



1199SEIU

Greater New York Benefit Fund

SUMMARY PLAN DESCRIPTION
OF YOUR HEALTH AND
WELFARE BENEFITS

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This booklet describes the healthcare and other benefits provided to participants in the 1199SEIU Greater New York Benefit Fund employed in the metropolitan New York area (the “Benefit Fund” or “Fund”). It serves as both the Summary Plan Description (“SPD”) and Plan Document for the Plan.

The Plan is administered by the Board of Trustees (the “Trustees”) of the Benefit Fund. No individual or entity, other than the Trustees (including any duly authorized designee thereof), has any authority to interpret the provisions of the Plan or to make any promises to you about the Plan.

The Trustees reserve the right to amend, modify, discontinue or terminate all or part of the Plan for any reason and at any time when, in their judgement, it is appropriate to do so. These changes may be made by formal amendments to the Plan, resolutions of the Board of Trustees, actions by the Trustees when not in session by telephone or in writing, and/or any other methods allowed for Trustee actions.

If the Plan is amended or terminated, you and other active and retired employees may not receive benefits as described in this SPD. This may happen at any time, even after you retire, if the Trustees decide to terminate the Plan or your coverage under the Plan. In no event will any active employee or retiree become entitled to any vested or otherwise non-forfeitable rights under the Plan.

The Trustees (including any duly authorized designee of the Trustees) reserve the complete authority and discretion to construe the terms of the Plan (and any related Plan documents) including, without limitation, the authority to determine the eligibility for, and the amount of, benefits payable under the Plan. These decisions shall be final and binding upon all parties affected by such decisions. This SPD and the Benefit Fund staff are your sources of information on the Plan. You cannot rely on information from co-workers or Union or Employer representatives. If you have any questions about the Plan and how its coverage works, the Benefit Fund staff will be glad to help you. Because telephone conversations and other oral statements can easily be misunderstood, they cannot be relied upon if they are in conflict with what is stated in this SPD.



NEED HELP WITH THE SUMMARY PLAN DESCRIPTION (“SPD”)?

This SPD is a summary of your benefits and the policies and procedures for using these benefits with the 1199SEIU Greater New York Benefit Fund.

If the language is not clear to you, you can get assistance by writing the Benefit Fund at:

**330 West 42nd Street
New York, NY 10036**

or calling (646) 473-9200.

Office hours for the Fund are 8:00 am to 6:00 pm, Monday through Friday.

¿NECESITA AYUDA CON EL SUMARIO DE DESCRIPCIÓN DEL PLAN?

Este folleto es un sumario en inglés de sus derechos y beneficios bajo el Fondo de Beneficios del Gran Nueva York de 1199SEIU.

Si usted no entiende este sumario y necesita ayuda, escriba al Fondo:

**330 West 42nd Street
New York, NY 10036**

o llame: (646) 473-9200.

Las horas de oficina del Fondo son de 8:00 am a 6:00 pm de lunes a viernes.

June 2017

Dear 1199SEIU Member:

Your Benefit Fund provides a wide range of benefits for both full-time and part-time eligible participants while allowing you to choose your doctor, hospital or other healthcare professional.

This SPD is designed to make it easier for you to find the information you need and to understand your rights and responsibilities under the Plan.

It is important that you read the entire SPD so that you know:

- What benefits you are eligible to receive;
- What policies and procedures need to be followed to get your benefits; and
- How to use your benefits wisely.

As you know, healthcare costs have been rising every year. As costs have risen, your Benefit Fund has been looking in new directions and developing programs to provide you with coverage for primary and preventive care.

By using one of the Benefit Fund's Participating Providers, you and your family can receive comprehensive care at little or no cost. Many providers are affiliated with institutions where you work or near where you live. And if you sign up for the Benefit Fund's **Member Choice** Program, your care for Covered Services is covered in full when you use Participating Providers at your Member Choice network hospital.

If you have any questions or concerns about any of your benefits or coverage for a specific medical problem, call the Benefit Fund's Member Services Department at (646) 473-9200. The Benefit Fund staff can answer your questions, refer you to another department or take the information and get back to you later with an answer.

