COMMUNICATIONS WORKERS OF AMERICA ▪ LOCAL 1180 ▪ AFL-CIO

RETIREES BENEFITS FUND

SUMMARY PLAN DESCRIPTION

Welcome

November 2024

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
www.cwa1180.org

Board of Trustees

Gloria Middleton, Chairperson
Teesha Foreman
Gerald Brown
Robin Blair-Batte
Debra Paylor
Arthur Cheliotes

Fund Administrator

Damien Arnold

Counsel

Spivak, Lipton, LLP

Consultants

Policy Research Group, LLC

Certified Public Accountant

Gould, Kobrick & Schlapp, PC

TABLE OF CONTENTS

INTRODUCTION

HOW TO USE THIS BENEFIT SUMMARY PLAN DESCRIPTION 1
HOW TO CONTACT THE FUND OFFICE 2

BENEFITS FUNDS OVERVIEW

SUPPLEMENTAL HEALTH BENEFITS 3
PRESCRIPTION DRUG COST REIMBURSEMENT BENEFIT 4
GENERAL MEDICAL REIMBURSEMENT BENEFIT 4
MENTAL HEALTH BENEFIT 4
OPTICAL BENEFIT 4
DEPENDENTS UNDER AGE NINETEEN 19 – NO-COST 4
HEARING AID REIMBURSEMENT BENEFIT 4
PODIATRY BENEFIT 4
RETIREE DIVISION BENEFIT 5
LEGAL BENEFITS FUND 5

ELIGIBILITY

ELIGIBILITY FOR RETIREES 6
WHO IS COVERED? 6
WHO IS NOT ELIGIBLE FOR COVERAGE? 9
ENROLLMENT IN THE FUND 9
WHEN YOUR COVERAGE BEGINS 9
WHEN YOUR BENEFITS END 10

COORDINATING YOUR BENEFITS

WHAT IS COORDINATING YOUR BENEFITS? 11
IF YOU AND YOUR SPOUSE ARE COVERED BY DIFFERENT PLANS 11
IF YOU AND YOUR SPOUSE ARE BOTH ELIGIBLE RETIREES 12
IF YOU AND YOUR SPOUSE BOTH HAVE DEPENDENT COVERAGE FOR YOUR CHILDREN 12
WHEN OTHERS ARE RESPONSIBLE FOR YOUR ILLNESS OR INJURY SUBROGATION,
REIMBURSEMENT AND RECOVERY 13
WHEN MOTOR VEHICLE OR NO-FAULT INSURANCE PROVIDES COVERAGE 14
ADDITIONAL COORDINATION RULES 14

YOUR CONTINUATION COVERAGE (COBRA)

WHAT IS COBRA CONTINUATION COVERAGE? 15

WHAT ARE COBRA QUALIFYING EVENTS? 16
HOW LONG DOES COBRA CONTINUATION COVERAGE LAST? 18
HOW DO I ELECT COBRA CONTINUATION COVERAGE? 18
ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE? 19
HOW DO I ADD COBRA COVERAGE FOR NEW DEPENDENTS? 20
WHAT IF MY SPOUSE OR DEPENDENTS LOSE OTHER HEALTH INSURANCE COVERAGE? 20
HOW MUCH DOES COBRA CONTINUATION COVERAGE COST? 21
WHEN AND HOW MUST PAYMENT FOR CONTINUATION COVERAGE (COBRA) BE MADE? 21
WHAT IF I ELECT COVERAGE UNDER ANOTHER GROUP HEALTH PLAN? 22
KEEP THE FUND INFORMED OF ADDRESS CHANGES 23

YOUR PRIVACY

SECTION 1: PURPOSE OF THIS NOTICE AND EFFECTIVE DATE 24
SECTION 2: YOUR PROTECTED HEALTH INFORMATION 24
SECTION 3: YOUR INDIVIDUAL PRIVACY RIGHTS 28
SECTION 4: THE FUND'S DUTIES 30
SECTION 5: YOUR RIGHT TO FILE A COMPLAINT 31
SECTION 6: IF YOU NEED MORE INFORMATION 32
SECTION 7: CONCLUSION 32

APPLYING FOR YOUR SUPPLEMENTAL HEALTH BENEFITS

APPLYING FOR YOUR SUPPLEMENTAL HEALTH BENEFITS 35
WHEN BENEFITS MAY BE WITHHELD OR DENIED 35
RECOVERY OF OVERPAYMENTS OR MISTAKEN PAYMENTS 35
RIGHT TO AUDIT AND VERIFY CLAIMS 35
REQUEST FOR REVIEW OF DENIAL OF CLAIM: BOARD APPEAL PROCEDURES 36
DENTAL BENEFIT APPEALS 37

YOUR DENTAL BENEFIT PLAN

THE SCHEDULED DENTAL BENEFIT PLAN 40
WHEN IS COVERAGE PROVIDED? 40
WHAT EXPENSES ARE COVERED BY THE SCHEDULED DENTAL BENEFIT PLAN? 40

SCHEDULED DENTAL BENEFIT PLAN
WHEN YOUR TREATMENT COSTS $500 OR MORE 41
GETTING YOUR BENEFIT 42
WHAT IF I WANT TO CHANGE TO A DIFFERENT DENTAL PLAN? 42
WHAT'S NOT COVERED? 43

