COMMUNICATION WORKERS OF AMERICA
LOCAL 1182 SECURITY BENEFITS FUND

Active Benefits Plan

Dear Member,

We are pleased to provide you with this benefits handbook that describes all the benefits provided to you through the Communication Workers of America, Local 1182 Security Benefits Fund.

The Security Benefits Fund offers benefits to all active and retired participants and their eligible dependents which supplements their benefits as an employee of The City of New York. Benefits available to active participants and their eligible dependents are:

- Dental
- Optical
- Prescription Drugs
- Prepaid Legal

In addition, active member **only** are entitled to:

- Life Insurance
- Accident and Sickness Benefits
- Accidental Death and Dismemberment Coverage

This contains the details of all these benefits. However, this is not an insurance or provider contract. The full text of the insurance contracts and provider contracts entered into by the Trustees specify the exact benefits provided by the Fund and supersedes any inconsistent provision which may be set forth in this handbook.

We suggest that you read this carefully, that you share it with your family. We are happy to provide these benefits for you and where applicable, your eligible dependents.

If you have any questions, do not hesitate to contact the Fund office.

Sincerely,
The Board of Trustees

Syed Rahim
William Gallagher
Donna Ellaby
Nicholas Zimmitti
Albert Sloh
Olufemi Sokumbi
Theresa Ferzola

COMMUNICATION WORKERS OF AMERICA LOCAL 1182 SECURITY BENEFITS FUND

58-38 69th street, 2 Front
Maspeth, New York 11378
(718) 268-6373
FAX (718) 793-4220

THE BOARD OF TRUSTEES
SYED RAHIM
WILLIAM GALLAGHER
DONNA ELLABY
NICHOLAS ZIMMITTI
ALBERT SLOH
OLUFEMI SOKUMBI
THERESA FERZOLA

ADMINISTRATOR
THERESA FERZOLA

FUNDS' COUNSEL
BARNES, IACCARINO & SHEPHERD, LLP

FUNDS' AUDITOR
GOULD KOBRICK & SCHLAPP, P.C.
STEVEN SCHLAPP, CPA

GENERAL PROVISIONS

INTRODUCTION

The Security Benefits Fund described in this book is administered by the Board of Trustees. The plan Administrator's duties are the control and administration of the Plan and the interpretation and implementation of the Plan's provisions. The benefits provided by this Fund may, from time to time, be changed, modified, augmented or discontinued by the Board of Trustees. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions are subject to such rules and regulations and to the Trust Agreement that established the Fund and governs its operations. Benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees. The Trustees may expand, modify or cancel the benefits for active members and retirees; change eligibility requirements; and otherwise exercise their prudent discretion at any time without legal right or recourse by an active member, retiree, or any other person. Every effort has been made to present this information in clear, straightforward language.

All contributions to these plans are made solely by The City of New York according to its collective bargaining agreements with The Communications Workers of America, on behalf of Local 1182.

How Do You Enroll

In order to become eligible for coverage you must enroll with the Fund office by completing and signing a Security Benefits Fund registration card. You will be required to submit copies of marriage and birth certificates when enrolling your dependents, or other such documentation as requested by the Fund. When any change occurs in your status; such as marriage, divorce, change of address, birth or death of eligible dependent, please **notify the Fund office**. It is extremely important that any change in your work status (i.e., leave of absence maturity leave or return to work) be reported to this office by you.

When Does Coverage Start

There is a 60 day waiting period for all new employees. Your coverage starts 60 days after the first day you start working for the City of New York in the jurisdiction of Local 1182, provided that you have enrolled with the Fund office.

Benefits are provided from The Funds' assets which are accumulated under the provisions of the Agreements and the Trust Agreements, and are held in the trust funds for the purpose of providing benefits to covered participants and eligible dependents and defraying reasonable administration expenses. Some of the benefits are provided through insurance policies.

Who is Eligible
You are eligible for coverage if you work for the City of New York in the jurisdiction of the Communication Workers of America Local 1182, provided that you comply with eligibility requirements established by this Plan. You will also remain eligible for certain benefits if you are receiving a monthly pension from The New York City Employees Retirement System (NYCERS) and you worked in the jurisdiction of Local 1182 immediately prior to your retirement. The benefits continued for such pensioners are:

- Dental
- Optical
- Prescription Drugs
- Life Insurance
- Limited Prepaid Legal

Who Are Eligible Dependents
Your eligible dependents include your spouse and your unmarried children. Your unmarried children are covered until December 31th of the year in which they turn 19. Dependent children include your natural children, step-children, adopted children and any child for whom you have legal custody or guardianship.

The active and retired members **must** provide the Fund office with copies of the legal documents granting child custody or adoption. Without these documents, your child will not be able to receive benefits from the Fund.

In order for your overage dependents (19-26) to continue to be eligible for benefits, active and retired participants must complete an overage dependent affidavit form and mail it along with a copy of the child's Birth Certificate for each eligible child. The child will not be eligible if he/she is covered under another insurance.

If your child cannot support him/herself because of a physical or mental disability you must submit proof of your dependent child's incapacity to the Fund Office within 31 days after the date he/she attains the age at which his/her coverage would otherwise terminate. Proof of continued incapacity must be furnished to the Fund from time to time at its request.

Your covered dependents are only eligible for the following benefits:

- Legal
- Dental
- Prescription Drugs
- Optical
    Dependent children – every year
    Spouse or domestic partner – every other year.

Domestic Partners/ Same Sex Marriage Coverage
The benefits under Local 1182 Security Benefits Fund available to domestic partners are identical to the health benefits offered to spouses. Benefits are available only to those who have qualified and been certified as domestic partners by the City of New York and eligible to receive basic health plan coverage. Employees and retirees who meet the requirements for domestic partnership and register with The City of New York will receive a letter from NYC Office of Labor Relations certifying your domestic partner for health benefits, a copy of this letter & your health ID card is needed by the Fund Office.