The Benefit Fund cares about you and your family. With your help, your Benefit Fund can continue to provide a comprehensive package of Health Benefits in the years ahead for you and your family, and other participants and their families.

The Board of Trustees

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NEED TO KNOW WHAT “FAMILY” MEANS IN THIS SPD?

Refer to the Definitions Section

The Definitions section (Section IX) lists the terms used in this SPD and explains how they are defined by the Benefit Fund.

Refer to this section if you have any questions about the meaning of specific words or phrases, such as “spouse,” “family,” “Contributing Employer,” etc. For example, “family” as used in this SPD, refers only to your spouse or your children who are eligible for benefits from this Benefit Fund.

If you have any further questions, please call our Benefit Fund’s Member Services Department at (646) 473-9200.

YOUR BENEFIT FUND

The 1199SEIU Greater New York Benefit Fund is a self-administered, self-funded, labor-management, Taft-Hartley Trust Fund. Your coverage is provided as a result of a Collective Bargaining Agreement between your Employer and your Union, 1199SEIU United Healthcare Workers East. Eligibility Class I and II Benefits are plans that provide “minimum essential coverage” and exceed the “minimum value” standard, as those terms are defined by the Patient Protection and Affordable Care Act (the “Affordable Care Act”).

Self-administered means that the Benefit Fund staff is responsible for the day-to-day administration of the Fund, including processing your claims, answering your questions and performing other administrative operations.

Self-funded means all of the money your Employer pays to the Benefit Fund on your behalf goes directly to providing your benefits. The Benefit Fund does not exist to make profits, like an insurance company does. It exists only to provide you, other 1199SEIU members and your family with quality Health and Welfare Benefits. It also means that the Fund is not subject to state insurance laws. Instead, the Fund is governed by a federal law known as the Employee Retirement Income Security Act of 1974 (“ERISA”) (see Section VIII.A).

Labor-management means that the Benefit Fund is run by an equal number of trustees appointed by **1199SEIU** and by **Employers** who make payments to the Fund on behalf of their workers.

Taft-Hartley is the name of the federal law that allows these labor-management trust funds to be established.

Minimum essential coverage is healthcare coverage that the Affordable Care Act requires most people to have. The Eligibility Class III benefit plan **does not** provide minimum essential coverage.

Minimum value is a standard of health plan benefits established under the Affordable Care Act. A health plan meets this standard if it is designed to pay at least 60% of the total cost of medical services for a standard population. Individuals offered Employer-sponsored coverage that provides minimum value and that’s affordable won’t be eligible for a premium tax credit for coverage through the Health Insurance Marketplace.

YOUR EMPLOYER PAYS FOR YOUR BENEFITS

Your Union contract — the Collective Bargaining Agreement between your Employer and 1199SEIU — requires that your Employer make payments to the Benefit Fund on your behalf for Health and Welfare Benefits.

The cost of your benefits is paid through “contributions” to the Benefit Fund by your Employer. These payments are called contributions because they go into a large pool of money used to pay

for all the benefits for all 1199SEIU members and their families covered by the Plan.

Your Union dues are paid to 1199SEIU to cover the cost of running the Union — not to the Benefit Fund to cover the cost of providing Health and Welfare Benefits.

This Benefit Fund is Jointly Administered together with other affiliated Benefit Funds serving people in 1199SEIU bargaining units. All these funds are housed together and share staff, services and eligibility information. This allows your benefits to be administered efficiently.



OVERVIEW OF YOUR BENEFITS

IMPORTANT PHONE NUMBERS

**Member Services Department
(646) 473-9200**

For answers to questions about your benefits or to be referred to another Benefit Fund department.

**Program for Behavioral Health
(646) 473-6900**

For mental health and alcohol/
substance abuse.

**1199SEIU CareReview Program
(800) 227-9360**

For Prior Approval of hospital stays.

You can also visit our website at www.1199SEIUBenefits.org for forms, directories and other information. From our website, you can also click on “My Account” and create your own account to check your eligibility, find out whether a claim has been paid, change your address or update other information.