THE DENTCARE BENEFIT PLAN 44
WHEN IS COVERAGE PROVIDED? 44

HOW DOES THE PROGRAM WORK? 45
WHAT DENTAL SERVICES WILL YOU RECEIVE? 45

DENTCARE BENEFIT PLAN
TREATMENT OPTIONS/MATERIALS 45
WHAT IF MY REQUEST FOR DENTAL SERVICES IS DENIED? 46
WHAT IF I WANT TO CHANGE TO A DIFFERENT PLAN? 46
SOLSTICE S700B DENTAL HMO PLAN FOR FLORIDA RESIDENTS 48
THE EMBLEMHEALTH BENEFIT PLANS - PREMIUM OR STANDARD OPTION 49
THE ANTHEM BENEFIT PLAN 52

YOUR PRESCRIPTION DRUG COST REIMBURSEMENT BENEFIT
WHAT IS THE PRESCRIPTION DRUG COST REIMBURSEMENT BENEFIT? 54
WHEN IS COVERAGE PROVIDED? 54
WHAT EXPENSES ARE COVERED BY THE PRESCRIPTION DRUG COST REIMBURSEMENT? 54
WHAT KINDS OF PRESCRIPTION DRUGS ARE COVERED BY THE PLAN'S CAPITAL RX PRESCRIPTION DRUG COST REIMBURSEMENT BENEFIT PROGRAM? 55
WHERE DO I GET MY PRESCRIPTION DRUGS UNDER THE CAPITAL RX PLAN? 57
MAIL ORDER PRESCRIPTION DRUG PROGRAM 57
SPECIALTY DRUG - COST AVOIDANCE PROGRAM 58
NON-PARTICIPATING PHARMACIES 59
GETTING YOUR BENEFIT 59
ABOUT CHEMOTHERAPY, INJECTABLE, PICA AND ASTHMA DRUGS 61
MEDICARE ELIGIBLE RETIREES WITH THREE OR MORE ELIGIBLE DEPENDANTS 61
RETIREES, SPOUSE AND/OR DEPENDENTS WITH MEDICARE PART D PLAN 62

YOUR GENERAL MEDICAL REIMBURSEMENT BENEFIT
WHAT IS THE GENERAL MEDICAL REIMBURSEMENT BENEFIT? 63
WHEN IS COVERAGE PROVIDED? 63
WHAT EXPENSES ARE COVERED BY THE GENERAL MEDICAL REIMBURSEMENT BENEFIT? 63
RETIREES, SPOUSE AND/OR DEPENDENTS WITH MEDICARE PART D PLAN 64
GETTING YOUR BENEFIT 64
WHAT'S NOT COVERED? 65

YOUR MENTAL HEALTH REIMBURSEMENT BENEFIT
WHAT IS THE MENTAL HEALTH BENEFIT? 66
GETTING YOUR BENEFIT 66
WHAT'S NOT COVERED? 66

YOUR OPTICAL BENEFIT
WHAT IS THE OPTICAL BENEFIT? 67
WHEN IS COVERAGE PROVIDED? 67
WHAT EXPENSES ARE COVERED BY THE OPTICAL BENEFIT? 67

GETTING YOUR BENEFIT.....67
NO-COST OPTION.....68
WHAT'S NOT COVERED.....68

YOUR HEARING AID REIMBURSEMENT BENEFIT

WHAT IS THE HEARING AID REIMBURSEMENT BENEFIT? 69
WHEN IS COVERAGE PROVIDED?.....69
WHAT EXPENSES ARE COVERED BY THE HEARING AID REIMBURSEMENT.....69
WHAT IS NOT COVERED?.....69
GETTING YOUR BENEFIT.....70
NO-COST OPTION.....70
AT YOUR OWN EXPENSE.....70

YOUR PODIATRY BENEFIT

WHAT IS THE PODIATRY BENEFIT?.....72
WHEN IS COVERAGE PROVIDED?.....72
WHAT EXPENSES ARE COVERED BY THE PODIATRY BENEFIT? 72
GETTING YOUR BENEFIT.....72
WHAT'S NOT COVERED? 73

YOUR RETIREE DIVISION BENEFIT

WHAT IS THE RETIREE DIVISION BENEFIT? 74
WHAT BENEFITS ARE PROVIDED BY THE RETIREE DIVISION? 74
GETTING YOUR BENEFIT.....75

YOUR LEGAL FUND BENEFITS

WHO'S ELIGIBLE?.....78
WHEN DOES COVERAGE END? 78
HOW DOES THE LEGAL SERVICES BENEFIT WORK?.....79
MEMBER V. MEMBER DISPUTES.....80
LEGAL SERVICE BENEFIT OVERVIEW.....80
GENERAL MATTERS BENEFIT 81
CIVIL MATTERS BENEFITS.....82
CRIMINAL MATTERS BENEFIT 85
COURT COST DISBURSEMENT BENEFIT 85
WHAT IF I LIVE OUTSIDE THE GEOGRAPHICAL AREA COVERED BY THE FUND?.....86
GETTING YOUR OUT-OF-AREA LEGAL SERVICES BENEFIT.....87

WHAT IS NOT COVERED BY THE LEGAL BENEFITS FUND? 88
REQUEST FOR REVIEW OF DENIAL OF CLAIM 89

GENERAL INFORMATION ABOUT THE FUNDS

GETTING INFORMATION 91
AUTHORITY OF THE FUND ADMINISTRATOR 91
PLAN AMENDMENT AND MODIFICATION 92
FUND INFORMATION 93

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@cwa1180.org

Benefits Funds Overview

RETIREES BENEFITS FUND

Supplemental Health Benefits

Dental Benefits (Choose one of the following plans)

Scheduled Dental Plan: **or** Dentcare:

Scheduled Dental Plan:

- Use a participating dentist or any dentist of your choice.
- Maximum benefit of $2,400 per person, per calendar year.

Dentcare:

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

Solstice S700B DHMO Plan-Florida Only

- Services at moderate fees.

