CWA LOCAL 1181 SECURITY BENEFITS FUND

January 2018

GRAPHIC COMMUNICATIONS CONFERENCE UNION GCC/IBT LABEL 243-C INTERNATIONAL BROTHERHOOD of TEAMSTERS

CWA LOCAL 1181 SECURITY BENEFITS FUND

BENEFITS CONSULTANT

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BENEFIT ADMINISTRATOR

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Please Visit
www.asonet.com

JANUARY 2018

CWA LOCAL 1181 SECURITY BENEFITS FUND

To All Covered Participants:

We are pleased to present to you this revised booklet which contains important information regarding the benefit plan and administrative procedures.

The benefits outlined in this booklet are the current benefits. Since there have been changes in some of the benefits, please read this booklet carefully and show it to your family.

We shall continue to monitor the experience of the Fund in order to provide you the most favorable plan of benefits within the framework of prudent fiscal operations. The Board of Trustees is committed to maintaining benefits for Participants and their families. However, as future conditions cannot be predicted, the Plan reserves the right to amend or terminate coverage at any time and for any reason.

We urge you to read this booklet thoroughly and keep it for future eference. If you have any questions, the Fund Office is ready to help you at all times.

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CWA LOCAL 1181
SECURITY BENEFITS FUND

SCHEDULE OF BENEFITS-SUMMARY

PLEASE NOTE: THE FOLLOWING IS A SUMMARY OF BENEFITS. IF THERE IS A DISCREPANCY BETWEEN THE INFORMATION IN THIS SUMMARY AND THE MORE DETAILED PROVISIONS FOLLOWING THIS SUMMARY OR THE CERTIFICATE OF INSURANCE, THE MORE DETAILED PROVISIONS AND/OR CERTIFICATE OF INSURANCE SHALL GOVERN.

BENEFIT	VENDOR	PHONE	WEBSITE
Prescription Drugs	Express Scripts	800-451-6245	www.express-scripts.com
Dental	Administrative Services Only, Inc	800.537.1238	www.asonet.com
Optical	Davis Vision	877.923.2847	**www.davisvision.com**, select the member option and enter client code **2198**
Legal Services Plan	Fagenson and Puglisi, PLLC	212.268.2128	

PRESCRIPTION DRUG BENEFIT- Retail and Mail Order

ACTIVE MEMBERS

	Total Cap Dollars	Coinsurance*
All Medications	$0 - $2,500	20%
All Medications	$2,500.01 - $12,700.00	100%
All Medications	$12,700.01 and over	20%

RETIRED MEMBERS

	Total Cap Dollars	Coinsurance*
All Medications	$0- $2,200	20%
All Medications	$2,200.01 and over	100%

***Mail Order Minimum Co-Insurance**

Generic $10
Preferred Brand $30

DENTAL BENEFITS:

Deductible: There is no annual deductible

Annual Maximum: $2,000 per covered individual per calendar year for services other than orthodontic services

Member Co-Payments: Effective January 1, 2016 the dental schedule of plan allowances to participating providers was increased and there will no longer be any member co-payments.

Orthodontic: Maximum payable amount from the Fund is $2,100 per lifetime per covered member and eligible dependent.

OPTICAL BENEFIT:

- **When Using an In-Network Provider-** Every 12 months, comprehensive examination, one pair of glasses or an initial supply of contact lenses
- **When Using an Out-of-Network Provider-** there is an out-of-network option with a max of $125

EYE EXAMINATIONS ....Every 12 months, including dilation as professionally indicated.
Dependents up to the age of 19 ....unlimited if medically necessary.
In-Network Copayment... $0
Out-of-Network ....Reimbursed up to $25

EYEGLASSES
Frame .... Every 12 months
Spectacle Lenses .... Every 12 months
In-Network Copayment... $0

You may choose any Fashion or Designer level frame from Davis Vision's Frame Collection, covered in full. Or, if you select another frame in the network provider's office, a $50 credit, plus a 20% discount off any overage will be applied. This credit would also apply at retail locations that do not carry the Frame Collection. Members are responsible for the amount over $50 (less the applicable discount). For more information on lenses, please see "What lenses/coatings are included?" in the benefit booklet.

Out-of-Network ....Reimbursed up to $100 for materials.
CONTACT LENSES.. Every 12 months
In-Network Copayment... $0

LEGAL SERVICES PLAN

Active Members are provided with non-work related personal legal services as a benefit.

Here are just a few areas of law provided to the active members by the lawyers at Fagenson & Puglisi, PLLC located in midtown Manhattan (450 Seventh Ave., Suite 704, New York, NY 10123).

CWA Local 1181 pays all the legal fees and members pay the court filing fees.

• Criminal defense • Housing Court (tenant representation), • Child support	• Custody • Visitation • Divorces • Defense of Consumer collection cases	• Real Estate • Bankruptcy • Last Will and Testament

Retired Members-. There is also a limited legal services benefit available at no cost to retired members

Please contact:
Fagenson and Puglisi, PLLC
450 Seventh Avenue, Suite 704
New York, NY 10123
Telephone: 212.268.2128

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

	ACTIVE	RETIREE
LIFE BENEFITS	$10,000	$5,000
ACCIDENTAL DEATH AND DISMEMBERMENT	$10,000	N/A

WHEN YOUR COVERAGE BEGINS

BECOMING ELIGIBLE

OBTAINING COVERAGE

ACTIVE PARTICIPANTS

You will become eligible for benefits under the Plan when you are employed by the City of New York pursuant to a Collective Bargaining Agreement and contributions are made on your behalf.

RETIRED PARTICIPANTS

You will become eligible for benefits under the Plan when you retire from employment with the City of New York as long as contributions are made on your behalf.

The participant must complete an Enrollment Form. Any Dependent not listed on the Enrollment Form cannot be covered. Please be sure to keep Enrollment Forms updated, with any supporting legal documentation required. Enrollment Forms are available from the Fund Office and on-line at www.asonet.com. It is the member's obligation to notify the Fund Administrator immediately of any changes in family status, as the employee is responsible for reimbursement to the Fund for any benefits utilized by the spouse/domestic partner after the date of legal separation, divorce or dissolution of domestic partnership. It is also the employee's obligation to advise the Fund Administrator of any changes resulting in a Qualifying Event that would require the Fund Administrator to offer continuation coverage to your spouse or to any family member(s). See the section below entitled "CONTINUATION COVERAGE" for further information.

Please contact the Fund Administrator and provide the necessary documentation for the following:

A. If you change your address or telephone number

B. If you wish to add a spouse or Domestic Partner (marriage certificate or copy of New York City's Employee Health Benefits Program approval letter required).

C. If you wish to add a new baby or adopted child (birth certificate, adoption papers or other legal documents showing parenthood required).

WHEN YOUR DEPENDENTS' COVERAGE BEGINS

DEPENDENTS DEFINED

Eligible Dependents are your spouse (except in the event of divorce or annulment), your domestic partner (if such partner is registered as such with the NYC Clerk and has satisfied the criteria below), and your children in circumstances that vary based on the type of benefit.

Children are eligible when they are "Dependent Children" as defined in, i.e., your unmarried children, stepchildren if the signature of your spouse (i.e., the natural parent) is included in the Enrollment Form for the benefit, or legally adopted children; provided such children are dependent upon you for financial support and maintenance and are (1) at least 14 days old but under age 26; or (2) age 26 or older and disabled, provided that they became disabled before attaining age 23 and cannot support themselves because of mental or physical handicap. Please see the Certificate of Insurance for further details on coverage of Dependent Children for purposes of the life insurance benefit.

As to all other benefits provided for children, your children (including stepchildren, legally adopted children, and foster children placed with you by an authorized placement agency or court order) are eligible when they are less than twenty-six years old.

If your child is mentally ill, developmentally disabled or mentally retarded, or has a physical handicap when coverage would end because of the child's age, coverage (other than life) may be continued if, within thirty-one days after the date benefits would normally cease, you submit proof of your child's incapacity to Administrative Services Only, Inc.

No one will be eligible as a Dependent while covered as an employee. No Dependent may be insured by more than one employee.

The domestic partner and the employee must complete a notarized statement that they satisfy at least two items from the list of criteria in the declaration of financial interdependence. Where the employee and the domestic partner choose not to submit such notarized statement, they have the option of filing a joint declaration of financial interdependence.

For life insurance benefits, see the Certificate of Insurance for full details.

BECOMING ELIGIBLE

Each Dependent will be eligible on the later of these dates:

1. the date you become eligible for coverage.
2. the date that person becomes a Dependent as defined.

OBTAINING COVERAGE

If any of your Dependents is eligible under this plan for coverage as an employee, that person is not eligible for coverage as a Dependent. If both you and your spouse are covered under this Plan as employees, your children may only be covered as Dependents of you or your spouse.

Your Dependent will be covered beginning with the day he or she becomes eligible. In no event will your Dependent be covered before the date your coverage begins.

For Dependent life insurance benefits, see the Certificate of Insurance for full details.

HOW TO APPEAL A CLAIM

If your claim is denied in whole or in part and you do not agree with the reason for the denial, you should, within 60 days of the date you were notified of the denial, write to the person who wrote you to inform you of the denial. Be sure to state why you believe the claim should not have been denied, and submit any data, questions or comments you think are appropriate. Your appeal will be reviewed by the specific insurance carrier or, if it is a benefit paid for directly by the Fund, by the Board of Trustees.

You will be notified in writing of the final decision within 60 days of the date your appeal is received by the person you wrote to, unless there are special circumstances, in which case you will be notified in writing within 60 days of the date your appeal is received, of the day by which the final decision will be made.

WHEN COVERAGE TERMINATES

LOSS OF BENEFITS

The Board of Trustees is committed to maintaining benefits for Participants and their families. However, as future conditions cannot be predicted, the Plan reserves the right to amend or terminate coverage at any time and for any reason.

TERMINATION OF COVERAGE

Your coverage will terminate on the earliest date of the following events, including but not limited to:

1. When you are no longer part of an eligible class of employees within the bargaining unit.

2. When you begin an approved leave of absence during which you are no longer on active payroll status and the City of New York no longer makes contributions on your behalf.

3. When the bargaining agreement terminates.

4. When you are no longer working for the City of New York, due to resignation, termination, or other reason.

5. When you fail to make the contribution, if required; see the section entitled “CONTINUATION COVERAGE”.

Your dependent's coverage terminates on the earliest of the following events, including but not limited to:

1. When your coverage terminates.

2. When you fail to make the contribution, if required.

3. When the Dependent is no longer eligible (see "Dependents Defined").

CONTINUATION of COVERAGE

This section is intended to inform you, in a summary fashion, of your rights and obligations with respect to continuation coverage under the Fund. **If you have additional questions regarding your continuation coverage rights, contact the Fund Manager at:**

Administrative Services Only, Inc.
303 Merrick Road, Suite 300
Lynbrook, NY 11563
(516) 396-5500

COBRA CONTINUATION COVERAGE

Under a Federal Law called the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), group health plans must offer employees and their families the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates in certain instances where coverage under the Fund would otherwise end (called "Qualifying Events"). You, your spouse, and your Dependents (as defined above) could become qualified beneficiaries if your coverage under the Plan is lost because of the Qualifying Event. Under the Plan, qualified beneficiaries who elect COBRA coverage must pay for COBRA Continuation Coverage.

> **NOTE: 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.

If you are covered by the Plan as an employee, you have a right to choose COBRA Continuation Coverage through the Plan if you lose your group health coverage because of a reduction in your hours of employment

that leaves you ineligible for coverage by the Fund or the termination of your employment (for reasons other than gross misconduct on your part). Please remember that if you elect COBRA coverage under this Fund, the election applies only to this Fund. Your election with this Fund will not continue coverage for benefits provided elsewhere.

If you are the **spouse of an employee** covered by the Fund, you have the right to choose Continuation Coverage for yourself if you lose group health coverage under the Fund for any of the following four reasons:

(1) The death of your spouse;

(2) A termination of your spouse's employment (for reasons other than gross misconduct), or a reduction in your spouse's hours of employment with a Contributing Employer;

(3) Divorce or legal separation from your spouse; or

(4) Your spouse becomes entitled to Medicare (Part A, B or both).

