent.

*** Only Medicare Eligible Retiree - Age 65 and older**

Where Do I Get My Prescription Drugs Under the (American Health Care) Plan?

If you are a Retiree who does not have the Optional Drug Rider to your City Health Plan, the Fund will enroll you in the Prescription Drug Benefit Program. After you have been enrolled, American Health Care will mail you a Prescription Drug I.D. card which will be honored by:

➢**Participating Pharmacies**

Any pharmacy that is a participant in the American Health Care Prescription Drug Program will honor your doctor's prescription for covered prescription drugs upon presentation of your card.

➢**Mail Order Prescription Drug Program**

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.

Mail Order Prescription Drug Program

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

There is no co-payment on mail-order prescriptions.

- 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 $1,500 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 American Health Care. 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 Care at 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 Care with any questions regarding the program as follow:

American Health Care
3850 Atherton Road
Rocklin, CA 95765
1-800-872-8276
www.americanhealthcare.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 between the rate the Fund would have paid for the drug at the participating pharmacy and the non-participating pharmacy's charge, if greater. The reimbursed amount will be charged against your $1,500 annual family maximum benefit.

Getting Your Benefit

If you have the City Health Plan Optional Drug Rider:

- Submit photocopies of your pension check stubs showing the deductions made for the Optional Drug Rider, and any deductibles and out-of-pocket co-pay expenses you incurred to the Fund Office. If your pension check is deposited directly into your bank account, submit copies of your EFT (Electronic Funds Transfer) statement that you receive from your City pension plan.
- You may make two submissions each calendar year.
- You will be reimbursed up to a maximum of $1,500 per family, per calendar year for the prescription drug portion of the premium you paid for the Optional Drug Rider and any deductibles and out-of-pocket co-pay expenses you incurred for covered prescription drugs.
- Your claim must be received by the Fund Office no later than June 30th following the end of the prior calendar year.

Claims submitted after that date will be denied.

If you DO NOT have the City Health Plan Optional Drug Rider

- Once you are enrolled in the Prescription Drug Benefit program, take your doctor's prescription and your card to a participating pharmacy or use the Mail Order Program. Your family's prescription drug costs will be covered up to the $1500 per family annual maximum benefit.

If you use a non-participating pharmacy:

- Obtain a Prescription Drug Benefit Reimbursement Form from the Fund Office or from American Health Care's web site (www.americanhealthcare.com).
- Pay the pharmacist the full cost of the prescription.
- Sign and complete the form, be sure to attach pharmacy receipt where indicated and return it to the address shown on the reverse side of the reimbursement form.
- The Fund will reimburse you the cost of the prescription at the same rate that would be payable for that drug at a participating pharmacy, less that appropriate co-payment.
- Claims for prescription drugs filled by a non-participating pharmacy must be received by the Fund Office within 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 write or call to the following:

American Health Care
3850 Atherton Road
Rocklin, CA 95765
1-800-872-8276
www.americanhealthcare.com

About Chemotherapy, Injectable and Asthma Drugs

Asthma Medication

Eligible Retirees receive these medications through the CWA Local 1180 Prescription Drug Program.

Co-payments are as follows:

Retail Pharmacy	**Mail Order**
(up to 34 day supply)	(up to 90 day supply)

$10 Generic	$20 Generic
$25 Brand Name	$50 Brand Name

Chemotherapy and Injectable Medication

Non-Medicare Eligible Retirees, 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 Retirees, New York City Transit. These medications are subject to the same schedule of co-pays and deductibles (described above) which affect all Chemotherapy, Injectable and Asthma drugs.

N.B: 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.

ABOUT 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.

Medicare Eligible Retirees with Three or more Eligible Dependants

As of October 24, 2005, the benefit plan was amended to provide that in every family where the retiree 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 retiree, the participant shall have a $2,700 annual cap and the remaining beneficiaries shall have their own combined cap of $2,700 annually;

- If the Medicare-eligible individual is the spouse of the retiree, the spouse shall have a $2,700 annual cap and the remaining members of the family, including the participant, shall have their own combined cap of $2,700 annually;
- If both the retiree and spouse are Medicare-eligible and they have one or more dependent children, the retiree and spouse shall have a combined $2,700 annual cap and their dependent children shall have their own combined cap of $2,700 annually.