EmblemHealth

Premium Plan

- Maximum benefit of $2,500 per person, per calendar year.
- Emblem will pay 100% for covered services if you see a participating dentist, up to the $2,500 annual maximum.
- Monthly premiums of $29.76 are required for family coverage.

Standard Plan

- No monthly premium.
- Maximum benefit of $2,500 per person, per calendar year.
- Deductible of $75 per covered family member or $225 per family and fee schedule for certain dental services.

Anthem

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

Prescription Drug Cost Reimbursement Benefit

- For non-Medicare eligible Retirees who have the City Health Plan Optional Drug Rider, benefit of up to $1,500 per family, each calendar year towards your prescription drug costs.
- For Medicare eligible Retirees who have the City Health Plan Optional Drug Rider or receive prescription coverage under Medicare Part D, benefit of up to $2,000 per family (effective 1/1/2025), each calendar year towards your prescription drug costs.
- For Medicare eligible Retirees on the Fund's Prescription Drug Benefit Program administered by Capital Rx, benefit of up to $26,000 (effective 1/1/2025) each calendar year towards your prescription drug costs, subject to additional rules as described below.
- 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 Capital Rx 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 $200 benefit per person, per calendar year.
- Maximum of four claims per family, per calendar year.

Dependents Under Age Nineteen 19 – No-Cost

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

Hearing Aid Reimbursement Benefit

- Up to $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 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/domesticpartnership_ 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 from date of birth 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 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.

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, 3rd Floor
  New York, New York 10013-2898
  benefits@cwa1180.org

NOTE: *Fund Enrollment is* ***separate*** *from Union member enrollment. Just because you filled out a membership form for CWA Local 1180 Union does not mean you are enrolled for* ***benefits****. For benefits enrollment, 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 ONE 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 in 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 its full benefits. The other plan (the secondary plan) will pay any expenses in excess of the primary plan benefits, up to the maximum amount it would pay if the coordination of benefits provisions was not in force, but in no event more than the amount charged.

If You 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 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 provider's 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)

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

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

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

What is COBRA Continuation Coverage?

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

COBRA continuation coverage only covers the Plan's Prescription Drug, General Medical Reimbursement, Dental, Mental Health, Optical, Hearing Aid, and Podiatry Benefits. 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
benefits@cwa1180.org

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 –(the covered retiree) dies;
2. You become divorced or legally separated from your spouse (the 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-(the 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:

Fund Administrator
CWA Local 1180 Retirees Benefits Fund
6 Harrison Street
New York, NY 10013-2898
1-212-966-5353
benefits@cwa1180.org

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 <u>IN WRITING</u> 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
1-212-966-5353
benefits@cwa1180.org

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;
- 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.***

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

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 will also 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 Office 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 cost is 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: https://www.doleta.gov/tradeact/

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

If you elect Continuation Coverage, you do not have to send payment when you apply. However, no benefits will be paid until the initial payment is received. The initial payment for COBRA Continuation Coverage, retroactive to the date your active coverage terminated, is due 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 your decision about COBRA Continuation Coverage.

Under HIPAA, the period during which a group health plan may exclude or limit coverage for many pre-existing conditions is reduced or eliminated if the person had previous health coverage under another group health plan. However, credit is not given for earlier coverage if it was allowed to lapse, without replacement, for at least 63 days. If there will be some delay before you can enroll in the new plan, a break in health coverage can be avoided by maintaining COBRA Continuation Coverage in the meantime.

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

our Privacy

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

Section 1: Purpose of This Notice and Effective Date

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

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

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

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

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

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

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) means all individually identifiable health information related to an individual's past, present, or future physical or mental

health condition, or to payment for health care services. PHI includes information maintained by the Fund in oral, written, or electronic form.

When the Fund May Disclose Your PHI

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

- ***At your request.*** If you request it, the Fund is required to give you access to certain of your PHI in order to allow you to inspect and/or copy it;

- ***When required by applicable law;***

- ***As required by HHS.*** The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations;

- ***Public health purposes***. To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law;

- ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm;

- ***Health oversight activities***. To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure, or disciplinary actions (for example, to investigate complaints against health care providers), and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor);

- ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or court-ordered discovery request;

- ***Law enforcement health purposes***. When required for law enforcement purposes (for example, to report certain types of wounds);

- ***Law enforcement emergency purposes***. For certain law enforcement purposes, including:
  - identifying or locating a suspect, fugitive, material witness, or missing person, and
  - disclosing information about an individual who is or is suspected to be a victim of a crime;

- ***Determining cause of death and organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause

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

- ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent;

- ***Research.*** For research, subject to certain conditions;

- ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is to a person reasonably able to prevent or lessen the threat, including to the target of the threat;

- ***Workers' compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law;

- ***For treatment, payment or health care operations.*** The Fund and its business associates will use PHI in order to carry out:
    - Treatment,
    - Payment, and
    - Health care operations.

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

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

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

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

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

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

any purpose, and it will not under any circumstances use or disclose genetic information for underwriting purposes.

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

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

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

When the Disclosure of Your PHI Requires Your Written Authorization

Although the Fund does not obtain psychotherapy notes, it must generally obtain your written authorization in order to use or disclose psychotherapy notes about you. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you. ***Psychotherapy notes*** are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

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

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

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

If you want the Fund to disclose your PHI routinely to persons other than your spouse or domestic partner (e.g., to your children) then you must complete an authorization form designating that person as authorized to receive your PHI. Any authorization you

make can be revoked by you at any time. Authorization and revocation forms are available from the Privacy Official at the Fund office.