The value of the Funds welfare benefits will be taxable income for you and will be reported on your statement of earnings by your employer.

If you have any questions you can call the City's Domestic Partnership Liaison at 212-306-7336 (actives) or 212-513-0470 (retirees).

When Does Your Eligible Dependents' Coverage Start
Coverage for your dependents starts on the date when the member or retired member provides the Fund office with the legal documents proving that they are your dependents.

When Does Coverage End
Coverage for you and your eligible dependents ends on the day you leave employment in the jurisdiction of Local 1182. You are considered to have left employment when you are in no-pay status, regardless of whether you quit, are discharged, suspended or take a leave of absence. In all of these cases, the date you leave employment is the last date for which you are paid.

If you worked in the jurisdiction of Local 1182 immediately prior to your retirement, coverage for dental, prescription drugs, optical and life insurance continues for retired participants and their eligible dependents for as long as the retired participant receives a monthly pension from the New York City Employee's Retirement System (NYCERS).

CONTINUATION OF HEALTH CARE COVERAGE UNDER "COBRA"

INTRODUCTION

The right to elect COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are described below. After a qualifying event, COBRA continuation coverage is offered to each person who is a “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the coverage.

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because any of the following qualifying events occur:

(1) Your hours of employment are reduced; or
(2) Your employment ends for any reason other than your gross misconduct.

As an alternative to COBRA continuation coverage, you and your spouse may be eligible to elect coverage in the Plan’s Retiree Benefit Plan, described below. Please note that if you elect to receive benefits under the Retiree Benefit Plan you or your spouse may not thereafter elect COBRA coverage. Contact the Fund Office for details on this program.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occur:

(1) Your spouse dies;
(2) Your spouse’s hours of employment are reduced;
(3) Your spouse’s employment ends for any reason other than his or her gross misconduct; or
(4) You become divorced or legally separated from your spouse.

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

(1) The parent-employee dies;
(2) The parent-employee’s hours of employment are reduced;
(3) The parent-employee’s employment ends for any reason other than gross misconduct;
(4) The parent become divorced or legally separated; or
(5) The child stops being eligible for coverage under the Plan as a “dependent child.”

Children who are born to or placed for adoption with a covered employee during the period of the employee’s continuation coverage also are qualified beneficiaries entitled to COBRA continuation coverage. Once the newborn or adopted child is enrolled in continuation coverage pursuant to the Plan’s rules, the child will be treated like all other 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 child's birth or adoption).

Sometimes, filling a bankruptcy under Title 11 of the United States Code can be a qualifying event. If a bankruptcy proceeding is filed with regard to your employer and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, then the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse or surviving spouse will also be qualified beneficiaries if the bankruptcy results in the bankruptcy results in the loss of their health coverage under the Plan.

Notice of COBRA Qualifying Event and Electing COBRA Coverage

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction in hours of employment, the death of the employee or the commencement of a bankruptcy proceeding with respect to the employer, your employer must notify the Fund Office within 30 days of the qualifying events.

For all other qualifying events (i.e., divorce or legal separation of the employee and spouse, or a dependent child losing eligibility for coverage as a dependent child), you (or your family member) must notify the Fund Office, in writing, within 60 days after the later of the date the qualifying event occurs or the date of the loss of coverage due to the qualifying event. Written notices should be sent to the Fund Office. When notifying the Fund Office of a divorce or legal separation, you must provide the Fund Office with documentation of such divorce or legal separation, as well as the address and contact information for your spouse. When notifying the Fund Office of a child who is no longer eligible to receive Plan benefits, you must provide the Fund Office with the address and contact information for your child. The employee or family member can provide notice on behalf of themselves as well as other family members affected by the qualifying event.

Qualified beneficiaries have 60 days from the *later* of (i) the date of the loss of coverage because of the qualifying event, or (ii) the date of the notice of the right to elect COBRA continuation coverage. For each qualified beneficiary who elects COBRA coverage, coverage will begin on the date of the qualifying event or, if later, the date the Plan coverage would otherwise have been lost (although the maximum period of COBRA coverage will be computed from the date of the qualifying event). In order to elect COBRA coverage, qualified beneficiaries must timely return the Plan's Election form to the Fund Office.

How is COBRA Coverage Provided?

Once the Fund Office is notified that a qualifying event has occurred, COBRA continuation coverage will be offed to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect

COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

If you (or another qualified beneficiary) timely elect (and pay for) continuation coverage, you (and/or the qualified beneficiary, as applicable) are entitled to be provided with coverage that is identical to the coverage being provided under the Plan to similarly situated employees (or their family members). If coverage for similarly situated covered persons is modified after COBRA coverage has been elected, your COBRA coverage will be modified accordingly. **If continuation coverage is not timely elected (and paid for), group health coverage under the Plan will end.**

If the Fund Office receives notice from an individual that he or she has experienced a COBRA qualifying event and the Fund Office determines that the individual is not entitled to continuation coverage, the Fund Office will notify the individual that continuation coverage is not available. The notice will include an explanation as to why continuation coverage is not available, and it will be provided within 14 days of receipt of notice that a qualifying event may have occurred.

How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a depended child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or a reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for up to a total of 18 months. However, if the qualifying event is the end of employment or a reduction of the employee's hours of employment, and the employee enrolled in Medicare less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare enrollment. For example, if a covered employee enrolled in Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare enrollment, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

However, there are two ways in which an 18-months period of COBRA continuation coverage can be extended.