Retirees, Spouse and/or dependents with MEDICARE PART D Plan

- If you have elected to receive your prescription coverage under Medicare Part D, the CWA Local 1180 Retirees Benefits Fund will, on application consider reimbursement of out of pocket expenses that you incur for premiums, co-payments and deductibles under your Medicare Part D prescription coverage up to the family limit of $2700 per year ($1500 Prescription Drug Benefit plus $1200 General Medical Benefit). However, you may only claim your dependent(s) out-of-pocket expenses as they pertain to co-payments and, deductibles (not premiums) and only under your shared $1200 General Medical Benefit.
- If your spouse and/or your eligible dependent(s) elects to receive their prescription coverage under Medicare Part D, you may claim your dependent(s) out-of-pocket expenses as they pertain to co-payments and, deductibles (not premiums) under your shared $1200 General Medical Benefit.

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 $1200 per family, per calendar year for certain unreimbursed medical, dental, prescription drug and Medicare expenses.

When Is Coverage Provided?

Coverage is provided when:

- Services are received in accordance with the procedures described in this Benefit 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.

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 plan of medical and/or hospital insurance (including prescription drug riders) covering you, your spouse and eligible children .
- Unreimbursed Medicare Part B deductibles paid by you and your spouse.
- Where you do not have the Optional Drug Rider to your City Health plan and you, your spouse and eligible children are enrolled in the American Health Care prescription drug program, any covered prescription drug expenses you incur in excess of the $1,500 per family per calendar year benefit provided by the Fund’s Prescription Drug Cost Reimbursement Benefit will automatically be covered by the General Medical Reimbursement Benefit until you reach the $1,200 per family annual maximum benefit.
- If you are covered by the Fund’s Scheduled Dental Benefit Plan and you have reached the $2,000 per person per calendar year maximum benefit and you require additional covered dental services, you will be reimbursed the cost of the additional covered dental services in accordance with the Plan’s allowances for such dental services as provided in the Schedule of Dental Allowances up to the $1,200 per family annual maximum benefit.
- Any out-of-pocket expenses you incur for covered dental services provided by the Fund’s Dentcare program will be covered up to the maximum benefit of $1200 per family per calendar year.

Retirees, Spouse and/or dependents with MEDICARE PART D Plan

- If you have elected to receive your prescription coverage under Medicare Part D, the CWA Local 1180 Retirees Benefits Fund will, on application consider reimbursement of out of pocket expenses that you incur for premiums, co-payments and deductibles under your Medicare Part D prescription coverage up to the family limit of $2700 per year ($1500 Prescription Drug Benefit plus $1200 General Medical Benefit). However, you may only claim your dependent(s) out-of-pocket expenses as they pertain to co-payments and, deductibles (not premiums) and only under your shared $1200 General Medical Benefit.
- If your spouse and/or your eligible dependent(s) elects to receive their prescription coverage under Medicare Part D, you may claim your dependent(s) out-of-pocket expenses as they pertain to co-payments and, deductibles (not premiums) under your shared $1200 General Medical Benefit.

Getting Your Benefit

If you are submitting claims for unreimbursed premium payments, deductibles or co-payments under your City Health Plan, your Optional Drug Rider under the City Health Plan or any other medical, hospital and/or prescription drug plan covering you, your spouse and your eligible children:

- Save your health plan statements showing that you have met your deductibles, incurred premium payments for which you have not been reimbursed and had co-payment expenses for covered medical procedures, hospital charges, dental charges and prescription drugs.
- 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.

If you are submitting claims for unreimbursed Medicare Part B deductibles for you and/or your spouse:

- Save your Medicare statement showing that you have met the Part B deductible for the year.

- Submit photocopies of your Medicare statement(s) to the Fund Office, together with any additional covered medical expenses you incurred **once each calendar year, no later than June 30th** following the end of the prior year. Claims submitted after that date will be denied.

If you are enrolled in the American Health Care prescription drug program and exceed the $1,500 per family per calendar year maximum benefit provided by the CWA Local 1180 Prescription Drug Cost Reimbursement Benefit, you will automatically continue to be covered for prescription drugs covered by the Benefit until you reach the $1,200 per family per calendar year maximum benefit provided by the General Medical Reimbursement Benefit. American Health Care will inform you when you have reached your maximum annual benefit. You do not need to file claims for this benefit with the Fund Office.