Other Uses or Disclosures

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

Section 3: Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

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

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

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

Damien Arnold, Fund Administrator
CWA Local 1180 Benefits Fund
6 Harrison Street, 3rd Fl.
New York, NY 10013

You May Request Confidential Communications

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

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

You May Inspect and Copy Your PHI

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

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

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

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

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

You Have the Right to Amend Your PHI

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

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

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

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

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

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

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

Your Personal Representative

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

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

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

Information that Does Not Identify You

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

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

Section 4: The Fund's Duties

Maintaining Your Privacy

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

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

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

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

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

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI, or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

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

Section 5: Your Right to File a Complaint

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

You may also file a complaint with:

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

Section 6: If You Need More Information

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

Section 7: Conclusion

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

Your 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

Gloria Middleton, Chairperson

Teesha Foreman

Gerald Brown

Robin Blair-Batte

Debra Paylor

Arthur Cheliotes

Fund Administrator

Damien Arnold

Counsel

Spivak, Lipton, LLP

Consultants

Policy Research Group, LLC

Certified Public Accountant

Gould, Kobrick & Schlapp, PC

Applying For Your Supplemental Health Benefits

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 set forth under the heading "Getting Your Benefit" in each section below describing each type of 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 by logging into your member portal at www.cwa1180.org.

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: Board Appeal Procedures

If your claim for supplemental health benefits is denied and you disagree with the decision, you may request a review of your claim. For dental benefits, as explained below, your initial appeal must be submitted to the vendor through which the benefits are provided (such as Dentcare or EmblemHealth, for example), and if that appeal is denied, you have the option of submitting an additional, voluntary appeal to the Board of Trustees pursuant to the procedures set forth in this section.

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

- 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 an explanation as to why such material or information is necessary); and (iii) a description of the Fund's review procedures and applicable time limits, as well as a statement of the claimant's right to bring a civil action following and adverse benefit determination on review.
- If an adverse benefit determination is made by the Trustees, or their duly authorized designee, the Claimant (or his/her authorized representative) may request a review of the determination. All requests for review must be sent in writing to the Trustees within 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 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.

Dental Benefit Appeals

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

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

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

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

Dentcare's failure to render a determination of your appeal within 60 calendar days of receipt of the necessary information for a standard appeal will be deemed a reversal of the initial adverse determination.

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

CWA Local 1180 Retiree
c/o Daniel H. Cook Dental Assoc., Inc.
1040 Avenue of the Americas, 24th Fl.
New York, NY 10018

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

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

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

within 15 calendar days. They will respond within 30 calendar days of receiving your grievance.

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

If your appeal is denied by Dentcare, Daniel H. Cook Dental Associates, EmblemHealth or Anthem, you **may** submit an appeal of the denial (also known as an "adverse benefit determination") in writing to the Board of Trustees within 180 days of the date of the decision. This is a voluntary level of appeal. If you choose to submit the voluntary appeal, your appeal will be reviewed and decided by the Board pursuant to the procedures described in the "Board Appeal Procedures" section above.

Your Dental Benefit Plan

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 $2,400 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 $2,400 per eligible person in any calendar year. For services covered by the Scheduled Dental Benefit Plan, please see the Schedule of Dental Allowances available on the Fund website under "Resources" at www.cwa1180.org/resources or by contacting the Fund office at 1-212-966-5353. Call the Fund Office at 1-212-966-5353 for a current list of Participating Dentists.

<u>Covered Services Provided By Dentists Who Are Not Participating Dentists</u>

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. 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 $2,400 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 $2,400 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.

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 pre-treatment 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
> 1040 Avenue of Americas, 24th Fl.
> New York, NY, 10018

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 five dental plan options. If you are enrolled in the Scheduled Dental Benefit Plan but would like to change to Dentcare, Emblem, Anthem, or Solstice S700B Dental (Florida only), 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 multiple plans at the same time.

What's Not Covered

Benefits are not provided for:

- Treatment from anyone other than a licensed dentist, except routine cleaning of teeth and fluoride application which is performed by a licensed dental hygienist under the direct supervision of, and billed by, a dentist or physician.
- Facings, veneers, or similar material placed on molar crowns or pontics.
- Services performed by a member of you or your spouse's immediate family.
- Services or supplies that are cosmetic in nature or directed towards a cosmetic end.
- Any service or supplies incurred, installed, or delivered before you or your dependent(s) become eligible for benefits from this Fund.
- Replacing a lost, missing or stolen prosthetic appliance.
- A broken appointment.
- Any services received from a medical department, clinic, or any facility provided or furnished by your spouse's employer.
- Any service that is not medically necessary or is not normally performed for proper dental care of the condition or any service that is not approved by the attending dentist.
- Services or supplies that do not meet accepted standards of dental practice including experimental or investigational services or supplies.
- Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
- Any duplicate prosthetic appliance except as specifically provided.
- Charges for completing claim forms.
- Oral hygiene, dietary instruction, or plaque control programs.
- Wiring or bonding teeth or crowns to act as a splint for any reason.
- An injury arising from your former employment.
- Illness or injury covered by Workers' Compensation.
- Services or supplies for which you are not required to pay.
- Appliances, restorations, or any procedure to alter vertical dimension for cosmetic purposes.
- Services or supplies not specifically listed under the Schedule of Dental Allowances.
- Services for in-patient or out-patient hospital care.

- Services by a provider whose office is attached to, or a dental school which is a part of, certain hospitals within New York State (call the Fund Office for a list of such providers).

Any treatment costing $500 or more which is not submitted for Pre-Treatment Review, as required.

THE DENTCARE BENEFIT PLAN

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

Definitions

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

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

- Described in the "**Schedule of Covered Dental Services.**" The "Schedule of Covered Dental Services," is available on the Fund website under "Resources" at www.cwa1180.org/resources or by contacting the Fund office at 1-212-966-5353.
- Performed by a Participating Dentist.
- Not described as an exclusion or limitation in the Policy.