Dependents of an employee (as defined above) covered under the Fund have the right to choose continuation coverage if group health coverage under the Fund is lost for any of the five following reasons:

(1) The death of the employee-parent;

(2) The termination of the employee-parent's employment (for reasons other than gross misconduct), or a reduction in the employee-parent's hours of employment with a Contributing Employer;

(3) Parents' divorce or legal separation;

(4) The employee-parent becomes entitled to Medicare (Part A, B or both); or

(5) The Dependent ceases to be a "Dependent" under the terms of the Plan.

A child who is born to or placed for adoption with a covered employee during the period of the employee's Continuation Coverage is a "qualified beneficiary" and generally is eligible to be enrolled immediately for COBRA Continuation Coverage under the Plan. Once the child is enrolled pursuant to the Fund's rules, he or she will be treated like all other COBRA Qualified Beneficiaries with respect to the same Qualifying Event. The maximum coverage period for such a child is measured from the same date as for other Qualified Beneficiaries with respect to the same Qualifying Event (and not from the date of the birth or adoption).

Giving Notice of Qualifying Events

Under the law, you or your family member have the responsibility to inform the Fund Manager of a divorce, a legal separation, or a child losing Dependent status under the Fund within 60 days of the date of the Qualifying Event. *This notice must be in writing and must be sent to the Fund Manager at the address at the beginning of this section.* The employer has the responsibility to notify the Fund Manager of the Employee's termination of employment, reduction in hours of employment, death of the employee, or Medicare entitlement (in Part A, B or both).

How COBRA Coverage is Provided

When the Fund Manager is notified that a Qualifying Event has happened, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Under the law, within 60 days of the later of (i) the date you ordinarily would have lost coverage because of one of the events described above, or (ii) the date of the notice of your right to elect Continuation Coverage, you must inform the Fund Manager that you want Continuation Coverage. Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage. Covered employees may elect Continuation Coverage on behalf of their spouse, and parents may elect Continuation Coverage on behalf of their children.

If you do not choose Continuation Coverage during this 60-day period, your coverage under the Fund will end.

How Long Will Continuation Coverage Last?

If you choose Continuation Coverage, you are entitled to be provided with coverage that is identical to the coverage being provided under the Fund to similarly situated employees (or their family members). Continuation Coverage is a temporary continuation of coverage.

If group health coverage is lost because of a termination of employment or reduction in hours of employment, and the employee has not become entitled to Medicare (Part A, B, or both) within the 18 months prior to such Qualifying Event, the law requires that Qualified Beneficiaries be afforded the opportunity to maintain Continuation Coverage for up to 18 months. If, however, the employee did become entitled to Medicare (Part A, B, or both) less than 18 months prior to such Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the employee lasts for 36 months from the Medicare entitlement.

In the case of other Qualifying Events, Qualified Beneficiaries will be afforded the opportunity to maintain Continuation Coverage for up to 36 months.

Disability Extension of 18-month Continuation Coverage.

An 18 month period of Continuation Coverage may be extended for up to 11 months (up to 29 months in total), if you or any other Qualified Beneficiary is determined by the Social Security Administration (SSA) to be disabled. The disability would have to have started at some time before the 60th day of Continuation Coverage and must last at least until the end of the 18-month period of Continuation Coverage. In order to receive this 11-month extension, you or your family member must notify the Fund Manager during the initial 18 month Continuation Coverage period and within 60 days of the later of (a) such determination by the SSA, (b) the date of the Qualifying Event, or (c) the date on which the Qualified Beneficiary loses coverage due to the Qualifying Event. ***This notice must be in writing and must include a copy of the disability award letter from the Social Security Administration. Please send the notice to the Fund Manager at the address at the beginning of this section.***

Second Qualifying Event Extension of 18-month Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of Continuation Coverage, your spouse and Dependents can get up to 18 additional months of Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Fund Manager. This extension may be available to your spouse and Dependent receiving Continuation Coverage if you die, if you become enrolled in Medicare (Part A, B or both), if you and your spouse divorce or become legally separated, or if the Dependent stops being eligible under the Fund as a Dependent, but only if the event would have caused your spouse or Dependent to lose coverage under the Fund had the first Qualifying Event not occurred.

When COBRA Coverage Ends:

Your Continuation Coverage may be cut short prior to the expiration of the 18, 29 or 36 month period for <u>any</u> of the following five reasons:

1. The Fund no longer provides group health coverage;
2. The premium for your Continuation Coverage is not paid on time;
3. The individual becomes covered under another group health plan (as an employee or otherwise);
4. The individual becomes enrolled in Medicare (Part A, B or both); or
5. Coverage has been extended for up to 29 months due to disability and there has been a final determination by the SSA that the individual is no longer disabled. You are required to notify the Fund Manager within 30 days of any such final determination.

Once your Continuation Coverage terminates for any reason, it cannot be reinstated.

You do not have to show that you are insurable to choose Continuation Coverage. However, Continuation Coverage under the law is provided subject to your eligibility for coverage under the Fund. The Board of Trustees reserves the right to terminate your Continuation Coverage retroactively if you are determined to be ineligible.

Cost of COBRA Continuation Coverage

Under the law, you may have to pay the premium for your Continuation Coverage. During the initial 18 or 36 month period of Continuation Coverage, you will have to pay 102% of the applicable premium for your Continuation Coverage. However, during the additional 11 months of Continuation Coverage for disability, the Fund may charge up to 150% of the applicable premium for such Continuation Coverage. In the event that Continuation Coverage is extended to 36 months for a disabled Qualified Beneficiary who experienced a second Qualifying Event during the 11 month disability extension (described above), the Fund may require payment of up to 150% of the applicable premium until the end of the 36 month maximum coverage period. However, if the disabled Qualified Beneficiary experiences a second Qualifying Event during the original 18 month period of Continuation Coverage, the premium will be 102% of the applicable premium.

It is easiest to make your **first payment** when you file your COBRA election form. In no event may your payment be made later than 45 days from the date you mail your signed election form to the Fund Office. Your first check should cover the period from the date your group coverage ended and COBRA coverage began <u>through</u> the current month. All **subsequent payments** after the first payment will be due on the first day of each month for that month's coverage (for example, by June 1 for June coverage). Keep in mind that the Fund Office does not send monthly bills for COBRA coverage and it is your responsibility to see that your payment is at the Fund Office by the due date.

There is a 30-day **grace period** for all payments after the first payment (for example, the end of the grace period for payment for coverage in the month of June is June 30). However, if you have a claim during a month for which you have not paid your premium, the claim will not be paid until after the Fund Office receives your payment for the month.

COBRA premiums are generally reviewed once a year and are subject to change. You will be notified by the Fund Office if the amount of your monthly payment changes. In addition, if the benefits change for active employees, your coverage will change as well.

If You Have Questions

Questions concerning your COBRA Continuation Coverage rights should be addressed to the Fund Manager at the address above. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the 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.) In the New York City, you may contact the Regional or District Office of the U.S. Department of Health and Human Services, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, New York 10278, (212) 264-4600. For more information about the Marketplace, visit www.HealthCare.gov.

Keep the Fund Informed of Address Change

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notice you send to the Fund Office.

USERRA CONTINUATION COVERAGE

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time.

If you are on active military duty for more than 31 days, USERRA permits you to continue coverage for you and your Dependents at your own expense for up to 24 months from the date the employee stopped working. For military service of less than 31 days, health care coverage is provided as if the service member had remained employed.

The Plan will offer the employee USERRA Continuation Coverage only after the Fund Manager has been notified by the employee in writing that they have been called to active duty in the uniformed services. The employee must notify the Fund Manager as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Premiums for USERRA coverage will be 102% of the cost of coverage. The rules for payment of USERRA Continuation Coverage premiums and termination of such coverage for non-payment of premiums are the same as those that apply to COBRA Continuation Coverage. (See COBRA Continuation Coverage, above.)

When you are discharged (not less than honorably) from “service in the uniformed services,” your full eligibility will be reinstated on the day you return to work with a participating employer, provided that you return to Covered Employment within:

1. 90 days from the date of discharge if the period of service was more than 180 days; or

2. 14 days from the date of discharge if the period of service was 31 days or more but less than 181 days; or

3. at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by active military duty, these time limits are extended for up to two years.

The employee must notify the Plan Administrator in writing within the time periods listed above.

Call your Employer if you have questions regarding military service leave. Contact the Fund Office at the address or phone number above if you have questions regarding coverage during such leave.

CERTIFICATE OF CREDITABLE COVERAGE

When your coverage ends, you and your covered Dependents are entitled by law to, and will be provided with, a Certificate of Creditable Coverage that indicates the period of time you and/or they were covered under the Plan. Such a certificate will be provided to you shortly after the Plan knows or has reason to know that coverage for you and/or your covered Dependent(s) has ended. In addition, such a certificate will be provided on receipt of a request for such a certificate that is received by the Fund Office within two years after the date coverage has ended. If, after your coverage under this Plan ends, you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered Dependents a health insurance policy,. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after your or their coverage under this Plan ends. If you (or any of your covered Dependents) elect COBRA Continuation Coverage, another certificate will be sent to you (or them if COBRA Continuation Coverage is provided only to them) by first class mail shortly after the COBRA Continuation Coverage ends for any reason.

As previously indicated, a certificate will be provided to you and/or any covered Dependent on receipt of a request for such a certificate if that request is received by the Fund Office within two years after the later of the date your coverage under this Plan ended or the date COBRA Continuation Coverage ended, if the request is addressed to:

Administrative Services Only, Inc.
303 Merrick Road, Suite 300
Lynbrook, NY 11563

DENTAL BENEFITS

ELIGIBILITY: Members and eligible dependents, which include the lawful spouse and dependent children from birth until age 26.

ANNUAL MAXIMUM: There is a $2,000 maximum per covered individual per calendar year for dental services other than orthodontic.

ANNUAL DEDUCTIBLE: There is no annual deductible.

ORTHODONTIC MAXIMUM- Maximum payable amount from the Fund is $2,100 per lifetime per covered member and eligible dependents.

COVERED EXPENSES: Covered Expenses include charges incurred for the performance of Dental Services provided for in the Schedule of Covered Dental Expenses, when the Dental Service is performed by or under the direction of a duly licensed Dentist, is essential dental care, and begins and is completed while the individual is covered for benefits.

A Dental Service is deemed to start when the actual performance of the service starts except that:

- for fixed bridgework and removable dentures, it starts when the first impressions are taken and/or abutment teeth are prepared;
- for a crown, it starts on the first date of preparation of the tooth involved;
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

HOW TO FILE A CLAIM: After dental work is performed, have your Dentist complete all items in the Dentist Information portion of the Universal or Standard ADA Claim Form and list the procedures, dates of services and charges and sign in the space provided for Dentist signature. You should then complete all items in the Employee section. Be sure to include spouse and dependent information. Completed claim forms, with x-rays and other attachments, should be sent to:

Administrative Services Only, Inc
P.O. Box 9005, Dept 47 Active or Dept 48 Retiree
Lynbrook, NY 11563-9005
516-396-5500 / 718-204-7172

Dental claims must be filed within 12 months after the date of service. Claims filed after 12 months will not be reimbursed. If you would like the payment made directly to your Dentist, you may do so by signing the “Authorization to Assign Benefits” box on the claim form.

CLAIMS APPEAL AND REVIEW PROCEDURE: Your right to appeal and review of denied claims is described in the CWA 1181 Benefits Fund Summary Plan Description.

EXTENSION OF BENEFITS: An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while that person was eligible if:

- for crowns, fixed bridgework and full or partial dentures, a pre-treatment authorization was issued and impressions were taken and/or teeth were prepared while that person was an eligible beneficiary and the device was installed or delivered within one month after that person's eligibility terminated.

- for root canal therapy, the pulp chamber of the tooth was opened while that person was eligible for benefits and the treatment was completed within one month after that person's eligibility terminated.