(1) <u>Disability Extension of 18-month Period of Continuation Coverage</u>

In you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Fund Office in a timely fashion, you an your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have

started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You are required to notify the Fund Office, in writing, within 60 days of the latest of: (i) the date of the disability determination by the Social Security Administration; (ii) the date of the initial qualifying event; or (iii) the date of the loss of coverage due to the initial qualifying event, and notice must be provided before the end of the initial 18-month COBRA continuation period. You must provide to the Fund Office a copy of the disability determination by the Social Security Administration.

(2) Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child.

You must notify the Fund Office in writing within 60 days after a second qualifying event occurs if you want to extend your continuation coverage. The notice must include the covered employee's name, the type of second qualifying event, the date on which the event occurred, and the name(s) of the qualified beneficiary(ies) whose coverage may be extended due to the second qualifying event. In addition, you must include with the notice a copy of the employee's death certificate, divorce decree, proof of legal separation, or a copy of the child's birth certificate or other appropriate proof, as applicable depending on the event.

Types of Coverage

Only the following Fund benefits may be elected for COBRA continuation:

Core Plus Coverage: prescription, dental, and vision coverage
Core: Rx only

None of the other benefits provided under the Plan, such as the death and prepaid legal benefits, are available through COBRA continuation Coverage.

Paying COBRA Premiums

Generally, each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount that you and other qualified beneficiaries will need to pay will be 102

percent of the cost to the group health plan for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent).

The monthly premium rates may be adjusted due to changes in coverage. Even in the absence of any changes in coverage, premiums charged for continuation coverage may change on a yearly basis or as otherwise permitted by applicable law. After you or your family members experience a qualifying event, you will receive an election form that notifies you of the actual premium that will apply.

If you (or another qualified beneficiary) elect COBRA continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first premium payment for continuation coverage no later than 45 days after the date of your election. (This means 45 days after the date that your Election Form is post-marked, if mailed). If you (or another qualified beneficiary) do not make your first premium payment within this 45-day period, you (or the qualified beneficiary, as applicable) will lose all rights to COBRA continuation coverage under the Plan and your coverage will terminate (as of the date it would otherwise terminate under the Plan).

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Payment is due on the first day of the month for which the payment applies. That means that the payment for coverage for the month of June is due on June 1. You must pay the required monthly payments on time.

Although periodic payments are due on the dates described above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, you coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan and your coverage will terminate as of the last date for which you made a timely payment.

Early Termination of Continuation Coverage

The law provides that continuation coverage may be cut short prior to the expiration of the applicable 18, 29 or 36 month period for any of the following five reasons:

(1) The group health coverage provided to you is terminated (and the plan sponsor is not required by COBRA to provide you with other group health coverage that is maintains, if any);
(2) The premium for continuation coverage is not timely paid (within the applicable grace period);
(3) The individual first becomes, after electing COBRA coverage, covered under another group health plan (as an employee or otherwise) that does not contain any preexisting condition exclusion or limitation applicable to the individual;
(4) The individual becomes enrolled in Medicare (under Part D) after electing COBRA coverage; or
(5) Coverage has been extended for up to 29 months due to disability and there has been a final determination by the Social Security Administration that the individual is no longer disabled. In this case, coverage will end as of the month that begins more than 30 days after the date of such final determination. You are required to notify the Fund Office in writing within 30 days of any such final determination.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If a participant and his/her eligible dependents choose a dentist who does not participate (does not have a signed contract) in our plan, the participant may be required to pay the full bill directly to the dentist and then the participant will be reimbursed according to the our fee schedule. Your dental claims must be received no later than 90 days after treatment is completed. If your dentist is mailing the claim for you make sure they are aware of the time frame to submit a claim and that abide by it. If you use an out-of-network dentist, we suggest that you always ask what the charge will be for the work before it is started.

OPTICAL BENEFITS

Your optical benefits are provided by the Security Benefits Fund through **General Vision Services (GVS)**. Participants and their eligible dependent children are entitled to optical benefits once every 12 months. Eligible spouses are entitled to the benefit once every 24 months. The voucher is worth between $150 - $200 depending on the store. It includes a comprehensive eye exam, frames and prescription lenses. Regular contact lenses can be received instead of glasses. Any charges over the $150 - $200 will be the patients' responsibility.

Please see the GVS Brochure at http://www.cwalocal1182sbf.org

DENTAL BENEFITS

Your dental benefits are provided directly by The Security Benefits Fund and administered by

Sele-Dent, Inc,
One Huntington Quadrangle
Suite 1N09
Melville, New York 11747

There is a $1500 Cap for each family member from January – December
You may obtain a Sele-Dent provider from either their web site www.Sele-dent.com or 800-520-3368.

Every one of these providers must accept our fee schedule as their full payment, therefore, when you use one of these dental providers there will be no out-of-pocket expense unless you exceed your cap of $1500 per person for each calendar year or agree to a non covered procedure (see the following for more information).

Whether you are a retiree or active member and you choose to use a non-panel dentist, you or your provider will be reimbursed at the panel schedule; however, you may still be responsible for the balance bill. Make sure to speak with your dentist and understand the billing process before you start any work. All dental forms are accepted so you are not responsible for bringing one with you.

The orthodontic (braces) lifetime maximum for eligible dependent children age 9-18 is $1000. Sele-Dent, Inc. has various Board Certified Orthodontists who will complete orthodontic cases for a total of $2,400 to $3,300. For a list of these preferred orthodontic locations please visit www.Sele-dent.com

Please note that each member and each eligible dependent is allowed one panoramic x-ray once every year. A full oral examination, full x-ray series and full cleaning is allowed once every six months. Full dentures are allowed to be replaced once every five years. Partial dentures or fixed bridges are allowed to be replaced once every three years. All procedures over $400 must be pre-authorized before any work can be done.

If you choose a dentist who does not participate (does not have a signed contract) in our plan, you may be required to pay the full bill directly to the dentist and then you will be reimbursed according to our fee schedule. Your dental claim must be received no later than 90 days after the dates of service.