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

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

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

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

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.

How Does The Program Work?

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

What Dental Services Will You Receive?

Covered Services Provided By Dentcare Participating Dentists

- Covered benefits include a wide variety of typical dental services. For a list of covered dental services, please see the "Schedule of Covered Dental Services."
- If you require the services of a specialist, your Dentcare Participating Dentist will refer you to a participating specialist.
- In the event that a Dental emergency occurs outside of the Dentcare coverage area or if you are unable to visit a Dentcare Participating Dentist, Dentcare will reimburse up to $40 per eligible family member per contract year if you submit copies of the bills for treatment to alleviate the Dental Emergency.
- In the event you are unable to reach your own participating dentist, contact Dentcare's administrator, Healthplex, Inc. by calling Member services at 877-591-1789 or using the find a dentist feature online at www.yourdentalplan.com/healthplex

Treatment Options/Materials

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

What If My Request For Dental Services Is Denied?

- If your request for dental services is denied and you disagree with the decision, you may request a review of your claim under Dentcare's procedures for review of such claims.
- Please see the "**Dental Benefits Appeals**" section above and/or contact the Fund Office for more information about Dentcare's review procedures.

What If I Want To Change To A Different Plan?

The Fund offers five dental plan options. If you are enrolled in Dentcare but would like to change to the Scheduled Dental Benefit Plan, Anthem, Emblem, or Solstice S700B Dental (Florida only), follow these simple steps:

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

If you move out of the geographical area served by Dentcare Delivery Systems, you may change to the Scheduled Dental Benefit Plan without delay.

Exclusions and Limitations

The following are not covered:

- Any dental services which were not rendered or approved by a participating dentist except in cases of out-of-area Dental Emergency. In the event that a Dental Emergency occurs outside of the Dentcare coverage area, Dentcare will reimburse up to $40 per eligible family member per contract year if you submit copies of the bills for treatment to alleviate the Dental Emergency;
- A service not performed by a dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or for an x-ray ordered by a dentist;
- Treatment of a disease, defect, or injury covered by a major medical plan, Workers' Compensation Law, occupational disease law, or similar legislation.
- General anesthesia, analgesia, and any service rendered in a hospital environment;
- Any dental procedures which are undertaken primarily for cosmetic reasons or dental care to treat accidental injuries, congenital, or developmental malformations;
- Services which were started prior to the person becoming covered under this plan;
- Implants, grafts, precision attachments, or other personalized restorations or specialized techniques;
- Broken Appointments – If specified by plan dentist for appointments not canceled 24 hours in advance, there is a $30.00 charge;

- Replacement of any existing crown, bridge, or denture, which can be made serviceable according to common dental standards;
- Procedures, appliances, or restorations (except full dentures) whose main purpose is to: change vertical dimension, diagnose or treat conditions or dysfunction of the temporomandibular joint, stabilize periodontally involved teeth, or restore occlusion;
- Treatment of unmanageable children and/or unruly patients. If the assigned dentist is unable to treat a patient by virtue of apprehension or any other reason, and is referred to another office for treatment, the responsibility for payment lies with either the patient or with the parents/guardians of the patient;
- Services not listed in the "**Schedule of Covered Dental Services"** may not be covered. Please visit healthplex.com or submit a pre-certification prior to receiving treatment.

The following are covered only to the extent stated:

- Oral exams, bitewing x-rays, prophylaxis, and fluoride treatments - Once every 6 mos;
- Full mouth and panoramic x-rays - Once every 36 mos;
- Crowns, bridges, and dentures - Once every 60 mos;
- Orthodontic treatment of Class II/Class III malocclusions - One case per covered individual.

Medical Necessity

- Dentcare covers certain benefits as long as the service is Medically Necessary. The fact that a dentist has prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that it will be covered.
- The decision may be based on a review of:
  - Your dental records.
  - Dentcare's dental policies and clinical guidelines.
  - Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment.
  - The opinion of Health Care Professionals in the generally-recognized health specialty involved.
  - And the opinion of the attending providers, which have credence but do not overrule contrary opinions.
- Services will be deemed Medically Necessary only if:
  - They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for your illness, injury, or disease;
  - They are required for the direct care and treatment or management of that condition;
  - Your condition would be adversely affected if the services were not provided;
  - They are provided in accordance with generally-accepted standards of dental practice;
  - They are not primarily for the convenience of you, your family, or your dentist.

Making Inquiries To Dentcare

Customer Service staff members are available to explain policies and procedures. They can also answer questions about benefits and claim determinations. For information or help, a member may call or write Dentcare. The toll-free telephone number for the Customer Service Department is 877-591-1789. The address of Dentcare is:

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

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

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

SOLSTICE S700B Dental HMO Plan for Florida residents

Your Dental HMO plan option has upgraded. Your former plan, the Solstice S700, has transitioned to the Solstice S700B (formerly known as Healthplex America Value Plus Plan).

Solstice S700B Plan Highlights:

- No deductibles or plan maximums.
- No waiting periods.
- No claim forms to submit.
- Members receive most diagnostic and preventive care at no charge for services provided by a participating in-network general dentist.
- Cosmetic and orthodontial treatment is covered when provided by a participating in-network general dentist.

For a full description of the plan and a fee schedule, please contact our Fund office, visit the Fund website under "Resources" and/or **call the Solstice** Member Services Department: 1-888-200-0322

Members can locate a participating provider at www.solsticebenefits.com or call the Member Services Department: 1-888-200-0322

THE EMBLEMHEALTH BENEFIT PLANS – PREMIUM OR STANDARD OPTION

This EmblemHealth Premium or Standard Option plans allow you to choose a network dentist or specialist for services covered under your plans. You don't have to pick a specific primary care dentist.
With both plans, you can cover your children until the end of the year they turn 21. Children can be covered for orthodontic services until the end of the year they turn 19.