There is no extension for any dental service not shown above.

PRE-TREATMENT REVIEW: This process is intended to inform you and your dentist, in advance of treatment, what benefits are provided by the Dental Program. It enables you to obtain knowledge of the operation of your dental plan prior to undertaking treatment and incurring expenses.

A Claim Form for Pre-Treatment Review should be filed by your Dentist if the course of treatment prescribed for you is expected to cost more than $500 in a 90 day period and/or includes any of the following services: crowns, bridges, dentures, laminate veneers or periodontal surgery. The Dentist should complete the claim form describing the planned treatment and the intended charges before starting treatment. Complete your part of the form and mail it together with the necessary x-rays and other supporting documentation to:

Administrative Services Only, Inc
P.O. Box 9005, Dept 47 Active or Dept 48 Retiree
Lynbrook, NY 11563-9005

Our dental consultants will review the proposed treatment and apply the appropriate Plan provisions. You and your Dentist will receive a report showing the amount the Plan will pay for each procedure. If there is a disallowance, it will be indicated and an explanation will be provided. Discuss the treatment plan and the benefits payable with your Dentist.

If you receive a pre-treatment authorization for a proposed course of treatment that was submitted by one Dentist, that pre-authorization will remain valid if you elect to have some or all of the work done by another Dentist. The pre-authorization will be honored for one year after issuance.

Please be aware that a pre-treatment authorization is not a promise of payment. Work must be done while you are still covered by the Fund for benefits (except where there is an Extension of Benefits) and no significant change occurred in the condition of your mouth after the pre-estimate was issued. Payment will be made in accordance with plan allowances and limitations in effect at the time services are provided.

ALTERNATE BENEFITS PROVISION: Due to the element of choice available in the treatment of some dental conditions, there may be more than one course of treatment that could produce a suitable result based on accepted dental standards. **In these instances, although you may elect to proceed with the original treatment plan, reimbursement allowances will be based on a less expensive Alternate Course of Treatment.** This should in no way be considered a reflection on your treating dentist's recommendations. By using the pre-treatment review and authorization procedures you and your Dentist can determine, in advance, what benefits are available for a given course of treatment. If the course of treatment has already begun, or has been completed without a pretreatment authorization estimate, the benefits paid by the Dental Plan may be based on the less expensive treatment.

COORDINATION OF DENTAL BENEFIT: If you or your family members are eligible to receive dental benefits under another group plan in addition to the **CWA 1181 Benefits Fund** Dental Plan, benefits will be coordinated with the benefits from your other group plan so that up to 100% of the **allowable expenses** incurred will be paid jointly by the plans. The **allowable expense** for a procedure is defined as the average usual and customary charge for a specific geographic area. In order to obtain all of the benefits available, you and your family members should file claims under each plan. Members should file with the primary plan first and then the secondary plan. Be certain to enclose a copy of the payment voucher from the primary plan when filing a claim with the secondary plan.

BIRTHDAY RULE: The Birthday Rule is applied for determining the primary carrier for payment of dental benefits for dependent children. The plan of the parent whose birthday, month and day, falls first in the calendar year is the primary carrier. For example, if your birthday is July 9 and your spouse's birthday is October 27, your dental plan will be primary. Payment claims for dependent children should be submitted to the primary plan first, and then to the secondary plan, enclosing a copy of the payment voucher from the primary plan.

MISSING TOOTH EXCLUSION: Any replacement of missing teeth extracted prior to coverage is not covered unless the member is eligible for at least three years.

EXPENSES NOT COVERED: Covered Expenses will not include, and no payment will be made for, expenses incurred for:

1. Treatment solely for the purpose of cosmetic improvement.
2. Replacement of a lost or stolen appliance.
3. Replacement of a bridge, crown or denture within five years after the date it was originally installed.
4. Replacement of a bridge, crown or denture which is or can be made usable according to common dental standards.
5. procedures, appliances or restorations (except full dentures) whose main purpose is to:
    a) change vertical dimension; or
    b) diagnose or treat conditions or dysfunctions of the temporomandibular joint; or
    c) Stabilize periodontally involved teeth.
6. Multiple bridge abutments.
7. A surgical implant of any type, including any prosthetic device attached to it.
8. Dental services that do not meet common dental standards.
9. Services not included as Covered Dental Expenses in the Dental Schedule.
10. Services for which benefits are not payable according to the “General Limitations” section.
11. Any replacement of missing teeth extracted prior to coverage unless the member is covered for at least three years.

GENERAL LIMITATIONS: No payment will be made for expenses incurred for you or any one of your Dependents:

1. For or in connection with services or supplies resulting from an accidental injury and which are deemed to be the responsibility of a third party.
2. For or in connection with a sickness or injury arising out of, or in the course of, any employment for wage or profit, which is covered under any workers compensation, occupational disease, or similar law.

3. For charges made by a hospital owned or run by the Federal, State and Municipal agencies unless there is a legal obligation to pay such charges whether or not there is any insurance.

4. For charges which would not have been made if the person had no insurance, including services provided by a member of the patient's immediate family.

5. To the extent that they are more than Reasonable and Customary Charges.

6. For charges for unnecessary care, treatment or surgery.

7. To the extent that you or any of your Dependents is in any way paid for, or furnished by, any government agency, except Medicaid; or that the Insured is not required to pay.

8. For a sickness or injury that is the result of war, declared or undeclared, or any act of war or aggression.

9. For an injury that is the result of participation in any criminal act, a riot, or an insurrection.

10. For or in connection with experimental procedures or treatment methods not accepted.

MetroDENT Dental Network

This feature of your dental plan is designed to substantially reduce or eliminate the non-reimbursed portion of your dental bill. Since usual and customary dental charges generally exceed Dental Plan reimbursements, you will realize a significant savings in the cost of your dental care when you use a participating **Metrodent provider.**

You will not incur any out-of-pocket expenses when you use a participating provider, except in the following instances:

- For services that are listed in the Schedule but for which the Plan will not pay, e.g.:

  a) where dental plan benefits exceed your $2,000 calendar year maximum

  b) where procedure frequency limitations have been met

In these instances, the participating dentist's charges may not exceed the Maximum Charges as stated in the Schedule.

- For non-covered services.

The DIRECTORY OF PARTICIPATING DENTISTS- includes the names, addresses, and telephone numbers of participating **General Practitioners, Periodontists, Endodontists, Oral Surgeons, Pedodontist, Orthodontists and Prosthodontists.** You should be aware that although several dentists may practice at the same location, only the dentist whose name and address appears on the list is a Participating Dentist.

SELECTING A DENTIST- You are free to select the dentist or dental specialist of your choice. And of course, each family member may select his or her own dentist. You may utilize the services of a participating specialist whether or not you utilize the services of a participating general dentist for your routine care. You may change your dentist at any time for any reason. **It is important to understand that the** CWA 1181 Benefits Fund **does not recommend or endorse any particular dentist. You should exercise the same care and apply the same criteria in selecting a participating dentist as you would in selecting a non-participating dentist.**

FOR THE MOST CURRENT LISTING OF PARTICIPATING PROVIDERS, PLEASE VISIT OUR WEB SITE AT:
www.asonet.com

SCHEDULING AN APPOINTMENT- After selecting a dentist from the directory, call the dental office for an appointment. Identify yourself as a member of CWA 1181 Benefits Fund covered by the Metrodent Dental Network when scheduling your appointment and have a copy of this pamphlet with you at the time of your visit. **Due to the fact that there are occasional additions and deletions, please verify that the dentist is still participating when scheduling your appointment and at the time of your visit. If you have any questions, please contact Administrative Services Only, Inc. at 1-800-537-1238 / 1-516-396-5500**

FILING A CLAIM - Participating dentists will handle all the necessary paper work. You simply complete the Assignment of Benefits section of your claim form and reimbursement will be paid directly to the dentist. You will be responsible for reimbursing the dentist only in those instances stated above.

MEMBER ASSISTANCE

If you have any specific questions regarding the treatment you received or charges incurred when utilizing the services of a participating dentist, please call or write:

Administrative Services Only, Inc.
PO BOX 9005
Lynbrook, NY 11563
516-396-5500/ 800-537-1238
www.asonet.com

CWA LOCAL 1181 BENEFITS FUND
SCHEDULE OF DENTAL PLAN ALLOWANCES
JANUARY 2016

	NON-PPO ALLOW	PPO ALLOW
DIAGNOSTIC & PREVENTIVE		
ORAL EXAMINATION	19.00	15.00
Maximum-two in a calendar year. For dependent children under age 19, additional Oral Examinations will be covered, when medically necessary.		
FULL MOUTH SERIES X-RAYS	48.00	25.00
10 to 14 periapical and bitewing films		-
PANORAMIC FILM	34.00	25.00
INTRAORAL FILM	-	
periapical, first film	7.00	3.00
bitewing, first film	7.00	3.00
each additional periapical or bitewing film	3.00	3.00
OCCLUSAL FILM	10.00	10.00
CEPHALOMETRIC FILM	27.00	34.00
POSTERIOR-ANTERIOR, LATERAL FILM	50.00	50.00
EXTRAORAL FILM	25.00	25.00
TEMPOROMANDIBULAR FILM	66.00	25.00
PROPHYLAXIS, including scaling and polishing		
Adult > 12 Years of Age	19.00	22.00
Child- < 12 Years of Age	15.00	22.00
Maximum two cleanings per year		
FLUORIDE TREATMENT, *excluding prophylaxis*	20.00	10.00
to age 19, one application per year		
SPACE MAINTAINER	99.00	100.00
BASIC RESTORATIVE		
SILVER AMALGAM FILLINGS-primary or permanent teeth		
one surface	17.00	25.00
two surfaces	27.00	35.00
three surfaces	40.00	45.00
four surfaces	54.00	55.00

	NON-PPO ALLOW	PPO ALLOW
COMPOSITE RESIN-ANTERIOR		
one surface	40.00	32.00
two surfaces	54.00	36.00
three surfaces	69.00	40.00
four or more or incisal angle	9.00	40.00
COMPOSITE RESIN-POSTERIOR		
one surface	40.00	32.00
two surfaces	54.00	36.00
three surface or more surfaces	69.00	40.00
METALLIC INLAY *(once in five years for Inlays and onlay)*		
one surface	93.00	150.00
two surfaces	118.00	190.00
three surfaces	158.00	230.00
one surface	145.00	170.00
two surfaces	145.00	200.00
three surfaces	145.00	230.00
MAJOR RESTORATIVE *(not more than once in five years)*		
CROWNS		
acrylic jacket	197.00	110.00
porcelain jacket	211.00	325.00
plastic with metal	224.00	325.00
porcelain with metal	262.00	375.00
full or 3/4 cast	184.00	300.00
LABIAL VENEER-lab processed	132.00	215.00
STAINLESS STEEL CROWN, primary tooth	86.00	75.00
PIN RETENTION-per tooth	15.00	15.00
POST & CORE, prefabricated	50.00	75.00
CAST POST & CORE	65.00	95.00

	NON-PPO ALLOW	PPO ALLOW
ENDODONTICS ***x-ray evidence of satisfactory completion required***		
PULP-CAP, direct	17.00	10.00
PULPOTOMY	34.00	40.00
ROOT THERAPY		
Anterior I	132.00	165.00
Bicuspid	197.00	215.00
Molar	241.00	275.00
APICOECTOMY-per root	93.00	130.00
APICOECTOMY, maximum per tooth	93.00	260.00
RETROGRADE FILLING-per root	60.00	60.00
PROSTHODONTIC REPAIRS DENTURE RELINE		
office procedure-complete denture	73.00	75.00
office procedure-partial denture	73.00	70.00
laboratory procedure-complete denture	171.00	25.00
laboratory procedure-partial denture	171.00	100.00
DENTURE REPAIRS		
denture adjustment, complete or partial denture	25.00	25.00
repair partial acrylic saddle/base	47.00	75.00
repair cast framework	47.00	95.00
broken denture base	47.00	65.00
replace tooth in denture	47.00	60.00
replace broken clasp	75.00	75.00
add tooth to existing partial denture	66.00	65.00
add clasp to existing partial	66.00	75.00