The Benefit Fund has no pre-existing condition exclusions. A pre-existing condition is a medical condition, illness or health problem that existed before you enrolled in the Fund.

Eligibility Class I and II have an annual restriction on out-of-pocket costs, which includes co-payments, as required by the Affordable Care Act.

OVERVIEW OF ELIGIBILITY CLASS I AND II BENEFITS

ELIGIBILITY CLASSES

Eligibility Class I: Full-time members

Eligibility Class II: Part-time members who work, on average, more than 60%, but less than 100%, of a full-time schedule (generally three or four days per week)

NOTE: Certain benefits described in this SPD are subject to co-payments. Please see the individual sections of this SPD for more details.

The following is a quick reference guide that gives you an overview of your benefits. Do not rely on this chart alone. Please read the rest of this SPD for a full explanation of each benefit.

LEGEND

Member – You, the member

Spouse – Your spouse, if eligible

Children – Your children, if eligible

Family – You, your spouse and your children, if eligible

See Section I.A of this SPD to determine if you, your spouse or your children are eligible for benefits.

Benefit Coverage	Eligibility Classes	
	I	II

HOSPITAL CARE	Family	Family
<ul style="list-style-type: none"> This benefit is for the hospital's charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered, as described in Section II.H of this SPD. Up to 365 days per year (100% of the Benefit Fund's allowance) Semi-private room and board Acute care for Medically Necessary services Inpatient admissions Outpatient or ambulatory facilities Observation care and services Up to 30 days per year for inpatient physical rehabilitation in an acute care facility. Benefits are not provided for care in a nursing home or skilled nursing facility. 	<p><i>You must call 1199SEIU CareReview at (800) 227-9360 before going to the hospital or within 48 hours of an Emergency admission.</i></p>	

HOSPICE CARE	Family	Family
<ul style="list-style-type: none"> Up to 210 days of Medicare-certified hospice care per lifetime in a hospice center, hospital, skilled nursing facility or at home 	<p><i>You must call 1199SEIU CareReview at (800) 227-9360 for Prior Approval of inpatient hospice care.</i></p>	<p><i>You must call the Prior Authorization Department at (646) 473-9200 for Prior Approval of outpatient hospice care.</i></p>

Benefit Coverage	Eligibility Classes	
	I	II

EMERGENCY DEPARTMENT VISITS	Family	Family
<ul style="list-style-type: none"> This benefit is for the hospital's charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered, as described in Section II.H of this SPD. Use of the Emergency Department must be for an Emergency within 72 hours of an accident/injury or the onset of a sudden and serious illness Observation care and services (see Section II.C of this SPD) Benefit Fund pays negotiated or reasonable rates — \$75 co-payment if you are not admitted to the hospital 		

PROGRAM FOR BEHAVIORAL HEALTH	Family	Family
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Mental Health

<ul style="list-style-type: none"> Outpatient visits – \$5 co-payment Intensive Outpatient Programs (IOP) Inpatient care Partial Hospitalization Programs (PHP) 	<p><i>To pre-certify PHP and IOP services, you must call the Fund at (646) 473-6868.</i></p>
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<i>Alcohol/Substance Abuse</i>	<p><i>You must call 1199SEIU CareReview at (800) 227-9360 to pre-certify inpatient treatment.</i></p>
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<ul style="list-style-type: none"> Inpatient detoxification and rehabilitation Outpatient visits – \$5 co-payment Intensive Outpatient Programs (IOP) 	
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Benefit Coverage	Eligibility Classes	
	I	II
SURGERY	Family	Family
<ul style="list-style-type: none"> Inpatient or outpatient (ambulatory surgery) Benefits based on the Benefit Fund's allowance for the surgical procedure Participating Surgeons bill the Benefit Fund directly and accept the Benefit Fund's payment as payment in full 	<p><i>You must call 1199SEIU CareReview at (800) 227-9360 before having non-Emergency surgery.</i></p>	
ANESTHESIA	Family	Family
<ul style="list-style-type: none"> Benefits based on the Benefit Fund's Schedule of Allowances No out-of-pocket costs with Participating Providers 		
MATERNITY CARE	Family	Family
<ul style="list-style-type: none"> An allowance which includes all prenatal and postnatal visits and delivery charges Hospital Benefit for the mother Hospital Benefit for the newborn, if the mother is you or your spouse Lactation consulting by a certified provider Breast pumps Disability Benefits through your Employer for you if you are the mother 	<p><i>Call the Wellness Department at (646) 473-8962 to register for the Prenatal Program.</i></p> <p><i>Call the Benefit Fund at (646) 473-9200 for information about breast pump options.</i></p>	