If your dentist's office is mailing the claim form for you, make sure they are aware of the time frame and abide by it for you.

If you use an out-of-network dentist, we suggest you always ask what charges will be before any work begins.

DENTAL CARE PROGRAM

(Partial Listing)

	Patient Co-Payment
DIAGNOSTIC & PREVENTIVE SERVICES	
Full mouth x-ray	No Charge
Single Films (periapicals or bitewing)	No Charge
Bitewing Series	No Charge
Oral Examination	No Charge
Treatment in case of dental emergency	No Charge
Cleaning of Teeth	No Charge
Panorex X-Rays	No Charge
Space Maintainers	No Charge
Fluoride Treatments	No Charge
RESTORATIVE DENTISTRY	
Silver amalgam, one surface	No Charge
Silver amalgam, two surface	No Charge
Silver amalgam, three surfaces or more	No Charge
Composite filling, one surface	No Charge
Composite filling, two surface	No Charge
Composite filling, three surface or more	No Charge
ROOT CANAL THERAPY	
Pulp Capping Direct	No Charge
Pulpotomy	No Charge
Root Therapy - one canal	No Charge
Root Therapy - two canal	No Charge
Root Therapy - three canals	No Charge
Apicoectomy (anterior)	No Charge
PROSTHETICS CROWNS	
Full Cast Crown	No Charge
Porcelain Crown	No Charge
Porcelain with metal Crown	No Charge
Cast Post	No Charge
Recommendation, per crown	No Charge
PROSTHETICS FIXED BRIDGES	
Porcelain Crown or Pontic, per unit	No Charge
Porcelain with metal Crown or Pontic, per unit	No Charge
Recommendation, bridge	No Charge
PROSTHETICS REMOVABLE	
Full upper or lower denture, w/ adjustments	No Charge
Partial upper or lower denture, cast chrome	No Charge
Denture adjustments	No Charge
Broken Body of Denture	No Charge
Replacement of Broken/Missing Teeth	No Charge
Denture Relines & Rebasing	No Charge
PERIODONTICS	
Perio Scaling per quad	No Charge
Gingivectomy, per quad	No Charge
Perio Surgery per quad	No Charge
ORAL SURGERY	
Routine Extraction - per tooth	No Charge
Surgical Extraction	No Charge
Soft Tissue Impactions	No Charge
Boney Impactions	No Charge
Alveotectomy, one quadrant	No Charge
Cyst Removal	No Charge
General Anesthesia	No Charge
Tissue Biopsy	No Charge
Incision and Drainage	No Charge

Every one of these providers must accept our fee schedule as their full payment, therefore, when you use on of these dental providers there will be no out-of-pocket expense unless you exceed your cap of $1,500 per person for each calendar year or agree to a non covered procedure (see the following pages for more information).

Whether you are a retiree or active member and you choose to use a non-panel dentist, you or your provider will be reimbursed at the panel schedule; however, you may still be responsible for the balance bill. Make sure to speak with your dentist and understand the billing process before you start any work. All dental forms are accepted so you are not responsible for bringing one with you.

The orthodontic (braces) lifetime maximum for eligible dependent children ages 9-18 is currently $1000. Sele-Dent, Inc. has various Board Certified Orthodontists who will complete orthodontic cases for a total of $2,400 to $3,300. Attached is a list of these preferred orthodontic locations.

Please note that each member and each eligible dependent is allowed one panoramic x-ray once every year and a full oral examination, full x-ray series and full cleaning once every six months. Full and partial dentures or fixed bridges are allowed to be replaced once every five years. All procedures over $400 must be pre-authorized before any work can be done.

PRESCRIPTION DRUG BENEFIT

Your prescription drug benefit is provided by the Fund through EmpiRx.

How The Plan Works

As proof of eligibility for prescription drugs, participants will receive an identification card. Only the member's name will appear, however, all eligible dependents will be active in the EmpiRx system. This card must be presented with your prescriptions. You will be required to pay a co-payment for each prescription received.

1) The Fund will pay the first $3,500.00 for covered prescriptions for you and your eligible dependents. The co-payments are listed below.
2) When The Fund has paid $3,500.00 for you and/or your eligible dependents and you are still in need of prescription medicine, you will have an out-of-pocket expense of $12,700.00 for family coverage or $6,350.00 for member only coverage. (including co-payments)
3) You will be responsible for keeping track of the receipts as proof that you have met the out-of-pocket total. Each pharmacy receipt must contain: name of member (with last 4 digits of your SS#), name of patient (if different), Rx number and amount of payment. After you have reached the out of pocket total amount, mail all necessary paperwork (we suggest you sent it certified or bring it in person) to our office.
4) If everything is in place, you will again be eligible for your prescriptions to be covered in full by The Fund for the remainder of that calendar year. Normal copays will apply.

$1.00 for every generic prescription you receive
$15.00 for every brand prescription you receive
$40.00 per prescription, when you receive a **brand when there is a generic available.**

What The Program Covers

This program covers all medications which, by federal or state law, require a prescription and are prescribed by a licensed practitioner.

Prescriptions can be written by your physician for up to a 34 day supply plus 3 refills. All refills will be dispensed according to your doctor's directions.

If you go to a non-participating pharmacist you can receive a partial reimbursement for your prescription. However, you must pay for the prescription when filled and then ask for a direct Reimbursement Claim form from the Fund Office. You must have a separate form for each prescription. After you complete the form, mail it to the EmpiRx. You will be reimbursed according to the fee schedule, **not** what you paid the pharmacy. You are always responsible for the co-payment.

If you have any questions about your claims, call the Fund Office.