RECEMENTATION		
crown or inlay	18.00	20.00
bridge	54.00	30.00
space maintainer	30.00	30.00

	NON-PPO ALLOW	PPO ALLOW
PROSTHODONTICS *(not more than once in five years)* COMPLETE DENTURE		
Immediate	432.00	400.00
Permanent	393.00	400.00
PARTIAL DENTURE-unilateral	135.00	150.00
PARTIAL DENTURE-bilateral		
acrylic base with clasps and rests	288.00	225.00
cast metal base	459.00	400.00
BRIDGE ABUTMENT		
crown-plastic with metal	224.00	300.00
crown-porcelain fused to metal	262.00	375.00
crown-full cast	184.00	300.00
BRIDGE PONTIC		
full cast	106.00	300.00
plastic with metal	132.00	300.00
porcelain with metal	197.00	375.00
TISSUE CONDITIONING	40.00	40.00
PERIODONTICS		
Although eight teeth constitute the anatomic compliment of a quadrant, for purposes of settling claims for periodontal treatment, payment will be based on five teeth per quadrant. Accordingly, if at least five teeth are treated in a quadrant, payment will be based on the allowance for a full quadrant. If fewer than five teeth are treated, payment will be pro-rated on the basis of five teeth per quadrant. When more than one periodontal procedure is performed on the same day, claims for services will be combined and payment will be based on the most costly procedure.		
ROOT SCALING, GINGIVAL CURETTAGE & BITE CORRECTION, *including prophylaxis,*		
per visit	27.00	40.00
occlusal adjustment complete	66.00	60.00
periodontal maintenance	55.00	55.00
following periodontal surgery PERIODONTAL SURGERY GINGIVAL SURGERY gingivectomy, gingivoplasty and mucogingival surgery		

	NON-PPO ALLOW	PPO ALLOW
per quadrant	164.00	100.00
osseous graft, per site	90.00	90.00
osseous graft, maximum per quadrant	250.00	250.00
OSSEOUS SURGERY including gingivectomy-per quadrant	240.00	300.00
ORAL SURGERY		
ROUTINE EXTRACTION	17.00	30.00
SURGICAL EXTRACTION ***must be demonstrated by x-ray***		
erupted tooth	40.00	60.00
impaction-soft tissue	40.00	90.00
impaction-partial bony	66.00	140.00
impaction-complete bony	118.00	185.00
ALVEOLOPLASTY-per jaw	33.00	125.00
BIOPSY OF ORAL TISSUE	75.00	75.00
REMOVAL OF CYST OR TUMOR		
less than 1.25 cm	47.00	45.00
greater than 1.25 cm	118.00	90.00
INCISION & DRAINAGE	34.00	50.00
no other treatment that visit		
FRENULECTOMY	66.00	95.00
ROOT RECOVERY	40.00	90.00
ADJUNCTIVE SERVICES		
SPECIALIST CONSULTATION, including exam	50.00	50.00
PALLIATIVE TREATMENT	19.00	30.00
no other treatment that visit GENERAL ANESTHESIA/IV SEDATION		
first 30 minutes	90.00	90.00
ORTHODONTIC SERVICES Maximum payable from Fund is $2,100 per lifetime per covered member and eligible dependents. The Maximum charge when being treated by a participating provider is $2,100		

	NON-PPO ALLOW	PPO ALLOW
MINOR TOOTH MOVEMENT & INTERCEPTIVE TREATMENT		
removable appliance	225.00	225.00
fixed appliance	400.00	400.00
active treatment, per month	50.00	50.00
Maximum charge	650.00	650.00
COMPREHENSIVE TREATMENT-		
removable appliance	225.00	225.00
harmful habit appliance	225.00	225.00
fixed appliance	422.00	400.00
active treatment, per month of treatment	49.00	50.00
maximum- 24 months		
passive treatment, per 3 months of treatment	71.00	50.00
maximum- 9 months		
post-treatment stabilization device	100.00	100.00
Maximum PPO Charge		2,100.00

VISION BENEFITS

CWA 1181 Security Benefits Fund is pleased to provide this information about your vision care plan administered by Davis Vision, Inc., a leading national administrator of vision care programs. Eligibility for vision care benefits is determined by the same rules that apply to your health care benefits.

How do I receive services from a provider in the network?

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a Davis Vision member and CWA 1181 Security Benefits Fund member or dependent.
- Provide the office with the member ID number located on your Davis Vision ID card and the name and date of birth of any covered dependent needing services.

It's that easy! The provider's office will verify your eligibility for services, and claim forms are not required.

Who are the network providers?

They are licensed providers in both private practice and retail locations who are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained. Please access Davis Vision's website at **www.davisvision.com** and utilize the "Find a Doctor" feature, or call **1.800.999.5431** to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you.

What are the plan benefits, frequencies and costs?

EYE EXAMINATIONS Every 12 months, including dilation as professionally indicated.

Dependents up to the age of 19 ....unlimited if medically necessary.
In-Network Copayment.. $0
Out-of-Network ....Reimbursed up to $25

EYEGLASSES

Frame ....Every 12 months
Spectacle Lenses ....Every 12 months
In-Network Copayment.. $0

You may choose any Fashion or Designer level frame from Davis Vision's Frame Collection, covered in full. Or, if you select another frame in the network provider's office, a $50 credit, plus a 20% discount off any overage will be applied. This credit would also apply at retail locations that do not carry the Frame Collection. Members are responsible for the amount over $50 (less the applicable discount). For more information on lenses, please see "What lenses/coatings are included?"

Out-of-Network ....Reimbursed up to $100 for materials.
CONTACT LENSES .... Every 12 months
In-Network Copayment $0

In lieu of eyeglasses, you may select contact lenses. Any contact lenses from Davis Vision's Contact Lens Collection will be covered in full per the number indicated below, and your evaluation, fitting and follow up care will also be covered.

Davis Vision Contact Lens Collection (includes evaluation, fitting, follow-up):

Disposable...Four boxes/multi-packs
Planned Replacement ....Two boxes/multi-packs

In lieu of the Davis Vision contact lenses, members may use their $100 credit, plus a 15% discount off any overage toward the provider's own supply of contact lenses, evaluation, fitting and follow-up care. This credit would also apply towards all contact lenses received at participating retail locations.

Medically necessary contact lenses will be covered up to $125 with prior approval.

Out-of-Network ....Reimbursed up to $100 for materials.

Please note: Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses.

What lenses/coatings are included?**

- Plastic single vision, bifocal or trifocal lenses, in any prescription range.
- Oversize lenses.
- Post-cataract lenses.
- Tinting of plastic lenses.

- Polycarbonate lenses for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

- Scratch-resistant coating.

Are there any optional frames, lens types or coatings available?**

Yes, you can pay the low, discounted fixed fees indicated (in addition to your basic copayment) and receive these exciting optional items:

- $25 for a Premier frame from the "Collection".

- $30 for polycarbonate lenses.

- $20 for single vision scratch protection plan.

Multifocal scratch protection plan is $40.

- $12 for ultraviolet (UV) coating.

- $30 for intermediate-vision lenses.

- $35 for standard ARC (anti-reflective coating). Premium ARC is $48. Ultra ARC is $60.

- $75 for polarized lenses.

- $65 for plastic photosensitive lenses.

- $55 for high-index (thinner and lighter) lenses.

- $50 for standard progressive addition multifocal lenses. Premium progressive addition multifocal lenses are $90***

***These lens options and copays apply to in-network benefits only.*
****Progressive addition multifocals can be worn by most people. Conventional bifocals will be supplied at no additional cost for anyone who is unable to adapt to progressive addition lenses; however, the copayment will not be refunded.*

When will I receive my eyewear?

Generally, your eyewear will be delivered to your provider from the laboratory within five business days. More delivery time may be needed when out-of-stock frames, anti-reflective coating, specialized prescriptions or a participating provider's frame is selected.

What about out-of-network provider benefits?

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Only one claim per service may be submitted for reimbursement each benefit cycle. To request claim forms, please visit the Davis Vision website at **www.davisvision.com** or call **1.800.999.5431.**

May I use the benefit at different times?

You may "split" your benefits by receiving your eye examination and eyeglasses (or contact lenses) on different dates or through different provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one provider. Continuity of care will best be maintained when all available services are obtained at one time from either a network or an out-of-network provider. To maximize your benefit value we recommend that all services be obtained from a network provider.

Information about Laser Vision Correction Services:

Davis Vision provides you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at discounts of up to 25% off a participating provider's normal charges, or 5% off any advertised special (please note that some providers have flat fees equivalent to these discounts). Please check the discount available to you with the participating provider. For more information, please visit us at www.davisvision.com or call 1.800.999.5431.

Mail Order Contact Lenses:

Replacement contacts (after the initial benefit) through www.davisvisioncontacts.com mail order services, ensures easy, convient, purchasing online and quick, direct shipping to your door. Log on to Davis Vision, Incs.'s website for details.

Warranty Information:

One-year eyeglass breakage warranty included at no additional cost. All plan eyeglasses come with a breakage warranty for repair or replacement of the frame and/or lenses for a period of one year from the date of delivery. The warranty applies to all plan covered eyeglasses, i.e. spectacle

lenses, Davis Vision Collection frames and national retailer frames (where our Exclusive Collection is not displayed).

Are there any exclusions?

The following items are not covered by this vision program:

- Medical treatment of eye disease or injury.
- Vision therapy.
- Special lens designs or coatings, other than those previously described.
- Replacement of lost eyewear.
- Non-prescription (plano) lenses.
- Contact lenses and eyeglasses in the same benefit cycle.
- Services not performed by licensed personnel.
- Two pairs of eyeglasses in lieu of a bifocal.

For more information, please visit Davis Vision's website at www.davisvision.com or call Davis Vision at 1.800.999.5431 to:

- Learn more about your benefits
- Locate a Davis Vision provider
- Verify eligibility
- Print an enrollment confirmation
- Request an out-of-network provider reimbursement form
- Contact a Member Service Representative

Member Service Representatives are available:

- Monday through Friday, 8:00 AM to 11:00 PM, Eastern Time
- Saturday, 9:00 AM to 4:00 PM, Eastern Time
- Sunday, 12:00 PM to 4:00 PM, Eastern Time

Participants who use a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services by calling 1-800-523-2847.

Your rights as a patient:

Davis Vision recognizes that all patients have specific rights, including, but not limited to:

- The right to complete information about their healthcare options and consequences.
- The right to participate in all treatment decisions.
- The right to dignity, privacy, confidentiality and non-discrimination.
- The right to complain or appeal any decision.

Patients also have the responsibility:

- To provide complete and accurate information.
- To follow care instructions.

For a complete copy of your Rights and Responsibilities as a Patient, please visit Davis Vision's website at: **www.davisvision.com** or call **1.800.999.5431.**

*All insured products are underwritten by either HM Life Insurance Company or HM Life Insurance Company of New York." Davis Vision may operate as Davis Vision Insurance Administrators in California.

PRESCRIPTION DRUG PLAN

The Prescription Drug Plan is administered by Express Scripts (ESI).

ESI's customer service telephone number is (800) 818-6602. Patient Care Advocates are available around the clock to assist you. A pharmacist is available Monday through Friday from 8 a.m. to 11 p.m. E.S.T. and on Saturday from 8 a.m. to 5 p.m. E.S.T. You may also access Express Scripts, Inc. via their website at **www.express-scripts.com**.