Benefit Coverage	Eligibility Classes	
	I	II

Benefit Coverage	I	II
MEDICAL SERVICES	Family	Family
<ul style="list-style-type: none"> • Treatment in a doctor’s office, clinic, hospital, Emergency Department or your home — \$5 co-payment for primary care visits and \$10 co-payment for specialist visits • Well-child care for dependent children • Immunizations • X-rays (co-payments for certain high-end imaging tests, including MRI, MRA, PET and CAT scans and certain nuclear cardiology tests) and laboratory tests — \$15 co-payment • Dermatology: up to 20 treatments per year • Chiropractic: up to 12 treatments per year • Podiatry: up to 15 treatments per year for routine care • Allergy: up to 20 treatments per year, including diagnostic testing • Physical/Occupational/Speech therapy: up to 25 visits per discipline per year • Durable medical equipment and appliances • Ambulance services • Participating Providers bill the Benefit Fund directly and accept the Benefit Fund’s payment as payment in full 		

Benefit Coverage	Eligibility Classes	
	I	II
MEDICAL SERVICES REQUIRING PRIOR AUTHORIZATION	Family	Family
<ul style="list-style-type: none"> Home health care Non-Emergency ambulance services Durable medical equipment and appliances Medical supplies Specific medications, including specialty drugs (Eligibility Class II not covered) Certain home infusion drugs administered on an outpatient basis 	<p><i>You must call the Prior Authorization Department at (646) 473-9200 for Prior Approval of services, except Emergency ambulance and the services listed below.</i></p>	<p><i>You must call the Prior Authorization Department at (646) 473-9200 for Prior Approval of services, except Emergency ambulance and the services listed below.</i></p>
<ul style="list-style-type: none"> MRI, MRA, PET and CAT scans and certain nuclear cardiology tests 	<p><i>You must call Care Continuum at (877) 273-2122 for Prior Approval of certain home infusion drugs administered on an outpatient basis.</i></p>	<p><i>You must call eviCore healthcare at (888) 910-1199 for Prior Approval of radiological tests, molecular and genomic testing, radiation therapy and medical oncology services.</i></p>
<ul style="list-style-type: none"> Molecular and genomic testing Radiation therapy Medical oncology services Hospice care 	<p><i>You must call 1199SEIU CareReview at (800) 227-9360 for Prior Approval of inpatient hospice care. You must call the Prior Authorization Department at (646) 473-9200 for Prior Approval of outpatient hospice care.</i></p>	
<ul style="list-style-type: none"> Ambulatory surgery or inpatient admissions Certain mental health and alcohol/substance abuse services 	<p><i>You must call 1199SEIU CareReview at (800) 227-9360 for Prior Approval of ambulatory surgery or inpatient admissions.</i></p>	

Benefit Coverage	Eligibility Classes	
	I	II
VISION CARE	Family	Family
<ul style="list-style-type: none"> One eye exam every two years One pair of glasses or one order of contact lenses every two years No out-of-pocket cost when using a Participating Provider for lenses and frames included in the Benefit Fund's vision program 	<i>Co-payment required for most contact lenses and progressive lenses. Lens coatings are not covered.</i>	
HEARING AIDS	Family	Family
<ul style="list-style-type: none"> Once every three years Call for referrals to a Participating Provider Co-payments may apply 		
DENTAL	Family	Not Covered
Preferred Panel of DDS Dentists:	<i>Prior Authorization is required for dental services of \$300 or more and for all orthodontic services.</i>	
<ul style="list-style-type: none"> Use a dentist on the preferred panel Coverage in full for preventive and basic services Set co-payment for major restorative and orthodontic services for dependent children Maximum benefit of \$1,200 per eligible person per calendar year (excluding essential oral pediatric services) 		