What is not Covered

Under this program, no benefits are paid for:

- Medications for which you don't need a prescription (over-the-counter)
- Devices or appliances, support garments or other non-medical substances
- Hard Equipment i.e., Syringes, Nebulizer, Glucometer, these are probably covered by your health insurance card (GHI, HIP…)
- Unauthorized refills
- Prescriptions covered under federal, state or local programs including workers' compensation, Medicare or Medicaid. Medication for eligible members and dependents who are confined to a rest home, sanitarium, extended care facility, hospital or similar institution
- 2 categories of medicine are covered by your IC Card issued directly by NYC: Injectables & Chemotherapy

The following medicines need prior authorization/and/or letter of medical necessity with a diagnosis from a medical doctor.

Smoking Cessation
Enbrel
Anabolic Steroids
Topical Acne Agents
Erectile Disfunction

Exclusions from Coverage

Only drugs which by law require a prescription are covered. Diet supplements, infant formulas, vitamins (except pre-natal supplements), transparenteral or other enteral therapies (TNP), supplies and services, and any over-the-counter products are excluded from coverage. No coverage is available for drugs dispensed by anyone other than a duly licensed pharmacist.

The following drugs are also excluded from coverage by the Fund: investigative or experimental drugs, unauthorized refills, lost or stolen medication, immunosuppressants, therapeutic devices or appliances, drugs whose sole purpose is to promote or stimulate hair growth, immunization agents and biological, blood or blood plasma, and drugs used to enhance sexual function, devises or appliances, support garments, medications provided while confined to a rest home, nursing home, sanitarium, extended care facility, hospital or similar facility.

No coverage is available for durable medical equipment, including insulin syringes and needles, under the Fund's prescription drug benefits program. Coverage for durable medical equipment may be available under your major medial benefits program.

IC Program: Injectables & Chemotherapy
If you have elected medical coverage through NYC then you will also receive a IC Card for these 2 group of medications. Determination of eligibility for you and your dependents (for this card) is determined by NYC. If you do not receive this card please contact Benefits of NYC (646-610-5122).

ACCIDENT & SICKNESS BENEFIT

This benefit is only available to you if you meet the eligibility requirements described previously and you work for the City of New York, under the jurisdiction of CWA Local 1182 and are not on a leave of absence at the time of the injury or illness. If you suffer an injury on the job or suffer from an illness due to the job, you must apply for workers' compensation. In the event that a workers compensation claim is denied because the disability did not arise in the course of employment, then you need to furnish the Fund Office with copies of the notice of controversy and medical reports in order to qualify for disability benefits. This benefit is not available to dependents. Accident and sickness benefits are paid directly by the Fund.

What your Benefits are

If you become totally disabled and unable to work because of an accident or illness **off the job**, you will receive a weekly benefit $200 minus FICA.

Proof Of Disability

You submit proof of your disability on a form prescribed by the Trustees no later than 90 calendar days after your first sick no pay day (FSNP) due to the disability for which you are claiming benefits. Disability forms are provided by the Fund Office.

Benefits begin on the ninth (9^{th}) sick no pay day following an illness or accident. However, benefits are not payable while you being paid for your "sick days". In other words, you must use up your sick days before you can collect benefits from the Fund. You may choose to use your vacation days (annual leave), the waiting period of 8 days from the FSNP always applies. At no time will you get paid for the first 8 SNP days.

Payments continue for up to a maximum of 26 weeks during the 12 month period from the onset of the illness or injury you are claiming benefits for. You are allowed one claim every 365 days. A follow-up evaluation is required every 25-30 days during your time out – it must be submitted to the Fund Office no later than 10 days, past the due date indicated on the top of the evaluation form sent to you. Failure to do so, may jeopardize your continuation of disability benefits.

At any time, continuation of your disability payment may be subject to your submitting to an examination by an independent doctor of the Fund's choosing.

There is one important exception to the benefit's maximum payment period. If a disability is due to substance abuse (brought on by dependence on drugs or alcohol), then a total of no more than 26 weeks of benefits for the substance abuse will be paid in any three year period.

Claim forms are available from the Fund Office.

Maternity Disability
Members are entitled to disability due to pregnancy. If you deliver vaginally, you will receive 8 weeks of disability pay. If a caesarean delivery is necessary, you will be entitled to 10 weeks of disability pay. A copy of your operative report is needed to qualify for the extra 2 weeks. When an illness disables you during your pregnancy, no more than a total of 26 weeks of disability is allowed.

Please note weekly sickness benefits are taxable income.

LIFE INSURANCE

Term Life Insurance and Accidental Death and Dismemberment (AD&D) is provided for you by the Fund through The Hartford Co.

This benefit is only available to you if you meet the eligibility requirements previously described and are not on leave of absence at the time of your death. Your dependents are **not** eligible for this coverage. You are also not eligible if the City of New York is no longer paying the Fund for your benefits.

What Your Life Insurance Benefit Is
If you die from any cause while you are insured, your designated beneficiary(s) will receive $20,000. You may name any person or persons as your beneficiary(s) at any time by filling out the proper form available from the Fund Office.

For a complete explanation of coverage please contact the Fund Office and request a copy of the Group Summary of Life Insurance and AD&D Coverage.

Termination And Conversion
Your life insurance coverage ends as described previously.

If your life insurance coverage ends, you may convert it to an individual policy within 31 days, without having to furnish proof of good health.

AD&D
Accidental death and dismemberment coverage is provided by the Fund through Standard Life Insurance Co. Your dependents are **not** eligible for this coverage.

What Your AD&D Benefit Is
If you suffer a bodily injury or loss of life due to an accident, while insured, you may be entitled to receive up to $20,000 or a part thereof. For a complete explanation and terms of this benefit please see the summary provided by The Hartford Co. No more than the full amount will ever be paid for all losses due to any one accident.