PRESCRIPTION DRUG BENEFIT- Retail and Mail Order- Generic, Preferred Brand Drugs and Non-Preferred Drug Brands

	Total Cap Dollars	Coinsurance*
All Medications	$0- $2,500	20%
All Medications	$2,500.01 - $12,700.00	100%
All Medications	$12,700.01 and over	20%

RETIRED MEMBERS

	Total Cap Dollars	Coinsurance*
All Medications	$0- $2,200	20%
All Medications	$2,200 and over	100%

***Mail Order Minimum Co-Insurance -**
Generic $10
Preferred Brand $30

Benefits will be paid at the Benefit payable as shown in the Schedule of Benefits, if you and your Dependents are covered under this benefit and incur Medically Necessary charges for Prescription Drugs for Illness and/or Injuries. Such drugs must be:

1. Obtained by a Physician's written Prescription; and

2. Dispensed by a licensed pharmacy

For Prescription Drugs obtained at a Participating Pharmacy, benefits will be payable as follows:

1. You or your Dependent will present drug card to the pharmacist when the Prescription is filled or refilled,

2. You or your Dependent will pay the co-insurance of the negotiated price of the Prescription Drug.

For Prescription Drugs obtained at a non-Participating Pharmacy, you or your dependent must pay the full amount of the Prescription Drug, then submit claim forms and the receipts directly to ESI.

Participating retail pharmacies

ESI contracts with a large network of participating retail pharmacies. To find a pharmacy near you, log in to the Express Scripts website, www.express-scripts.com and select “Locate a pharmacy” from the menu under “Manage prescriptions.” You can also call Member Services toll-free at (800) 818-6602 to access the interactive pharmacy locator.

My Rx Choices

The CWA Local 1181 Security Benefit Fund includes the My Rx Choices® prescription savings program. View cost-saving opportunities online: Visit My Rx Choices® at www.express-scripts.com to identify potential cost-saving alternatives for the medicines you take on an ongoing basis—or for a prescription you need in the future. My Rx Choices shows you how much you could save by using effective, lower-cost alternatives.

Your doctor knows which medications are right for you but may not know their cost. My Rx Choices provides you with available lower-cost options so that you and your doctor can make the most informed decisions based on health and cost.

Generics

What are generic drugs? Medicines should be affordable. That’s why FDA-approved generic drugs are a great option. They’re safe, effective alternatives to brand-name drugs – and typically cost much less. Each year, more brand-name drugs lose their patent protection and that means drug companies can make less-expensive generics for doctors to prescribe.

FDA-approved generic drugs:

- Have the same active ingredients as their brand-name equals
- Are expected by the FDA to work the same way as the original brand-name drugs
- Have the same quality, strength and purity

Home delivery

Convenient home delivery services through the Express Scripts Pharmacy℠. You’ll be able to have up to a 102 day supply of long-term medicine delivered directly to you for one home delivery copayment. Plus, standard shipping is free. (A long-term medicine is one that is taken to treat an ongoing condition, such as high blood pressure, high cholesterol or diabetes).

Getting started with home delivery is easy using one of these methods:

For new prescriptions

- Call Express Scripts at (800) 818-6602. In most cases, Express Scripts can contact your doctor to set up your first home delivery of the medicine.
- Ask your doctor to fax prescriptions or send them electronically to Express Script.
- Mail the prescription along with the required co-payment and a completed home delivery order form to the address on the form.

To transfer long-term prescriptions from a retail pharmacy to home delivery

- Log in at www.express-scripts.com and go to "Transfer your retail prescriptions." Express Scripts will contact your doctor.
- Call Express Scripts Member Services at (800) 818-6602 to request a transfer. You will need to have your member ID number handy when you call.

The automatic refill program

Your Plan provides this service to help you avoid running out of your medicine. After enrolling your maintenance prescriptions in the program, Express Scripts will automatically calculate your medicine usage and remaining day's supply. When it's time to refill your prescription, Express Scripts will fill and mail it to you automatically. You'll be notified 7 days before Express Scripts begins processing your next refill. You have the option to change the next processing date or cancel the prescription from the automated refills program at any time before processing begins.

There are 3 convenient ways to enroll in automatic refills:

- Log in at www.express-scripts.com, and select "Manage Automatic Refills" from the menu under "Manage Prescriptions." Select the prescriptions you'd like to have refilled automatically.
- When refilling a prescription, Express Scripts asks if you want to enroll it in automatic refills. If you answer "yes," all future refills will be processed automatically.
- Call Member Services at (800) 818-6602and tell the representative that you want to enroll in automatic refills.

express-scripts.com and the Express Scripts Mobile App

Helpful resources on express-scripts.com. Once you register at www.express-scripts.com, you can order home delivery refills and renewals; check order status; compare medicine costs to find potential lower-cost options under your Plan; receive timely medicine-related safety alerts; check claims, balances and make payments; obtain forms and much more.

Stay on track with the help of the Express Scripts Mobile App. You can download the app for free from your mobile app store. Then anywhere, anytime, you can check order status; refill and renew orders; locate a pharmacy and get directions; check drug interactions; set up medicine alerts; and access your virtual member ID card.

Stretch your mail-order payments with the Extended Payment Program

Instead of paying in full up front, you will be billed for the cost of your medications over three installments. The Extended Payment Program (EPP) allows you to spread your home delivery prescription payments over three credit or debit card installments so you don't have to pay all at once. There's no waiting. Your medicine will be shipped from the Express Scripts Pharmacy after the very first payment. When you enroll in EPP, it applies to every home delivery prescription for you and your covered dependents. To learn more, call Member Services at (800) 818-6602. You can also log in at www.express-scripts.com and select "Edit payment information" from the drop-down menu under "My Account." In "Payment information" select "Edit information" in the upper right corner. Next to Extended Payment Program, you will see a link to "Learn More" about the program.

Prior Authorization

What is Prior Authorization (PA)?

Prior authorization, also known as coverage approval, is a program that helps you get the prescription drugs you need with cost savings. It helps you get the most from your healthcare dollars with prescription drugs that work well for you and are covered by your prescription benefit. It also helps control the rising cost of prescription drugs for everyone in your Plan.

The Plan requires prior authorization (approval) before certain medicines can be covered. Similar to prior authorization for medical tests to determine what procedures are necessary. If you take a medicine that requires prior authorization, Express Scripts will consult with your doctor to determine whether the medicine meets your Plan's coverage requirements and is medically necessary.

How can I find out whether my medicine needs prior authorization?

Log in at www.express-scripts.com and select “Price a Medication” from the drop-down menu under “Manage Prescriptions.” After you look up a medicine’s name, click “View coverage notes.” You can also call Express Scripts Member Services at (800) 818-6602 to ask about your prior authorization

Specialist pharmacists

Express Scripts Specialist Pharmacists have expertise in the long-term medicines used to treat diabetes, heart disease, high cholesterol, high blood pressure, asthma, arthritis, migraines, depression, cancer and women’s health condition. They can answer your medicine questions, help you avoid drug interactions and even help you and your doctor identify potential prescription drug savings. To speak with an Express Scripts Specialist Pharmacist, call Member Services at (800) 818-6602 and ask for a specialist pharmacist.

Specialty medicines

Specialty medicines are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia,Hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis.

Accredo Health Group, Inc., an Express Scripts specialty pharmacy, is composed of therapy specific teams that provide an enhanced level of individual service to patients with special therapy needs. Counseling, scheduled delivery, and safety checks are just a few of the services that Accredo provides.

By filling specialty prescriptions through Accredo, you’ll pay only your plan’s co-payment and receive a variety of specialized services, including:

- Safe, prompt delivery. Accredo will schedule and quickly ship all your specialty medications, including those that require special handling such as refrigeration.
- Personalized care. You’ll have access to a team of pharmacists and nurses who have received specialized training in your medical condition.
- Supplies. Most supplies, such as syringes, needles and sharps containers, will be provided with your medication.
- Support – 24/7. Trained pharmacists and nurses are available around the clock to answer your questions and will assist you in managing your condition.

- Refill reminders. Accredo will contact you regularly to schedule your next refill and see how your therapy is progressing. For convenience, some specialty medication refills can be ordered online, safely and securely, through Express-Scripts.com.

Drug safety monitoring. As an Express Scripts pharmacy, Accredo can access your prescription information on file at all Express Scripts pharmacies to monitor for potential drug interactions and side effects of your medications

How do I start using home delivery?

You can choose one of these easy methods:

- Call us at (800) 818-6602 and let us do all the work. For most medications, we'll be able to contact your doctor and arrange for your first home delivery supply.

- Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to 1 year (if appropriate). Then have your doctor fax the prescription to Express Scripts. (Only your doctor can fax your prescriptions.)

For refills remaining on covered medications you take regularly and fill at a retail pharmacy, log in to www.Express-Scripts.com, scroll down the Order Center page to "Transfer your retail prescriptions" and select the medications you'd like to transfer. We do the rest. (If you're a first-time visitor to the website, please take a moment to register using your member ID number and a recent prescription number.)

How long will it take to receive my home delivery medications?

Usually you'll receive your first supply within 8 days after we receive your order. Refills usually take about 5 days.

How can I avoid running out of medication when I use home delivery?

For your convenience, we offer Automatic Refills a service that provides you with automatic refills on eligible medications you take regularly. Your medication will be shipped automatically as you near the end of your current supply. To see whether your medications are eligible and to enroll them in Worry-Free Fills. Call Member Services at (800) 818-6602or log in to www.Express-Scripts.com.

If I send in more than one prescription, will it be shipped in more than one package?

It is possible. Depending on the availability of your medications, those prescriptions may need to be dispensed from different Express Scripts home delivery pharmacies.

I'd rather use my local drugstore for my long-term medications. Why must I use home delivery?

Many prescription drug plans require members to use home delivery for long-term drugs as a way to reduce costs for the Plan and member. Under your Plan, you can purchase a covered long-term medication up to three times at a participating retail pharmacy for your regular retail co-payment. After the second fill, you will be charged the medication's full cost unless you purchase it through home delivery. Then you will be charged only your home delivery co-payment for up to a 90-day supply.

Pricing and Coverage

How can I find out how much my medication costs?

Log in at www.Express-Scripts.com, select "Price a medication" from the menu on the left side of the screen, and follow the instructions to your medication name. You can also call Member Services at (800) 818-6602.

What is the Extended Payment Program?

In addition to the savings already offered by home delivery, you can better manage your expenses by spreading your costs over three credit-card installments (with a service fee at a 5% annual percentage rate. or APR). Your medication will be shipped after the first payment. If you are interested in enrolling in the program, please call Member Services. Once you enroll, the program will apply to every home delivery prescription for you and your eligible dependents going forward. If at any point you wish to leave the program, you may change your payment method on www.Express-Scripts.com or call Member Services to be removed.

What are the automatic payment options for home delivery prescriptions?

For your convenience, you can choose to enroll in AutoCharge or eCheck. With AutoCharge, you authorize us to charge all future home delivery orders and any outstanding balances to the credit card you designate. The credit card information you provide will be used for all prescription purchases made by you and your covered household members. With eCheck, your payments are conveniently deducted from your checking account. Plus, there's a 10-day grace period between the time your order is sent and when the amount is deducted from the assigned checking account.

What is an account limit?

An account limit -also called a floor limit- is the maximum outstanding balance you can have on your home delivery account. Under your Plan, the account limit is $100. If your outstanding balance exceeds this limit, Express Scripts will hold your orders until the balance is paid. Please be

aware that prescriptions held for more than 7 days because of outstanding balances will be mailed back to you unfilled. You will need to reorder the medication after you pay the balance. You can check account balance by viewing an account summary on www.Express-Scripts.com or by calling Member services.

What is a courtesy limit?

If you pay by credit card or eCheck and you submit an order that exceeds $500, Express Scripts will first call to get your permission to process the order and apply it to your card or your checking account. (For credit cards, we will call whether you are enrolled in AutoCharge or you are making an Individual credit card payment)

How do I find potential lower-cost alternatives to my medications?

On www.Express-Scripts.com, we've designed two powerful tools to help reduce your out-of-pocket costs:

- "Price a medication" compares cost at retail and through home delivery. Simply enter the name of a medication and search. You will see how much your plan pays for the medication, along with your share of the cost and formulary alternatives covered by your plan (if applicable).

- Discover possible cost-saving opportunities for medication you take regularly with the My Rx Choices prescription savings program. This valuable tool provides personalized results based on your prescription benefit and medications. If My Rx Choices shows potential savings alternatives for your medication, you can even print the results to share with your doctor. You can also find My Rx Choices on the Express Scripts mobile app.