Predetermination of Benefits

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

Dental Services Not Covered under the Premium or Standard Plan:

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

Annual Maximum: Both plans have a $2,500 annual maximum per person. This is the most your dental plan will pay toward the cost of dental care during your benefit period. You are responsible for paying costs above the annual maximum. Both plans have a $2,500 lifetime orthodontic maximum per covered family member. Orthodontic benefits are available until the end of the month your covered child turns 19. Adult orthodontia is not covered.

Premium Plan Premium: Under the Premium Plan, Emblem will pay 100% for covered services if you see a participating dentist, up to the $2,500 annual maximum. For family coverage, you must pay a monthly premium of $29.76.

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

EMBLEMHEALTH BENEFIT PLAN

Preventive & Diagnostic Dental Services - exams, cleanings, x-rays, fluoride treatments, and more

Premium Option

In-Network: EmblemHealth pays 100% of the Preferred Fee Schedule for covered services with a Preferred Network dentist or specialist.

Out-of-Network: EmblemHealth reimburses 100% of the Preferred Fee Schedule. You are responsible for paying any costs that are more than this amount that an out-of-network provider may bill for.

Standard Option

In-Network: EmblemHealth pays 100% of the Preferred Fee Schedule for covered services with a Preferred Network dentist or specialist.

Out-of-Network: EmblemHealth reimburses 100% of the Preferred Fee Schedule. You are responsible for paying any costs that are more than this amount that an out-of-network provider may bill for.

Basic Dental Services – fillings, root canals, surgery, and more

Premium Option

In-Network: EmblemHealth pays 100% of the Preferred Fee Schedule for covered services with a Preferred Network dentist or specialist. You are responsible for additional costs on any upgraded material.

Out-of-Network: EmblemHealth reimburses 80% of the Preferred Fee Schedule. You are responsible for paying any costs that are more than this amount that an out-of-network provider may bill for.

Standard Option

In-Network: After you meet the deductible, EmblemHealth pays 50% of the Preferred Fee Schedule for covered services with a Preferred Network dentist or specialist. You pay 50% of the cost of covered services after the $75 per covered family member, or $225 per family deductible. You are responsible for additional costs on any upgraded material.

Out-of-Network: After you meet the deductible, EmblemHealth reimburses 50% of the Preferred Fee Schedule. You are responsible for paying any costs that are more than

this amount that an out-of-network provider may bill for. $75 per covered family member, or $225 per family deductible applies.

<u>Major Dental Services</u> – fixed and removable prosthetics and major restorations

Premium Option

In-Network: EmblemHealth pays 100% of the Preferred Fee Schedule for covered services with a Preferred Network dentist or specialist. You are responsible for additional costs on any upgraded material.

Out-of-Network: EmblemHealth reimburses 80% of the Preferred Fee Schedule. You are responsible for paying any costs that are more than this amount that an out-of-network provider may bill for.

Standard Option

In-Network: After you meet the deductible, EmblemHealth pays 50% of the Preferred Fee Schedule for covered services with a Preferred Network dentist or specialist. You pay 50% of the cost of covered services after the $75 per covered family member, or $225 per family deductible. You are responsible for additional costs on any upgraded material.

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

<u>Orthodontics</u>

Orthodontics is available to your covered children. Adult orthodontia is not covered. EmblemHealth covers up to 20 months of treatment. Beyond that, you are responsible to pay the full cost of services and must pay for any charges for missed appointments or additional cosmetic banding options.

Premium Option

In-Network: EmblemHealth issues an initial payment of 100% for covered services to the Preferred Network orthodontist upon receipt of a claim confirming the initiation of comprehensive orthodontic treatment. The balance of the available orthodontia benefit due will be issued in subsequent monthly or quarterly payments.

Out-of-Network: EmblemHealth reimburses 50% of the Preferred Fee Schedule. You are responsible for paying any costs that are more than this amount that an out-of-network provider may bill for.

Standard Option – Not Covered

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

THE ANTHEM BENEFIT PLAN

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

ANTHEM BENEFIT PLAN

Covered Dental Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Orthodontic Services: Not Covered

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

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 outlined below 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 are not Medicare eligible and 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.
- Effective January 1, 2025, if you are Medicare eligible and 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 $2,000 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 (for non-Medicare-eligible Retirees) or $2,000 per calendar year (for Medicare-eligible-Retirees, eff. 1/1/2025), 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 Capital Rx. Upon presentation of your prescription card, for non-Medicare eligible Retirees, participating pharmacists will provide covered prescription drug benefits at no out-of-pocket cost up to the $1,500 per family annual maximum.
- Effective January 1, 2025, if you are a Medicare-eligible Retiree enrolled in the Fund's Prescription Drug Benefit Program and do not have prescription drug coverage through a City Health Plan Optional Drug Rider or a Medicare Part D Plan (referred to herein as "Medicare Eligible Cardholders"), your annual maximum prescription drug benefit is $26,000. The $26,000 annual maximum applies to each Medicare Eligible Cardholder. For example, if both you and your spouse are Medicare Eligible Cardholders, one $26,000 maximum will apply to you and a separate $26,000 maximum will apply to your spouse. The $26,000 limit applies to covered prescription drug expenses.
- Effective January 1, 2024, if you are a Medicare Eligible Cardholder, the Fund's ***"General Medical Reimbursement Benefit"*** cannot be used to reimburse prescription drug expenses.
- Effective January 1, 2024, the following copays will apply to Medicare Eligible Cardholders:
  - $10 for generic drugs, and $25 for brand drugs, for a 30-day supply;
  - $20 for generic drugs, and $50 for brand drugs, for a 90-day supply.