No death benefit will be paid for deaths caused by intentional self-destruction, over consumption of alcohol or illegal narcotics.

Termination And Conversion
Your AD&D coverage ends as described previously. This coverage cannot be converted to an individual policy.

The death benefits described above will be paid to the beneficiary you named on the Fund enrollment card that is filed with the Fund Office. You may change your beneficiary at any time by filling a change of beneficiary card with the Fund Office. No beneficiary designation will be effective until it is filed with the Fund Office.

If your named beneficiary dies before you, or you have not named a beneficiary, your death benefit will be paid as follows:

- To your spouse, or if your spouse is not living,
- To your children in equal shares, or if none of your children survive you,
- To your surviving parent(s) in equal shares,
- Then finally to your estate.

Your death benefits terminate when you leave covered employment.

LEGAL SERVICES

How Does The Plan Work

Legal services are provided by Fagenson & Puglisi. Attorneys at Law at 450 seventh Avenue, Suite 704, New York, New York 10123 212-268-2128

If you need a lawyer for any of the services listed below call the Plan attorney. This way, all contact is directly between you and the Plan attorney and assures you of a confidential relationship with you 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, Monmouth and Ocean (south to a line drawn between Trenton and Toms River).

What Does The Plan Cover

The Local 1182 Prepaid 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 action for damages. This does not include personal injury and property damage 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 of modifications of those orders, child abuse and neglect and spousal abuse (this benefit is not available to the dependent of a member)*

- All criminal matters and traffic offenses. Defense of state violations and misdemeanor 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. It does not include defense of federal crimes or violations. It also does not include representation in connection with federal or state criminal investigation, subpoenaed and/or pre-indictment proceeding. 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.
- 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 Fund 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 Plan attorney, 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 1182 and both file for these benefits, the first one of you to contact the Plan attorney will be represented by that firm. The member who contacts the Plan attorney second will be referred to an attorney from a different law firm, not affiliated with the Plan attorney, 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 Plan attorney first.

What Is Not Covered By The Plan

The local 1182 Prepaid Legal Services Benefit Fund 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.
- Chases 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 become eligible for benefits from this Plan (or before the Plan became effective)
- Any proceeding against the Plan attorneys, 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 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 frivolous, without merit or brought for the purpose of harassments
- Claims which can be handled in a Small Claims Court (currently, in NYC, if the amount in controversy in not more than $5,000)
- 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 Employers Liability Act
- Any grievance or arbitration under a contract between the Union and the Employer
- Workers' 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
- Those matters stated not covered in basics benefit section

Other Special Rules
In addition to the coverage's 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 Your Are Involved In A Legal Dispute With Your Dependents

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

What If You Dependent Needing Legal Services Is A Minor

If your minor dependent needs legal services, they are provided only if you sign a form required by the Trustees at the time your minor dependent requires benefits authorizing the Plan attorney to proceed on behalf of your minor dependent.

What If You Are Involved In A Legal Dispute With Another Agent

If you and another agent represented by Local 1182 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 Plan attorneys 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.

Notification and Waiver of Spousal Legal Services Benefit

Where **CWA Local 1182** provides expansive legal service benefits to eligible members, their spouses and dependents as outlined in The CWA Local 1182 benefits booklets.

Whereas **Fagenson & Puglisi** (the Legal Service Provider) has encountered many cases of "Conflict of Interest" where an eligible member's spouse requests legal representation from Fagenson & Puglisi and then, subsequent thereto, the member requests representation from Fagenson & Puglisi in a divorce, Family Court, Criminal Court, or other legal matter wherein the member's spouse is the opposing party. Fagenson & Puglisi is then legally barred from representing the eligible member because the law firm had in the past represented the spouse.

Therefore effective November 1, 2009, the legal service benefit is amended as follows:

The CWA Local 1182 member, at the time legal representation is requested for their spouse, must be given a copy of this "Notification and Waiver of Spousal Legal Services Benefit"; and

The member (*not the spouse*) must choose either:

_____ Initial

a. **Do not represent** my spouse in any legal matter so that I the member can be represented by the legal service provider in all legal actions where my spouse is the opposing party as outlined in the Legal Service Benefit Booklet provided by CWA Local 1182.

or

_____ Initial

b. I request that the legal service provider represent my spouse in all legal matters covered by the CWA Local 1182 legal services benefit and by requesting legal representation for my spouse **I waive the right to seek Legal representation for myself in any legal proceeding where my spouse is the opposing party.**

Agreed to this _____

Day of _____, 20_____ Sign: _____

Print Name: _____

*Note if your spouse is also a member of CWA Local 1182 there will be no waiver of legal service benefit and an alternative/conflict law firm will be provided as outlined in The CWA Local 1182 benefits booklet.

RIGHT TO APPEAL

If your claim for any benefit under this plan is denied, you will be notified by the Board of Trustees, in writing of:

1. The specific reason for the denial
2. The particular plan provision upon which the denial is based
3. An explanation of the Plan's claim review procedure

If additional information or documentation is required to substantiate your claim, you will receive an explanation of why such additional material is necessary. You may appeal the denial of the claim by:

1. A written application to the Board of Trustees made no later than 60 days after receipt of the denial along with submission of additional information and comments in writing that support your appeal.

You may review the pertinent documents upon which the denial is based.

The Board of Trustees will render a written decision specifying the reasons for its decision on the appeal no later than 60 days after receipt of the appeal, unless additional documentation is required. In this event, a decision will be rendered by the Board no later than 120 days after the receipt of the appeal.