What's Not Covered?

Benefits are not provided for:

- Optical, Podiatry or Mental Health Benefits
- Expenses otherwise covered by any other benefit provided by the Fund
- Expenses for which you have been reimbursed or are entitled to reimbursement under any other plan of insurance
- Expenses for procedures and treatments that are not medically necessary
- Cosmetic drugs, surgery or treatment
- Expenses not covered by any medical, hospital, dental or prescription drug plan of insurance in which you, your spouse or eligible dependents are enrolled
- 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).

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

The Fund will provide you, your spouse and eligible children a maximum of $125 per person per calendar year for eligible optical benefits. The benefit is limited to a maximum of four claims per family, per calendar year.

When Is Coverage Provided?

Coverage is provided when:

- Services are received in accordance with the procedures described in this Benefit 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.

What Expenses Are Covered By The Optical Benefit?

Reimbursements will be made for:

- Eye exams, whether or not vision correction lenses are prescribed.
- Eye glass frames, prescription lenses, tinting (if prescribed), sunglasses (if prescribed) or contact lenses.
- Use any ophthalmologist, optometrist or optician you choose.

Getting Your Benefit

Follow these simple steps:

- Obtain a claim form from the Fund Office.
- Visit any 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 the patient, the date services were provided and the 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.

No-Cost Option

The Fund has arranged with certain participating providers to make covered optical 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:**

- A Comprehensive Eye Exam
- A wide choice of eyeglass frames
- A choice of lenses, tinting and UV coating
- Instead of eyeglasses, choose contact lenses (stand soft or spherical contacts, or disposable lenses).

To obtain these benefits:

- Contact the Fund Office for a list of participating providers and their locations
- To avoid out-of-pocket costs, ask the participating provider to show you the lenses, frames and services covered by the program.
- No claim forms are required.
- Plan limitations apply (See "What Is The Optical Benefit").

What's Not Covered

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).

PLEASE NOTE

The Fund does NOT recommend or endorse specific providers. The no-cost option is made available to offer you potential cost savings. The decision to use this service is entirely up to you. As with any provider of services, you should apply the same criteria and care in choosing this provider that you would apply in choosing any other service you require.

YOUR HEARING AID REIMBURSEMENT BENEFIT

What Is The Hearing Aid Reimbursement Benefit

The Plan will provide you, your spouse and your eligible children up to a maximum of $600 toward covered hearing aid expenses once every two years.

When Is Coverage Provided?

Coverage is provided when:

- Services are received in accordance with the procedures described in this Benefit 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 under this Benefit Summary Plan Description.
- Services are not otherwise excluded.

What Expenses Are Covered By the Hearing Aid Reimbursement

Benefits are provided for:

- Charges incurred for a hearing aid prescribed by a physician, otologist or audiologist.
- Costs of hearing tests and evaluations performed by physicians, otologists or audiologists, but only if such tests result in the purchase of a hearing aid appliance prescribed by a physician, otologist or audiologist.

What Is Not Covered?

Benefits are not provided for:

- Expenses not recommended or approval 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.*

Getting Your Benefit

Follow these simple steps:

- Obtain a Hearing Aid Reimbursement 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 after the 90-day limit will be denied.

No-Cost Option

The Fund has arranged with certain participating providers to make covered hearing aid expenses available to you, your spouse and eligible dependents.

If you choose the no-cost option, you, your spouse and your eligible dependents will receive **at no out-of-pocket expense:**

- A comprehensive ear test

and

- An in the canal aid (ITC)

or

- An in the ear aid (ITE)

Or

- A behind the ear aid (BTE)

At Your Own Expense:

- Choose upgrades and second hearing aids at a 30% discount.

To Choose The No-Cost Option:

- Contact the Fund Office for a list of participating providers and their locations.
- Obtain a hearing aid claim form from the Fund Office.
- To avoid out-of-pocket costs, ask the participating provider to show you the hearing aids covered by the program.
- Plan Limitations apply (see "What Is the Hearing Aid Reimbursement Benefit?").

PLEASE NOTE:

The Fund does NOT recommend or endorse specific providers. The no-cost option is made available to offer you potential cost savings. The decision to use this service is entirely up to you. As with any provider of services, you should apply the same criteria and care in choosing this provider that you would apply in choosing any other service you require.