What is a coverage review or prior authorization?

Apollo Education Group uses coverage management programs to help ensure you receive the prescription drugs you need at a reasonable cost. Coverage management programs include prior authorization, step therapy and quantity duration. Each program is administered by Express Scripts to determine whether your use of certain medications meets your plan's conditions of coverage.

In some cases, a coverage review may be necessary to determine whether a prescription can be covered under your plan. Examples of drug categories requiring coverage reviews include, but are not limited to: migraine, hypnotic and dermatological medications.

If your prescription requires a coverage review, you or your doctor can initiate the review by calling Express Scripts directly. The review uses plan rules based on FDA-approved prescribing and safety information, clinical guidelines and uses that are considered reasonable, safe and effective.

What happens if my medication's coverage is approved?

If coverage is approved, you simply pay your normal co-payment for the medication. If coverage is not approved, you will be responsible for the full cost of the medication.

In some cases, why must I first try a different medication before my plan will cover the one that my doctor prescribed?

One coverage management program is called step therapy, in which your plan prefers that you first try certain medications to treat a particular condition. Typically, these preferred medications are chosen because they have been shown to work effectively and cost less than other medications in that category.

If you're taking a medication that requires step therapy, you'll receive a letter explaining that your plan will not cover it unless the alternative medication is tried first. The letter will also have information on starting a coverage review if your doctor believes you should take the original medication.

Are some medications only covered in certain quantities?

Yes, your plan has rules that may limit the quantity or specific period of time that it will cover some medications provided that you receive approval through a coverage review. These limits are intended to help protect patients and reduce the potential waste of certain drugs. Examples of drug categories with quantity limits include, but are not limited to, migraine, hypnotic and dermatological medications.

Miscellaneous

Can Express Scripts automatically substitute a generic medication when I order a brand-name drug?

Yes. Express Scripts home delivery pharmacies will automatically fill prescriptions with generic equivalents (if available), unless you specifically request the brand-name drug or your doctor has indicated DAW (dispense as written) on the prescription.

Please remember that if you choose to purchase a brand-name drug that has a generic equivalent you will be charged your generic co-payment, plus the cost difference between the brand and generic.

Why do you contact my doctor about certain prescriptions?

Your Plan permits us to contact your doctor for a number of reasons. For instance, we may need to do so if a prescription is unclear or if a newly prescribed drug might put you at risk for an interaction with another medication you're taking. We also may need to contact your doctor because of a program that's part of your prescription drug benefit. For example, if your doctor prescribes a non-preferred drug when a plan-preferred drug is available we may ask him or her to consider a substitution. Or we may need to contact your doctor if your prescription requires a coverage review (see "Pricing and Coverage" above).

How do I use the automated phone system to speak directly to a Member Services representative?

If you wish to be connected directly with a representative when calling Member Services, do not respond when asked by the voice prompt to tell in a few words what you're calling about or press 0 to be connected with a representative.

LEGAL SERVICES PLAN FOR ACTIVE MEMBERS

How does the plan work?

Legal services are provided by: Fagenson & Puglisi, PLLC, Attorneys at Law, 450 Seventh Avenue-Suite 704, New York, New York 10123, Tel: (212) 268-2128 Fax: (212) 268-2127 (the "Law Firm")

If you need a lawyer for any of the services listed below call the Law Firm. This way, all contact is directly between you and the Law Firm and assures you of a confidential relationship with your lawyer.

What is the geographical area covered?

Legal benefits will be provided by this Plan for legal matters in the five boroughs comprising the City of New York and in Nassau, Suffolk, Westchester, Putnam, Dutchess, Rockland and Orange Counties. In the following counties in the state of New Jersey: Hudson, Bergen, Passaic (west to a line drawn between Riverdale and Oakland), Essex, Union, Middlesex, Mommouth and Ocean (south to a line drawn between Trenton and Toms River).

What does the plan cover?

The CWA Local 1181 Legal Services Plan covers the specific legal services described below:

Basic Benefits

The following benefits are considered "basic benefits" under the Plan:

- Preparation of a simple will, including a joint will with your spouse and one codicil (change) each calendar year. Trusts or continuing estates are not covered.
- Estate administration and proceedings.
- Pre-bankruptcy planning, the preparation and filing of a personal bankruptcy petition; bankruptcy proceedings and Chapter 13 wage earner individual payment plans.
- Adoption proceedings.
- Change of name.
- Real estate transactions involving the purchase, sale or lease of a one or two family dwelling used by you as your principal residence.

- Land purchased for principal residence.
- Landlord/tenant proceedings involving a tenant's personal residence.

Consumer transactions-which include:

Defense of claims or suits arising from your purchase of personal goods and services.

Claims or suits for automobile deficiency balances or deficiency balances for any repossessed merchandise.

Claims or suits seeking collection of unpaid balance under contracts of purchase or for services rendered.

Defense against all supplementary legal procedures if judgment is entered.

Prosecution of civil actions for damages. This does not include personal injury and property damages actions nor medical, dental or legal malpractice.

Defense of civil actions for damages. This does not include cases where you are entitled to be represented by an insurance company or other source. Defense of personal injury or property damage actions are not covered.

- Divorce, separation or annulment actions, including negotiations for a separation from your spouse (this coverage is not available to spouses of members, except where your spouse is also a member covered by the Fund)*
- Family Court proceedings, including prosecution or defense of actions that involve custody, maternity, paternity, nonsupport or modifications of those orders, child abuse and neglect and spousal abuse (this benefit is not available to the dependent(s) of a member)*
- All criminal matters and traffic offenses, defense of state violations and misdemeanor and felony crimes. You are covered for arraignment, arranging bail hearings, pre-trial motions and trial. Traffic offenses are defended only if conviction mandates loss or suspension of your license to drive. The Plan does not include (that is, you are NOT covered for) defense of federal crimes or violations. The Plan also does not include representation in connection with federal or state criminal investigation, subpoenaed and/or pre-indictment proceedings. It also does not include representation in connection with criminal matters arising out of your employment or otherwise involving alleged crimes against the City of New York. Family members are not covered for felony charges or trials.

- Criminal assault program including legal representation when a member has been assaulted while performing job related duties or criminal charges arising out of such assaults where a member is a misdemeanor criminal defendant. The Plan does not provide coverage to a member against whom a criminal complaint has been asserted by another member.

- Veterans affairs, including any problems that relate to your rights as a veteran.

- Consultation and preparation of documents, including legal advice by telephone (where in the judgment of the Law Firm, it is possible to do so) or in person on any problem of a legal nature and preparation of related simple documents.

*If both you and your spouse are members of Local 1181 and both file for these benefits, the first one of you to contact the Law Firm will be represented by that firm. The member who contacts the Law Firm second will be referred to an attorney from a different law firm, not affiliated with the Law Firm, from a panel of attorneys established to handle such conflict of interest situations. The attorney who provides legal services to the member who applies for the benefit second will receive legal services on the same prepaid basis as the spouse who contacts the Law Firm first.

What is not covered by the Plan?

The Local 1181 Legal Services Plan does NOT provide legal counsel for any business or commercial matters or for the following matters:

- Any employment related matters, including but not limited to disputes involving your employer (The City of New York), the Union, the Funds, the Plans or any affiliated bodies, officers, agents or attorneys, or any provider to the Funds.

- Class actions, interventions, amicus curiae filings, etc.

- Cases involving your business interests other than personal legal services. This includes, but is not limited to: partnerships, corporations and business or commercial ventures or transactions, including any legal services which would ordinarily be deductible under the Internal Revenue Code as a necessary expense of doing business.

- Any matter where services have previously been provided by another attorney or where the member is currently being represented by another attorney.

- Court actions which arise from an event that occurred before you became eligible for benefits from this Plan (or before the Plan became effective).

- Any proceeding against the Law Firm, the Funds, or the Fund's Trustees, counsel, or providers.
- Real estate matters involving other than your personal principal residence and on matters involving disputes with other tenants where the member or their dependents act as landlord.
- All court or administrative appeals.
- Preparation and filing of tax returns and appellate-administrative proceedings, litigation before the U.S. Court of Claims or other courts involving tax and other federal matters.
- Cases deemed by the Law Firm to be frivolous, without merit or brought for the purpose of harassments.
- Claims which can be handled in a Small Claims Court.
- Immigration proceedings.
- Claims for unemployment compensation.
- Cases which cannot be handled within the geographic area covered by the Plan.
- Matters related to admiralty, patents, trademarks and copyrights or the Federal Employer Liability Act.
- Any grievance or arbitration under a contract between the Union and the Employer.
- Worker's Compensation cases.
- Any matter not included in basic benefits.
- Cases in which your eligible dependents are charged with a felony offense and family court proceedings involving your dependents.

Other Special Rules

In addition to the coverage listed and the exclusions, there are certain rules which do not fall into either category. Please read this section carefully.

What if other coverage is available to you?

Depending on the nature of your legal problem, you may be eligible for free legal assistance from an insurance company, a government agency program, your employer or another party. If you are eligible for such assistance, the Plan provides only excess coverage. It does not duplicate the legal services available from the other source.

Who pays for court costs and related expenses?

You are responsible for all court costs and related expenses. These costs include the following whenever applicable:

Court and filing fees, fees for service of summons or other process, deposition and discovery costs, investigative expenses, traveling expenses outside of the five boroughs of NYC, mailing expenses, including certified, registered or express mail, etc. Federal Express, telegrams, messengers, copying and reproduction, publication expenses, long distance telephone, recording fees, translations, interpreters, penalties, fines or damages assessed by a court and other incidental expenses.

What about fines or penalties?

The Plan provides no coverage for the payment of any fines, penalties, judgments, damages or other monetary awards assessed against you by a court or governmental administrative agency or tribunal. These payments are your responsibility.

What if the court awards attorneys' fees as part of a settlement?

If you are awarded the fees of an attorney and costs as part of a court settlement, the Fund must be repaid from this award to the extent that it paid these fees and costs.

What if you are involved in a legal dispute with your dependents?

If you need legal help in a problem involving your spouse or your children, only you are entitled to representation by the Law Firm.

What if your dependent needing legal services is a minor?

If your minor dependent needs legal services legal services are provided only if you sign a form required by the Trustees at the time your minor dependent required benefits authorizing the Law Firm to proceed on behalf of your minor dependent. The required form is available upon request to the Fund Office.

What if you are involved in a legal dispute with another agent?

If you and another agent represented by Local 1181 are covered by this Plan and you are involved in a civil action against each other, legal representation is provided as follows:

- The first agent who goes to the Law Firm for legal assistance will be represented by an attorney from that firm.

- The other agent is entitled to representation by another attorney designated by Fund counsel on the same prepaid basis as the first agent requesting legal assistance.

Modification of benefits

The Trustees retain the right in their sole discretion to modify or discontinue any of the terms of the legal services benefit and to interpret the Plan. The terms of the Plan are always subject to and superceded by the terms of the Fund's contract with the legal services provider which is available in the Fund Office for your review.

LEGAL SERVICES FOR RETIRED MEMBERS

Legal benefits will be provided under this Plan by Fagenson & Puglisi, PLLC (the "Law Firm") for legal matters in the five (5) boroughs comprising the City of New York and in Nassau, Suffolk, Westchester, Putman, Dutchess, Rockland and Orange Counties. In the following counties in the State of New Jersey: Hudson, Bergen, Passaic (west to a line drawn between Riverdale and Oakland), Essex, Union, Middlesex, Monmouth and Ocean (south to a line drawn between Trenton and Toms River).