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 Capital Rx 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 Capital Rx at 844-227-7962 for detailed instructions.*

Covered medications requiring a prior authorization from Capital Rx:**

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

***To obtain a prior authorization, call* Capital Rx at 844-227-7962. *You will need to obtain a physician's letter of medical necessity for certain of the above referenced medications. Please call Capital Rx 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 any 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.

<u>Generic Drugs vs. Brand Name Medications</u>

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, 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 Capital Rx 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, Capital Rx will mail you a Prescription Drug I.D. card, which will be honored by:

- **Participating Pharmacies**
  Any pharmacy that is a participant in the Capital Rx 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 Capital Rx**,** 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 Prescription Drug Cost Reimbursement Benefit.

- Your doctor can prescribe up to a 90-day supply.
- Prior to your first fill by mail order, you will need to setup an account with Costco Mail Order Pharmacy.
  - **Online:** Go to pharmacy.costco.com and follow prompts for setting up a new patient account.
  - **Phone:** Call the number on the back of your ID card and follow the prompts for medications delivered to your home.
- Choose one of the following options to complete setup and submit your prescription:
  - **E-prescribe:** After you setup an account with Costco Mail Order Pharmacy at pharmacy.costco.com, have your prescriber electronically send your prescription to Costco Pharmacy Mail Order #1348, Zip Code 47130.
  - **Fax:** After you set up an account with Costco Mail Order Pharmacy, have your prescriber fax your prescription to 1-877-258-9584. Faxed prescriptions may only be sent by a doctor's office and must include patient information.
  - **Mail:** Go to pharmacy.costco.com and access your patient account. Select refill or new prescriptions, and then follow the prompts to complete the request. Mail your paper prescription to: Costco Pharmacy, 260 Logistics Ave., Suite B, Jeffersonville, IN 47130.

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

SPECIALTY DRUG – COST AVOIDANCE PROGRAM

The Plan has a cost avoidance program, coordinated through Payer Matrix, for specialty drugs. A prescription drug is considered a "specialty drug" if:

- It requires a difficult or unusual process of delivery to the patient (preparation, handling, storage, inventory, distribution, risk evaluation and mitigation strategy programs, data collection, or administration)

  or
- It requires patient management prior to or following administration (monitoring, disease or therapeutic support systems).

You are eligible to participate in the Payer Matrix program if you are currently taking, or if you begin taking a specialty drug. The program will help you enroll in any applicable alternate funding programs for your eligible drug therapy, with the goal of helping you avoid any out-of-pocket expense for specialty medications.

Payer Matrix will, at least semiannually, send you information concerning alternate funding programs that are available for specialty drugs. You may also access their toll-free help line with questions about the programs. If you call the help line, Payer Matrix

will gather information needed for you to apply to programs for which you may be eligible, and send you application materials for the programs.

If you are not eligible for any alternate funding program through Payer Matrix or opt out of the Payer Matrix program, any specialty drug prescriptions covered by the Plan will be processed by Capital RX according to the otherwise applicable terms of the Plan.

For more information on how to access the specialty drug program, you may contact Payer Matrix at:

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

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 annual family maximum benefit.

Getting Your Benefit

<u>If you have the City Health Plan Optional Drug Rider:</u>

- Obtain a reimbursement form from the Retirees Benefits Fund office by contacting Members Services or through our Website: www.cwa1180.org.
- Submit photocopies of your pension check stubs showing the deductions made for the Optional Drug Rider. You can also submit 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 will be reimbursed up to a maximum of $1,500 per family per calendar year (for non-Medicare-eligible Retirees) or $2,000 per calendar year (for Medicare-eligible-Retirees, effective 1/1/2025), 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. You may submit copies of your Explanation of Benefits (EOB), pharmacy statements with the prescription name and amount paid.

- You may make two submissions each calendar year.

- 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. For non-Medicare eligible Retirees, your family's prescription drug costs will be covered up to the $1,500 per family annual maximum benefit. For Medicare-eligible Retirees, your prescription drug costs will be covered up to the $26,000 annual maximum benefit (effective 1/1/2025).

If You Use a Non-Participating Pharmacy:

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

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

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 Eligibility and Prescription Drug Caps

In every family in which the covered members include one or more Medicare-eligible individual(s), the $3,200 annual cap (effective 1/1/2025, consisting of the $2,000 prescription drug cap and the $1,200 medical reimbursement cap) shall apply to prescription drug claims as follows:

- If the family contains only two covered individuals, and one or both of them are Medicare-eligible, they shall have a combined $3,200 annual cap;
- If the family contains three or more covered individuals, and one or more of them is Medicare-eligible, all the Medicare-eligible individuals shall have one combined $3,200 annual cap and the remaining individuals shall have their own combined $2,700 (consisting of the $1,500 prescription drug cap and the $1,200 medical reimbursement cap) annual cap.

Except as described above, all other rules applicable to those caps apply to families with a Medicare-eligible retiree or spouse.

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 $3,200 per year (effective 1/2/2025, consisting of the $2,000 Prescription Drug Benefit plus $1,200 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 $1,200 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 $1,200 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 $1,200 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 are <u>not</u> Medicare eligible AND do not have the Optional Drug Rider to your City Health plan and you, your spouse and eligible children are enrolled in the Capital Rx 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 $2,400 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 $1,200 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 $3,200 per year (effective 1/1/2025, $2,000 Prescription Drug Benefit plus $1,200 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 $1,200 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 $1,200 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:

- Obtain a General Medical Reimbursement Benefit claim form from the Fund Office or the Local website at: www.cwa1180.org.
- 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 not Medicare eligible and are enrolled in the Capital Rx 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. Capital Rx 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.