If you have reasonable grounds to believe that the Board of Trustees has mistakenly or improperly denied your claim, you or your authorized representative may appeal within 90 days of recognize the denial the Board of Trustees' decision by filing a request for impartial arbitration with the American Association, 140 West 51st Street, New York, NY 10020 under the association's employee benefit plan claims arbitration rules which are in effect at the time. You will be responsible for your share of the costs. Each side will be responsible for half of the costs of the arbitrator and of the American Arbitration Association's fees for administering the case. The award of the arbitrator will be final and binding on both you and the Fund. This procedure is mandated by the public employer which makes contributions on your behalf to the Fund. This is the exclusive means to appeal the Board of Trustees denial of your claim for benefits.

FAILURE TO FILE

To file a petition for review of the denial, failure to appear and participate at a scheduled hearing and/or failure to file for arbitration within the allowable time period will constitute a waiver of your right to a review of the denial & bail any claim with regard to the denial.

AMENDMENT, MODIFICATION FOR TERMINATION

The Trustees expect to continue the Funds. However, the Trustee reserve the right, in their sole and absolute discretion, to amend, modify or terminate the Fund's benefit program (including any related arrangements, documents or policies), in whole or in part, at any time and for any reason, with respect to active or retired members and their dependents who are or may become covered under the Funds. Among other things, the Trustees have the authority at any time and from time to time, to change the eligibility rules, to increase or diminish the amount of benefits, to increase or require deductible and/or coinsurance, to eliminate particular types of benefits, to substitute certain benefits for others, to impose or decrease maximums in the amount of benefits payable or to terminate the Plan. If the program of benefits under the Funds is modified or terminated, the ability of employees, retirees or their family members to participate in and receive benefits from the Funds may be modified or terminated at any time.

Thus, all benefits provided under the Funds for active or retired participants and their dependents:

- Are not guaranteed;
- May be changed or discontinued by the Trustees at any time, in their sole and absolute discretion;
- Are subject to the rules and regulations adopted by the Trustees; and
- Are subject to the Trust Agreement, the collective bargaining agreement(s) and the other official Plan documents that establish and govern the Funds' operations.

In the event of termination of either Fund, the Trustees will apply the monies in the Funds to provide benefits or otherwise to carry out the purposes of the Fund in their sole and absolute discretion until the entire remainder of the assets has been disbursed. Under no circumstances will any benefits of the Funds become vested or nonforfeitable at any time with respect to active or retired participants or their dependents. In no event will any sums/monies revert to the City of New York or CWA Local 1182.

INTERPRETATION

Please also note that no individuals, other than the Trustees or their duly authorized designee(s) (which may be one or more of the insurance companies with which the Fund has contracted for benefits), have any authority to interpret the Plan documents or to make any promises to you about the plan of benefits, or to change any provision of the plan of benefits. Only the Trustees, or their authorized designee(s), have the right and power, in their sole and absolute discretion, to interpret the Plan and to decide all matters arising thereunder.

Neither this booklet nor the SBF is a contract of employment and do not guarantee employment or continued employment with the City of New York.

It is our hope to continue to provide the best benefits affordable. The cost of medical services and goods has increased rapidly. We request your assistance in utilizing these benefits

intelligently. Your prudent use of these benefits for which you are eligible will help us to continue to provide you with a program of high quality benefits.

THE FILING OF A FALSE OR MISLEADING APPLICATION FOR ELIGIBILITY OR CLAIM FOR BENEFITS IS A VIOLATION OF THE RULES OF THE FUND AND WILL RESULT IN:

1. DENIAL OF THE CLAIM
2. AN ACTION TO RECOVER BENEFIT PAYMENTS MADE TO YOU, OR ON YOUR BEHALF
3. FOR MISLEADING APPLICATION OR SELECTIVE PARTICIPATION OR ADVERSE ELECTION: THE EMPLOYER'S PERMANENT DISQUALIFICATION FROM THE FUND; AND
4. FOR A FALSE CLAIM FOR BENEFITS: A FIRST VIOLATION WILL RESULT IN SUSPENSION OF COVERAGE UNDER THE FUND FOR A PERIOD OF ONE YEAR BEGINNING ON THE DATE OF A FINAL DETERMINATION THAT A FRAUDULENT CLAIM HAS BEEN FILED. A SECOND VIOLATION MAY RESULT IN PERMANENT DISQUALIFICATION FROM THE FUND.

ALL DETERMINATIONS MADE IN CONNECTION WITH THIS SECTION WILL BE MADE BY THE TRUSTEES, IN THEIR SOLE AND ABSOLUTE DEISCRETION.

WHAT ELSE DO YOU NEED TO KNOW ABOUT HIS PLAN?

How is the Security Benefits Fund Administered?

The CWA Local 1182 Security Benefits Fund is administered by a Board of Trustees composed of five Trustees. The address and principal place of business of the Fund is 58-38 69th street, 2 Front, Maspeth, New York 11378 Tel: 718-268-6373

Members of Board of Trustees include:

Syed Rahim
William Gallagher
Donna Ellaby
Nicholas Zimmitti
Albert Sloh
Olufemi Sokumbi
Theresa Ferzola

The Fund Administrator is Theresa Ferzola

How Are Contributions Made?
The CWA Local 1182 Security Benefits Fund is maintained through collective bargaining agreements between various public employers and the Communication Workers of America AFL_CIO on behalf of Local 1182. These collective bargaining agreements provide that annual contributions to the Fund be made on behalf of each employee in a covered title.

How Are Benefits Provided?
Benefits are provided from the Fund's assets which are accumulated under the provisions of the collective bargaining agreement and the Trust Agreement for the purpose of providing benefits to covered members and defraying reasonable administrative expenses. Some of the benefits are provided through insurance policies; some are self-insured.
What If You Leave Payroll For Any Reason?
If you have been off payroll for any reason, you must advise the Fund Office when you return to work.

Failure to notify the Fund Office may cause interruption of your benefits. please refer to the section on Continuation of Coverage Rights (COBRA) on page 46.