YOUR PODIATRY BENEFIT

What Is The Podiatry Benefit?

The Fund will reimburse you and your spouse for expenses you incur for podiatry care.

When Is Coverage Provided?

Coverage is provided when:

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

What Expenses Are Covered By The Podiatry Benefit

When you and your spouse require podiatry care, the Fund will pay your unreimbursed out-of-pocket expenses for podiatry care you receive:

- Up to $10 per visit.
- Maximum of four visits each calendar year.

Getting Your Benefit

Follow these simple steps:

- Obtain a Podiatry Benefit Claim Form from the Fund Office.
- After you visit your podiatrist and you pay your bill, obtain a copy of the bill marked "paid".
- Complete and sign the claim form, and submit it to the Fund Office along with the bill.
- Podiatry 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 RETIREE DIVISION BENEFIT

What Is The Retiree Division Benefit?

Through its Retiree Division, the Retirees Benefits Fund makes available a variety of services and activities to you and your eligible dependents. Its goal is to provide stimulating activities and programs to help you achieve good physical and mental health and well-being in your retirement. The Division employs a variety of means to reach out to its retired members including publishing newsletters, conducting regional meetings and actively encouraging membership participation in its many activities.

What Benefits Are Provided By The Retiree Division?

The Retiree Division offers a wide variety of programs and events including:

- Exercise Programs
- Computer and Language Classes
- Educational Workshops and Seminars

- Recreational Activities
- Information and Referral
- Seminars
- Health Education
- Benefit Updates
- Excursions
- Flu and Pneumonia Immunization
- Nutrition
- Blood Pressure, Blood Glucose, Cholesterol Testing
- Lending Library
- Health Insurance Ombudsman
- Film Screenings

Getting Your Benefit

There are no enrollment fees to participate in the programs offered by the Retiree Division (there may be costs associated with some activities).

To participate in these programs and to learn more about the Retiree Division, please contact:

CWA Local 1180 Retiree Division
6 Harrison Street – Lower Level
New York, NY 10013-2898
(entrance located at 97 Hudson Street)
1-212-226-5800

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 Retirees' 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

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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 retired from a job title represented by CWA Local 1180, AFL-CIO.
- You are eligible for health coverage from the City or other qualified employers as a retiree.
- Contributions are received by the Legal Benefits Fund on your behalf pursuant to a collective bargaining agreement between your former employer and CWA 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 End?

- Your eligibility for benefits provided by the Legal Benefits Fund ends upon your death.
- Your spouse, domestic partner and eligible childrens’ coverage ends on your death, except for the “Estates and Administration Benefit” described in the section entitled “Civil Matters Benefits.”

How Does The Legal Services Benefit Work?

If you need a lawyer for any of the legal services covered herein:

- Call the Legal Benefits Fund Office at: 1-212-966-5353
- Visit the Fund Office at: 6 Harrison Street, New York, NY 10013-2898
- Tell the Fund Office that you would like to see a Panel Attorney.

Once the Fund Office determines that you are eligible for the legal services benefit, 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 the lawyer.

If you cannot be present for your scheduled appointment:

- Call 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 (see explanation below) 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.

Important Reminder

If you must miss a scheduled appointment with a Panel Attorney:

- Call the Fund Office at 1-212-966-5353 to cancel your appointment as soon as possible.
- Don't forfeit a half-hour consultation benefit for missed appointments.

IMPORTANT NOTE

- You are not 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 v. 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 your legal services benefit will be reported as income on your year-end W-2 statement of earnings.

Member v. Member Disputes

In cases where two covered retirees are involved on opposite sides of the same controversy or proceeding, and both retirees are entitled to Fund benefits in the matter, the retiree will be provided with an attorney. This will insure that each party to the dispute will receive the same high quality of legal service.

Legal Service Benefit Overview:

Types of Covered Legal Services

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 legal services.

Time Limitations

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.

Geographical Limitations

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 the state of New Jersey. For retirees 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 retirees 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.

General Matter Benefit

➢**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 Retiree 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 retiree to consult with an attorney if the retiree 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 retiree's name, fraudulently;
- opening telecommunications or utility accounts in the retiree's name, fraudulently;
- passing bad checks or opening a new bank account in the retiree's name, without authorization; and
- obtaining a loan in the retiree's name, fraudulently.