The following benefits are to be provided under the Plan to Retirees and their Dependents except as noted:

- Preparation of a simple will, including a joint will with your spouse and one codicil (change) each calendar year. Trusts or continuing estates are not covered.
- The purchase or sale of a primary residence (one or two family home)
- Defense of misdemeanors or criminal violations in state court
- Defense of housing court actions for tenants
- Chapter 7 bankruptcy filings
- Uncontested divorces

If a Retiree and his/her spouse are both Retirees from CWA Local 1181 and both file for these benefits, the first one to contact the Law Firm will be represented by the Law Firm. The Member who contacts the Law Firm second in a conflict situation will be referred to an attorney from a different law firm, not affiliated with the Law Firm, from a panel of attorneys established to handle such conflict of interest situations. The attorney who provides legal services to the Member who applies for the benefit second will receive legal services on the same prepaid basis as the member who contacted the Law Firm first.

The Law Firm is not to provide legal counsel for any business or commercial matters or for any matters not specified above.

If a Retiree is eligible for free legal assistance from an insurance company, a government agency program, their employer or another party, the Plan provides only excess coverage. It does not duplicate the legal services available from the other source.

The Retiree is responsible for all court costs and related expenses. These costs include the following whenever applicable:

Court and filing fees, fees for service of summons or other process, deposition and discovery costs, investigative expenses, traveling expenses outside of the five (5) boroughs of NYC, mailing expenses, including certified, registered or express mail, etc., Federal Express, telegrams, messengers, copying and reproduction, publication expenses, long distance telephone, recording fees, translations, interpreters, penalties, fines or damages assessed by a court and other incidental expenses.

The Plan provides no coverage for the payment of any fines, penalties, judgments, damages or other monetary awards assessed against Members by a court or governmental administrative agency or tribunal. These payments are the responsibility of the Retiree or Dependent, as applicable.

The Law Firm expressly reserves the right to decide which attorney handles a particular Eligible Participant's case. The Law Firm will maintain an office in the borough of Manhattan for the servicing and convenience of Eligible Participants.

YOUR ELIGIBLE DEPENDENTS

Your Eligible Dependents are:

1. your lawful spouse; and

2. each unmarried child under 19 years of age.

"Child" includes natural child, stepchild, legally adopted child, including any waiting period prior to the finalization of adoption and foster child, but only if such child is chiefly dependent upon you for support and maintenance.

If your unmarried child is chiefly dependent upon you for support and maintenance and is attending school or college as a full-time student, such child will continue to be eligible until the date he is no longer a full-time student, the date he marries, or the date he attains age 23, whichever is earlier.

Each claim for an age 19 to age 23 dependent student must be accompanied by a copy of the school bursar's receipt for the current semester.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

BASIC GROUP TERM LIFE INSURANCE

Please note: This is not a complete benefit comparison or a contract, and should only be viewed as a brief summary to assist you in understanding the benefit. A detailed benefits description, including limitations and exclusions, and claims and appeals is contained in the Certificate of Insurance. The terms, conditions, limits and exclusions shown in the Certificate of Insurance shall govern. Please visit www.asonet.com.

The Plan provides group term life insurance coverage for each Active and Retired members.

You may change your beneficiary at any time. To do so, you must contact the Plan Administrator for a new Life Insurance Beneficiary Designation Form. The change is effective only upon receipt of your fully completed life insurance beneficiary form.

If you die while insured for these benefits, the amount of your life benefits shown in the table below is payable to your beneficiary. Your beneficiary may choose to have this amount paid in a lump sum or in installments.

SCHEDULE OF BENEFITS

THE AMOUNT OF INSURANCE OF ANY PERSON SHALL BE BASED UPON THE FOLLOWING:

FORMS OF INSURANCE | **AMOUNT OF INSURANCE**

LIFE INSURANCE BENEFIT

CLASS

1	ACTIVE MEMBERS *(G-2147)*	$10,000.00
2	RETIREES (*GA-2147)*	$ 5,000.00

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

(Principal Sum)

CLASS

1 ACTIVE MEMBERS (*G-2147)* $10,000.00

When A Person First Becomes Eligible

A Person, who is in a Class of Eligible Persons on or after the Policy Effective Date, will be eligible for the insurance provided by the Policy on the later of the:

1. Policy Effective Date; or

2. first day of the calendar month which follows the date a Person becomes a member in good standing with the Policyholder provided he or she is in the active employ of a Participating Employer.

Effective Date of Person's Insurance

A Person's insurance will become effective on the date he or she is eligible. A retired Person will become insured on the date he or she retires.

Continuation of Eligibility

Once insured, a Person will continue to be eligible until he or she ceases to be a participant in the fund of the Policyholder.

When a Person's Insurance Terminates *(See Conversion Privilege)*

A Person's insurance under the Policy will terminate upon the earliest of:

1. the date the Policy terminates;

2. the date the Person is no longer in a Class of Eligible Persons under the Policy;

3. the date premium payments on behalf of the Person cease;

4. the date the Person fails to pay the required premium, if any, when due;

5. the date the Person enters into full-time active duty with the armed forces of any country; or

6. the date a Person ceases to be a member in good standing with the Policyholder.

Reinstatement of Insurance

If a Person's insurance terminates for any reason, he or she may again become eligible for the insurance by satisfying the requirement of eligibility as a new employee under the provision titled *When a Person First Becomes Eligible* in this Section of the Policy.

LIFE INSURANCE BENEFITS

PERSONS

The Life Insurance Benefit will be paid if a Person dies while insured under this benefit.

Benefit Determination

The amount of benefit to be paid will be the Amount of Insurance as shown in the **Schedule of Benefits** Section which is in force for the Person on the date of his or her death, subject to all the terms and conditions of the Policy.

Benefit Payment

The benefit will be paid to the Person's named Beneficiary, upon receipt of due proof of death, as provided in the **Claim Payment** Section.

Assignment of Benefits

A Person may not assign his or her Life Insurance Benefit under the Policy to any individual or entity.

BENEFICIARY

(Life Insurance and Accidental Death and Dismemberment Benefits)

For Persons

A Person's Beneficiary is the party or parties named by the Person, as shown on the Company's records, to receive the benefits payable under the Policy upon the Person's death. The Person may name one or more Beneficiaries to receive the death benefit.

The Person may change the Beneficiary at any time, without the consent of the previously named Beneficiary. Such change must be requested in writing on a form furnished by or satisfactory to the Company. Such change will take effect upon receipt of the signed form at the Executive Office of the Company.

Upon receipt of Satisfactory Proof of Claim, the Claims Administrator will pay the death benefit due under the Life Insurance and Accidental Death and Dismemberment Benefits to the Person's named Beneficiary as follows:

1. If the Person has named more than one Beneficiary, each surviving Beneficiary will share equally, unless otherwise indicated by the Person when the Beneficiaries were named.

2. If there is no named Beneficiary, or if no named Beneficiary is surviving at the time of death of the Person, payment will be made to the first surviving class in the following order of preference:

    a. the surviving spouse;

    b. the Person's children, in equal shares;

    c. the Person's parents, in equal shares;

    d. the Person's brothers and sisters, in equal shares; or

    e. the executors or administrators of the Person's estate.

In order to determine which class of individuals is entitled to the death benefit, the Claims Administrator may rely on an affidavit made by any individual listed above. If payment is made based on such affidavit, the Company will be reasonably discharged of its liability for the amount so paid, unless written notice of claim by another individual listed above is received before payment is made.

3. If the Beneficiary is a minor or someone not able to give a valid release for payment, the Claims Administrator will pay the benefit to his or her legal guardian. If there is no legal guardian, the Claims Administrator may pay the individual or institution who has, in its opinion, custody and principal support of such Beneficiary.

CONVERSION PRIVILEGE OF LIFE INSURANCE BENEFITS

If an individual's Life Insurance Benefit, or any portion thereof, terminates, he or she is entitled to convert all or a portion of the Amount of Insurance which has been terminated. This conversion will be to an individual policy of life insurance ("Conversion Policy"). The individual will not be required to submit proof of good health to convert.

Conversion Rights for Persons

Conversion Rights, upon Individual Termination or Class Change

If a Person's Life Insurance Benefit, or any portion thereof, terminates because he or she:

1. ceases to be an active full-time employee; or

2. ceases to be eligible under "Classes of Eligible Persons" appearing under PERSONS in the **Eligibility** Section; or

3. transfers from one Class of Eligible Persons to another, and the class to which he or she has transferred, offers lesser benefits; or

4. he or she retires;

he or she may convert up to the Amount of Insurance which terminated.

Conversion Rights Upon Individual Reduction due to Age or Retirement

If a Person's Life Insurance Benefit is reduced because of:

1. age;
2. retirement; or
3. amendment of the Policy;

he or she may convert up to the amount of the reduction.

Conversion Rights upon Policy or Class Termination

If a Person's Life Insurance Benefit terminates because the Policy:

1. terminates; or
2. is amended to terminate coverage for a Class of Eligible Persons under which the Person was insured;

he or she may convert to an amount that does not exceed the Amount of Life Insurance Benefits in effect for the Person on the date of termination. In the event of policy termination by the Company or Policyholder he or she may convert up to an amount that does not exceed the Amount of Life Insurance Benefits in effect for the Person on the date of termination less any amount for which he or she is or becomes eligible under the Policy or any other group policy (which replaces the Policy) within 31 days after the date of termination.

Notice of Conversion Privilege

The Policyholder must notify an individual of his or her right to convert. If the notice is not given 15 days but less than 90 days, before or after a terminating event, the individual will have an additional period in which to convert. The additional period will expire 45 days from the date he or she is notified, but in no event will the right to convert be extended more than 134 days beyond the date the individual's insurance terminated under the Policy. If the notice is not given within 90 days after the date the individual's insurance terminated under the Policy, the additional period will expire at the end of such 90 days. Written notice by the Policyholder presented to the individual, or mailed to his or her last known address, or written notice by the Company mailed to the individual at the last address furnished to the Company by the Policyholder, shall constitute notice for purposes of this provision.

Conversion Period

To qualify for a Conversion Policy, an individual must submit a written application to the Company and pay the first premium due within 31 days from the date his or her Life Insurance Benefit terminates under the Policy, unless an additional period in which to convert has been granted as shown in *Notice of Conversion Privilege* in this Section.

Conversion Policy

An individual who is eligible to convert is entitled to convert to any individual policy which is then being offered by the Company. However, the Conversion policy, may, at the Person's option, be preceded by preliminary term insurance of not more than one year.

Premium Rates

The premium rates for the Conversion Policy will be the Company's premium rates in effect for the amount and type of policy elected and based on the individual's class of risk and attained age (age nearest birthday at the date of issue of the Conversion Policy) on the effective date of the Conversion Policy.

Effective Date

The individual life insurance Conversion Policy will take effect on the later of the 31-day Conversion Period or the end of any additional period in which to convert that has been granted as shown in *Notice of Conversion Privilege* in this Section, provided the premium has been paid before the end of such period.

Death Within the Conversion Period

If an individual dies during the 31-day Conversion Period or any additional period in which to convert that has been granted as shown in *Notice of Conversion Privilege* in this Section, the maximum Amount of Insurance which he or she was entitled to convert under the Life Insurance Benefit will be paid as a benefit under the Policy, to the last Beneficiary named by the individual, whether or not conversion was applied for, and premium paid.

If a Conversion Policy was applied for, such Conversion Policy will be null and void even if the Conversion Policy had been issued; and no death claim will be payable under the Conversion Policy. The Company will return any premium paid for the Conversion Policy.

WAIVER OF PREMIUM (Persons Only)

A Person under the age of 60:

1. who becomes Totally Disabled while insured under the Policy;

2. who has been Totally Disabled for at least 9 months; and

3. for whom premium payments continue to be made; or whose coverage is terminated for failure to meet the Eligibility requirements stated in the Policy because of Total Disability;

may apply to continue his or her life insurance under this Waiver of Premium provision. The initial continuation of insurance under this provision will be for 12 months from the date premium payments on behalf of the Person cease but in no event longer than 24 months from the date Total Disability began; the date Total Disability began; or the date the application for waiver is approved; whichever occurs first.

Waiver of Premium will continue until the earlier of:

1. the date the Person's Total Disability ends; or

2. the end of the 12-month period.