RECOVERY OF ERRONEOUS PAYMENT

If you received benefits from the Fund to which you were not entitled the Fund has the right to recover the benefits you received in error. This can be accomplished through voluntary restitution by your or through an offset against future benefits!

AMENDMENT OR TERMINATION OF BENEFITS

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

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

- When the Fund is terminated.
- When you are no longer eligible.
- When there is non-payment of the direct pay premiums
- When the employer ceases to make contributions on your behalf to the Fund.

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

Privacy of protected health information

The Health Insurance Portability and Accountability Act of 1996("HIPAA") gives you certain rights with respect to your health information, and it also imposes certain obligations on the Plan as a group health plan. The following describes the ways your health information is protected under HIPAA, when that health information is disclosed to or used or disclosed by the Board of Trustees, in its capacity as the sponsor of the Plan. This information is referred to as "protected health information". These rules do not apply to any disability, death educational or non-health benefits provided under our plan.

A complete description of your rights under HIPAA is available in the Plan's Notice of Privacy Practices which then Plan is required to distribute to you. The statement that follows is not intended and cannot be considered to be the Plan's Notice of Privacy Practices.

Your "protected health information" is information about you, including demographic information that:

- Is created or received by the Plan, or by your health care provider or a health
- Care clearinghouse (and is not related to you non health benefits under the Plan, e.g., disability);
- Relates to your past, present, or future physical or mental condition;
- Relates to the provision of health care to you;
- Relates to the past, present, or future payment for the provision of health care to you; and
- Identifies you in some manner.

In order for the Plan to disclose any protected health information to the Fund Administrator, the Fund Administrator must first provide documentation that the Plan documents have been amended to incorporate the following provisions and the Fund Administrator agrees to abide by these rules:

- The Plan will disclose protected health information to the Fund Administrator only for the Fund Administrator to carry out "plan administration functions," as such term in defined under the privacy regulations published under HIPAA (45C.F.R. Parts 160 and 164) and within the requirements of HIPAA.

- The Fund Administrator will use or disclose protected health information only for plan administration functions as permitted or required by this Plan document or as required by law.

- The Plan will not disclose protected health information to the Fund Administrator unless the disclosures are explained in the Notice of Privacy Practices Distributed to the Plan participants and beneficiaries.

- The Plan will not disclosed protected health information to the Fund Administrator for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Fund Administrator, unless it receives the express written authorization of the Plan participant or beneficiary to do so.

- The Fund Administrator will not sure or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Fund Administrator, unless it receives the express written authorization of the Plan participant or beneficiary to do so.

- The Fund Administrator will only disclose protected health information to an agent or subcontractor if the agent agrees to the same restrictions and conditions included in this Plan document with respect to the use or disclosure of protected health information.

- The Fund Administrator will report to the Plan any sue or disclosure of protected health information that is inconsistent with the uses and disclosures allowed under this Plan documents of which it becomes aware.

- The Fund Administrator will make protected health information available to the Plan participant or beneficiary who is the subject of the information to the extent required by and in accordance with 45 Code of federal Regulations §164.524.

- The Fund Administrator will make protected health information available for amendment, and will amend protected health information to the extent required by and in accordance with 45 Code of Federal Regulations §164.526.

- The Fund Administrator will track disclosures if may make of protected health information so that it can make available the information required for the Plan to provide an accounting of certain types of disclosures of protected health information in accordance with 45 Code of Federal Regulations §164.528.

- The Fund Administrator will make available to the Plan and the U.S. Department of Health and Human Services its internal practices, books and records, relating to its use and disclosure of protected health information it receives in its capacity as the sponsor of the Plan to determine the Plan’s compliance the 45 Code of Federal Regulations Parts 160 and 164.

- The Fund Administrator will, if feasible, return or destroy all protected health information received by the Plan in whatever form or medium (including in any electronic medium under the Fund Administrator's custody or control) when protected health information is no longer needed for the Plan administration functions for which the disclosure as made. This includes all copies of any date or compilations derived from and allowing identification of any participant or beneficiary who is the subject of the protected health information. If it is not feasible to return or destroy all the protected health information, the Fund Administrator will limit the use or disclosure of any protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

The following employees or classes of employees or other workforce members under the control of the Fund Administrator may be given access to protected health information received from the Plan or a health insurance issuer or business associate servicing the Plan:

- Privacy Officer
- Medical Director
- Medical Department
- Fund's Board of Trustees
- Fund's Accounting Department

This list includes every employee or class of employees or other workforce members under the control of the Fund Administrator who may receive protected health information relating to Plan administration functions in the ordinary course of business on behalf of the Fund Administrator.

The employees, classes of employees or other workforce members identified above will have access to protected health information only to perform the plan administration functions that the Fund Administrator provides for the Plan.

The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions, up to and including termination of employment or affiliation with the Fund Administrator, for any use or disclosure of protected health information in non-compliance with the provisions of this plan document. The Fund Administrator will impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the non-compliance and will work to mitigate any harmful effect of the non-compliance on any participant or beneficiary, whose privacy has been violated.

There are also some special rules related to "electronic health information." Electronic health information is generally protected health information that is transmitted by, or maintained in, electronic media. "Electronic media" includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards. It also includes

transmission media used to exchange information already in electronic storage media, such as the internet, an extranet (which uses internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

- The Board of Trustees will take additional action with respect to the implementation of security measures (as defined in 45 CFR §164.304) for electronic protected health information. Specifically, the Board of Trustees will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan.

- Ensure that the adequate separation required to exist between the Plan and the Board of Trustees is supported by reasonable and appropriate administrative, physical and technical safeguards in its information systems.

- Ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect that information.

- Report to the Plan if it becomes aware of any attempted or successful unauthorized access, use disclosure, modification or destruction of information or interference with system operations in its information system.