The panel law firm will provide consultation and assistance* to a retiree 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 retirees.

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.

Civil Matters Benefits

You can use up to three Civil Matters Benefits listed below each calendar year. The Last Will and Testament Benefit is not counted towards this annual maximum:

- **Last Will and Testament Benefit**

You and your spouse, or certified domestic partner, are entitled to have a Last Will and Testament prepared and executed under the supervision of a Panel Attorney at no out-of-pocket expense. This benefit is provided once every two years.

- **Living Will/Health Care Proxy**

You and your spouse, or certified domestic partner, 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 in 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 on 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 a contested or uncontested divorce proceeding.

➢**Annulment Proceeding Benefit**

You are entitled to the services of a Panel Attorney if you are a defendant or a plaintiff in a contested or uncontested annulment proceeding.

➢**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 a 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**.**

➢**Change of Name Benefit**
This benefit provides you with legal advice and representation during name change procedures.

➢**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 2016 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**

If you own a house, a condominium or cooperative or are in the process of buying such a residence, you will be provided with the services of a Panel Attorney for:

- The sale or purchase of the primary residence in which you reside or intend to reside.
- Problems relating to the Board of Management or a similar group that governs certain aspects of a private dwelling, condominium or cooperative in which the retiree 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 a seller misinterpretation.

➢**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 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.

➢**A "Public Officer's Benefit" for retirees**

This means that a Panel Attorney will defend you, the retiree, if you are sued as a result of actions that arose out of your duties as a public employee by one other than your employer.

Criminal Matters Benefit

➢**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 on 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.

Court Cost Disbursement Benefit

The Fund will pay court costs, up 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 cost

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 If I live Outside The Geographical Area Covered By The Fund?

If you live outside the geographical area served by Panel Attorneys (see section entitled "Geographical Limitations"), the Plan provides for the payment of specified amounts to you for covered legal services you receive from an out-of-area attorney according to a reimbursement schedule. The maximum amount of allowable reimbursements for you, your spouse, certified domestic partner, and your eligible dependents combined is $1,000 each calendar year.

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 retiree 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).

Getting Your Out-of-Area Legal Services Benefit

- Follow these simple steps:
- Pay the out-of-area attorney for the covered legal services you receive.
- Obtain a legal benefits claim form from the Fund Office.
- Complete and sign the claim form after you receive and pay for your services.
- Submit the claim form and the Attorney's bill marked paid" to the Fund Office within 90 calendar days following the date on which the service is provided. ***Claims submitted after the 90 day limit will be denied***

WHO TO CALL

Call the Fund Office at 1-212-966-5353 or 1-888-966-5353 (out-of-area):

- To check whether you are eligible to receive benefits.
- For questions about what benefits are covered and what benefits are not.
- For a claim form.
- To get answers to any of your questions.

What Is Not Covered By The Legal Benefits Fund?

Legal services and benefits are not provided for:

- Cases against your former employer or your former employer's agents or officers.

- Cases against Communications Workers of America, AFL-CIO, or its Locals or any of their affiliated bodies, including the Security Benefits Fund and/or the Legal Benefits Fund, or any of the officers, agents, Trustees, 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 taxes, 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 for which you retained legal counsel before you became eligible for benefits from this Plan.
- Cases that cannot be handled within the geographical area handled by the Plan.
- Proceedings under the NYS Alcoholic Beverage and Control Law.
- Proceedings before the City Parking Violations Bureau or the State Department of Motor Vehicles.
- Any controversy, dispute, proceeding or matter which involves a retiree's business, commercial or investment interest.
- Legal matters for which you previously received benefits.
- Court costs above the $100 maximum benefit.
- Fines, penalties or other amounts you are required to pay as the result of a court judgment**.**

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 Retiree 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.

ENERAL 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 retirees.

Nothing in this Benefit 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 Retirees Benefits Fund

Communications Workers of America, AFL-CIO,
Local 1180 Legal Benefits Fund

Board of Trustees

Arthur Cheliotes,
Chairman

Gina Strickland
Trustee

Gloria Middleton,
Trustee

Gerald Brown,
Trustee

Lourdes Acevedo
Trustee

Fund Administrator
Dwight R. Kearns

Fund Address

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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 RETIREES BENEFITS FUNDS OFFICES

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