"Totally Disabled" and "Total Disability" mean the Person's complete inability; due to Injury or Illness; to engage in any business; occupation or employment; even on a part-time basis; for which the Person is qualified; or becomes qualified by reason of education; training; or experience; for pay; profit; or compensation.

The Person must submit satisfactory written proof (the "Initial Proof") of Total Disability within 12 months from the date the premium payments on behalf of such Person cease; but in no event more than 24 months from the date Totally Disability began.

The Initial Proof must show that the Total Disability:

1. began while the Person was insured under the Policy;

2. began before the attainment of age 60; and

3. has rendered the Person Totally Disabled for at least 9 consecutive months.

Notice of Application for Waiver Determination

The Company will give written notice to the applicant within 10 days of receipt of an application for waiver. The notice will state whether or not the application is approved; and give the reasons for any disapproval. If

the application for waiver is disapproved, the Person may continue eligibility under the Policy for Life Insurance only if the Policyholder continues the Person on a premium-paying basis.

A Person who is denied continuation of his or her group Life Insurance through Waiver of Premium and:

1. is not continued by the Policyholder on a premium-paying basis; or

2. did not exercise his or her right to convert to an individual policy of life insurance;

will be entitled to the same conversion rights that applied to the Person on the date his or her Life Insurance would have terminated in the absence of this Waiver of Premium provision.

A Person who holds an individual conversion policy and who has been denied continuation of his or her group Life Insurance through Waiver of Premium, may continue his or her coverage under the individual conversion policy.

Death of Person Before or While Waiver of Premium is in Effect

If a Person applies for waiver under this provision and dies before this Waiver of Premium is in effect, the Beneficiary must submit written proof that Total Disability continued without interruption from the date the Person became Totally Disabled to the date of death. Except that if at the time of death, Life Insurance on the Person has been continued on a premium paying basis, the Amount of Insurance in force under the Policy will be paid to the beneficiary, subject to the all the terms and conditions of the Policy.

If a Person dies while this Waiver of Premium is in effect, the Beneficiary must submit written proof that Total Disability continued without interruption from the last anniversary of the Company's receipt of Initial Proof to the date of death.

Benefit Amount

The amount of Life Insurance continued under this Waiver of Premium, will be the Amount of Insurance in force on the date the premium payments on behalf of such person ceased; he or she became Totally Disabled; or the date waiver was approved, whichever occurred first. The amount of Life Insurance continued under this Waiver of Premium is subject to any reduction or termination in the Amount of Insurance, as shown on the Schedule of Benefits.

Any Person who:

1. is approved for waiver under this provision; and

2. holds an individual policy of life insurance through exercise of the Conversion Privilege under the Policy;

is not entitled to receive benefits under both the Policy and the individual conversion policy for the same amounts of insurance. At the time of the Person's death, payment will be made under the Policy only if the individual policy is surrendered to the Company without claim other than for return of the premiums paid, less dividends.

Continuance of Waiver of Premium

A Person who has applied for and received approval of Waiver of Premium for the Life Insurance Benefit under the Policy, may continue the Waiver of Premium for additional 12-month periods; provided the Person:

1. remains Totally Disabled; and

2. submits written proof of continued Total Disability each year within 3 months of the anniversary of the Company's receipt of Initial Proof. Such proof must be sent to the Company at the Person's own initiative; the Company shall not be required to request such proof.

Right to Require Examination

The Company has the right to have the Person examined at its own expense, by a Doctor of its choice, at any reasonable time during the course of the Person's Total Disability. However, the Company will not require such an examination more than once a year after the Person's insurance has been continued for at least 2 full years under this provision.

Conversion Privilege

A Person, whose Life Insurance was continued by this Waiver of Premium, may be entitled to the same conversion rights that applied to the Person on the date his or her Life Insurance would have terminated in the absence of this Waiver of Premium provision.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Upon receipt of due proof of loss, the Accidental Death and Dismemberment Benefit will be paid if:

1. a Person, while insured under this benefit, suffers an accidental Injury; and

2. as the direct result of the accident, and independent of all other causes, the Person suffers a Covered Loss within 90 days after the accident.

A “Covered Loss” means permanent loss of:

1. life; or
2. a hand, by complete severance at or above the wrist joint;
3. a foot, by complete severance at or above the ankle joint;
4. an eye, involving irrecoverable and complete loss of sight in the eye;

except as excluded under *Exclusions* in this Section, and subject to all the terms and conditions of the Policy. The amount of benefit to be paid for a Covered Loss is determined as follows:

SCHEDULE OF LOSSES

FOR LOSS OF:	**THE BENEFIT IS:**
LIFE	THE PRINCIPAL SUM
TWO HANDS	THE PRINCIPAL SUM
TWO FEET	THE PRINCIPAL SUM
SIGHT OF TWO EYES	THE PRINCIPAL SUM
ONE HAND AND ONE FOOT	THE PRINCIPAL SUM
ONE HAND AND SIGHT OF ONE EYE	THE PRINCIPAL SUM
ONE FOOT AND SIGHT OF ONE EYE	THE PRINCIPAL SUM
ONE HAND OR ONE FOOT	ONE-HALF THE PRINCIPAL SUM
SIGHT OF ONE EYE	ONE-HALF THE PRINCIPAL SUM

If the Person suffers more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

Exclusions

No benefit will be paid for any loss that is caused directly or indirectly, or in whole or in part, by any of the following:

1. bodily or mental Illness or disease of any kind;
2. ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);

3. suicide or attempted suicide;
4. intentional self-inflicted Injury;
5. participation in a felony, or a riot;
6. war or act of war, declared or undeclared; or any act related to war, or insurrection;
7. service in the Armed Forces or units auxiliary to the Armed Forces; or
8. police duty as a member of any military, naval or air organization.

CLAIM PAYMENT PROVISIONS

LIFE INSURANCE

Proof of Claim

Satisfactory Proof of Claim will include a certified copy of the individual's death certificate and any other data that the Claims Administrator may require to establish the validity of the claim.

Facility of Payment

If an individual appears to the Claims Administrator to be equitably entitled to compensation because he or she has incurred expenses on behalf of the Person's burial, the Claims Administrator may pay to such individual the expenses incurred up to $500. Such payment, however, shall not exceed the amount due under the Policy. The Company will be fully discharged of its liability for any amount of benefit so paid in good faith.

Mode of Payment

Death benefit proceeds will be paid to the Beneficiary in one lump sum, unless the Person has elected to have the proceeds paid in installments under an optional plan that is then being offered by the Company. Details of such optional plans are available on request from the Company. If the Person does not elect an optional plan for payment of death benefit proceeds, the Beneficiary may do so after the Person's death.

Maximum Payment of Benefits

The total benefit payable under the Policy for Life Insurance will never exceed the Amount of Insurance shown in the **Schedule of Benefits** Section. In no event will payment be made under more than one of the following Life Insurance provisions:

1. Life Insurance Benefit;

2. Waiver of Premium; or

3. Conversion Privilege.

ACCIDENT AND HEALTH INSURANCE

Notice and Claim Forms

In order to receive a claim form for filing a claim, written notice of a claim must be given to the Claims Administrator within 90 days after the date of a loss which is covered under the Policy. Otherwise, the Claims Administrator must be notified as soon as it is reasonably possible to do so. If claim forms are available from the Policyholder, written notice of a claim is not required in order to receive a claim form.

Upon receipt of the written notice of claim, the Claims Administrator or Policyholder will provide claim forms for filing proof, to the Person making a claim. If the Person does not receive the claim forms within 15 days after he or she sent notice of a claim, the Person can file a claim without a claim form by sending the Claims Administrator written proof of claim which includes the information required under *Proof of Loss* as described below.

Proof of Loss

Proof of the loss for which a claim is made must be given to the Claims Administrator no later than 90 days after the date of loss, except for a claim for Loss of Time for disability which must be given no later than 30 days after the commencement of the period for which the Company is liable, and that subsequent written proofs of the continuation of such disability must be furnished to the Claim Administrator at such intervals as the Company may reasonably require. A claim will not be reduced or denied for failure to provide proof within this time, if it is shown that it was not reasonably possible to furnish proof, and that proof was provided as soon as it was reasonably possible.

The proof of the loss must include all information necessary for the Claims Administrator to determine the:

1. nature of the loss; and

2. date of the loss.

The Claims Administrator may require, as part of the proof, authorization to obtain medical and non-medical information. The Claims Administrator will notify the Person of any additional information required to process a claim.

Payment of Claims

Benefits that are payable under the Policy will be paid within 60 days as soon as the Claim Administrator receives satisfactory proof of the claim.

For a covered loss, benefits shall be paid directly to the Person. In case of loss of life, benefits will be made to the Person's beneficiary.

Right to Examination and Autopsy

The Claims Administrator, at its own expense, has the right to have:

1. the Person whose claim is pending examined, by a Doctor of its choice; and

2. an autopsy performed, if it is not prohibited by law.

Legal Actions

A claimant, or the claimant's authorized representative cannot start any legal action with respect to a claim:

1. until 60 days after proof of claim, as required above, has been given; nor

2. more than 3 years after the time proof of claim is required.

The Policy

The Policy, its amendments and endorsements, the Policyholder's application, a copy of which is attached, and any individual applications for Persons, form the entire contract between the Company and the Policyholder.

The rights of the Policyholder, or of any Person, or beneficiary thereunder will not be affected by any provision other than one contained in the Policy, or the riders or endorsements thereon or in the amendments thereto signed by the Policyholder and the Company, or in the copy of the Policyholder's application attached to the policy or in the individual statements, if any, submitted in connection therewith.

Statements; Incontestability of Insurance

All statements made by a Person are considered to be representations and not warranties. No such statements may be used to contest the validity of the Policy, or a Person's insurability unless:

1. it is in writing and signed by the Person; and

2. a copy of the statement is given to the Person or his or her Beneficiary.

The Policy will not be contested after it has been in force for 2 years from the date of issue, except for non-payment of premiums.

A Person's insurance, for which proof of good health was required, will not be contested after such insurance has been in force for 2 years during his or her lifetime except for non-payment of premiums.

New Entrants

Eligible new individuals may be added from time to time, to the group or class of individuals originally insured, in accordance with the terms and conditions of the Policy.

Clerical Error

If a clerical error is made with respect to individuals insured under the Policy, such error will not:

1. terminate a Person's insurance that would otherwise remain in force; or

2. continue insurance on an individual that would otherwise be terminated. Upon discovery of a clerical error, an adjustment may be made to the premium.

Misstatement of Age

If the age of a Person has been misstated, the Company will use the Person's true age to determine:

1. the effective date or termination date of the Person's insurance under the Policy;

2. the amount of insurance; and

3. any other rights or benefits affected by age.

Based on true age, the Company may make an adjustment to the premiums, the benefits, or both.

Conformity with State Statutes

Any provision of the Policy that is in conflict with the laws of the state in which the Policy is delivered, or issued for delivery, is amended to conform to the minimum requirements of those laws.

Defined terms are shown in the Policy with an initial capital letter. The following definitions apply to these terms when used in the Policy, unless otherwise defined where such term is used.

Claims Administrator: The entity assigned to pay claims in accordance with the terms and conditions of the Policy. The Claims Administrator may be the Company, the Policyholder, or a third party with whom the Company or the Policyholder has a valid contract to pay claims.

Company: The Union Labor Life Insurance Company, 8403 Colesville Road, Silver Spring, MD 20910.

Doctor: An individual licensed as a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.). The term "Doctor" shall also include any licensed or certified health care provider as required by state law, for services which are within the scope of the health care provider's license or certificate.

Illness: A disorder or disease of the body or mind. Illness shall include: (a) pregnancy; (b) childbirth; and (c) related medical conditions.

Injury: Bodily harm that: (a) the Person sustains while this benefit is in force; and (b) is not the result of an Illness.

Officer of the Company: The Chairman, Chief Executive Officer, President, a Vice President, the Secretary or Assistant Secretary of the Company.

Person: An employee and/or member of a Participating Employer who is insured under the Policy and in a Class of Eligible Persons.

Policy: The contract, the application, and any subsequent amendment that the Company issues to the Policyholder.