If you are Medicare eligible and are enrolled in the Capital Rx prescription drug program, the Fund's General Medical Reimbursement Benefit cannot be used to reimburse prescription drug expenses.

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 treatmen.t
- 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).
- If you are a Medicare eligible individual enrolled in the Fund's Prescription Drug Benefit Program administered by Capital Rx, the Fund's General Medical Reimbursement Benefit cannot be used to reimburse prescription drug expenses.

Your Mental Health Reimbursement Benefit

What Is The Mental Health Benefit?

If you or your eligible dependent is under the care of a duly licensed psychiatrist, psychotherapist, or psychologist, or certified social worker, the Fund will reimburse you for the actual expenses you incur for such care up to a maximum of $300 per calendar year for each covered member of your family.

These benefits will be paid only for out-of-hospital mental health or substance abuse care by a provider who is not part of a hospital or outpatient facility. 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 1996, if a doctor or covered provider's practice is part of a certain hospital or outpatient facility, benefits will not be paid for their services.

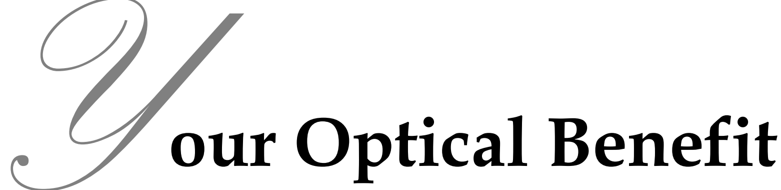
Getting Your Benefit

- Obtain a Mental Health Benefit Claim Form from the Fund Office or 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 $200 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

- Obtain a claim form from the Fund Office or the Local 1180 website at: www.cwa1180.org.
- 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 or the Local website at: wwa.cwa1180.org.
- 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.

<u>To Choose The No-Cost Option:</u>

- 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, and 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
New York, NY 10013-2898
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

Board of Trustees

Gloria Middleton, Chairperson
Teesha Foreman
Gerald Brown
Robin Blair-Batte
Debra Paylor
Arthur Cheliotes

Fund Administrator

Damien Arnold

Counsel

Spivak Lipton LLP

Consultants

Policy Research Group, LLC

Certified Public Accountant

Gould, Kobrick & Schlapp, PC

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 dependent(s), a dependent, as defined by the Fund, is your spouse or domestic partner and each child two 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:

- Contact the Legal Benefits Fund Office at: 1-212-966-5353 or benefits@cwa1180.org
- 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:

- Contact the Fund Office at benefits@cwa1180.org or 1-212-966-5353 to cancel your appointment as soon as possible.

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 Matters 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. There is also coverage for consultations and document reviews for your unemancipated children.

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

Identity Theft Protection Benefit

Who is eligible?

Any 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. Your adult children are also entitled to a Health Care Proxy, power of attorney and HIPAA authorization provided the adult child appoints you as his/her representative/proxy.

- **Designation of Person in Parental Relation**

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

- **Legal Defense Benefit**

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

- **Appeals Benefit**

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

This benefit provides legal representation for appeals 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.

- **Pre-Nuptial Agreement Benefit**

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

- **Divorce Proceeding Benefit**

A Panel Attorney will provide services if you are a defendant or a plaintiff in 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 with a 25% reduction in its current hourly rate of $450. This hourly rate is subject to change.

or

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

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

- **Homeowner Rights Benefit**

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.

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

- **Tenant Rights Benefit**

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

  - Matters involving the lease or sublease of the residence where you primarily reside or intend to primarily reside.
  - Problems with your landlord or management company.
  - Proceedings involving your right to sublet your primary residence, your right to possession of 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?

Contact the Fund Office at 1-212-966-5353 or benefits@cwa1180.org:

- 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 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 30 days prior to the next regularly scheduled meeting, in which case a decision will be made by no later than the date of the second regularly scheduled meeting following receipt of such request for review. If special circumstances require an extension of time for processing the request for review, the decision may be made at the third meeting following receipt of such request. The Claimant will be notified in advance of any such extension. The notice will describe the special circumstances requiring the extension and will inform the Claimant of the date as of which the determination will be made. If the extension is required due to the Claimant's failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to the Claimant until the date on which the Claimant responds to the Fund Office's request for information.
- The Claimant will be noticed in writing of the determination on review within five 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.

General Information About the Funds

Getting Information

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

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

You may also obtain copies of any of the documents by writing for them and paying the reasonable cost of duplication. You should find out what charges will be before requesting copies. If you prefer, you can arrange to examine a document during business hours at the CWA Local 1180 Union or the Benefits Funds Office. A summary of the Annual Report which provides details of the financial information of the Fund operation will be furnished free of charge to all covered 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

Gloria Middleton, Chairperson

Teesha Foreman

Gerald Brown

Robin Blair-Batte

Debra Paylor

Arthur Cheliotes

Fund Administrator

Damien Arnold

Fund Address

6 Harrison Street
New York, NY 10013-2898
1-212-966-5353
benefits@cwa1180.org

Counsel

Spivak Lipton LLP

Consultant

Policy Research Group, LLP

Certified Public Accountant

Gould, Kobrick & Schlapp, P.C

CWA LOCAL 1180 RETIREES BENEFITS FUND OFFICES

6 Harrison Street
New York, NY 10013
Tel: (212) 966-5353
Fax: (212) 219-2450
benefits@cwa1180.org
www.cwa1180.org