Benefit Coverage	Eligibility Classes	
	I	II

DENTAL (CONTINUED)	Family	Not Covered
<p>Non-Participating Dentists:</p> <ul style="list-style-type: none"> Coverage includes preventive, basic, major restorative and orthodontic services for dependent children Maximum benefit of \$1,200 per eligible person per calendar year (excluding essential oral pediatric services) Claims are paid according to the Benefit Fund’s Schedule of Allowances and member is responsible for the balance 	<p><i>Prior Authorization is required for dental services of \$300 or more and for all orthodontic services.</i></p>	

PRESCRIPTION DRUGS	Family	Limited Coverage
<ul style="list-style-type: none"> FDA-approved prescription medications No co-payments, no deductible when you use generic and preferred drugs if available Use Participating Pharmacies Mandatory Maintenance Drug Access Program for chronic conditions – <i>The 1199SEIU 90-Day Rx Solution</i> Prior Authorization needed for certain medications Please refer to “What Is Not Covered” in Section II.L of this SPD 	<p><i>Coverage is limited to certain Medically Necessary preventive prescriptions in accordance with the Affordable Care Act, including aspirin, iron, folic acid, oral fluoride, prenatal vitamins, certain vaccines, certain smoking cessation products and contraceptive medication if prescribed by a licensed prescriber.</i></p>	

Benefit Coverage	Eligibility Classes	
	I	II
DISABILITY <ul style="list-style-type: none"> The Benefit Fund does not provide Disability Benefits. This benefit may be provided by your Employer. Member must submit proof to the Benefit Fund that Disability Benefits have been received to maintain health coverage for up to 26 weeks within a 52-week period Follow the same procedure if you are receiving Workers' Compensation Benefits 	Member Only	Member Only
LIFE INSURANCE <ul style="list-style-type: none"> Eligibility Class I: During your first year of service, benefit is \$2,000. After your first year, benefit is based on your years of service and annual earnings up to a maximum of \$25,000. Eligibility Class II: During your first year of service, benefit is \$1,250. Maximum benefit amount is \$2,500. 	Member Only	Member Only
ACCIDENTAL DEATH AND DISMEMBERMENT <ul style="list-style-type: none"> For accidental death or injury Equal to, or one-half of, your life insurance 	Member Only	Member Only
BURIAL <ul style="list-style-type: none"> If available, a free burial plot with permanent care 	Member & Spouse	Member & Spouse

Benefit Coverage	Eligibility Classes	
	I	II

SOCIAL SERVICES

Family

Family

- Member Assistance Program
 - Citizenship Program
 - Earned Income Tax Credit Assistance Program
 - Home Mortgage and Financial Wellness Program
 - Weekly Legal Clinics
-

OVERVIEW OF ELIGIBILITY CLASS III BENEFITS

Eligibility Class III: Part-time members who work more than 20%, but less than 60%, of a full-time schedule (generally more than one, but less than three days per week)

The following is a quick reference guide that gives you an overview of your benefits. Do not rely on this chart alone. Please read the rest of this SPD for a full explanation of each benefit.

Benefit Coverage	Eligibility Class III (Member Only)
MEMBER CHOICE COMPREHENSIVE DENTAL BENEFIT	
<ul style="list-style-type: none">• 100% of the Benefit Fund's Comprehensive Schedule of Allowances for basic and preventive services• Maximum benefit of \$1,200 per year (excluding essential oral pediatric services)	<p><i>You must call DDS at (800) 255-5681 for Prior Approval of treatment over \$300.</i></p> <p><i>See Section II.K of this SPD for more details.</i></p>
VISION CARE	
<ul style="list-style-type: none">• One eye exam every two years• One pair of glasses or one order of contact lenses every two years	<p><i>See Section II.J of this SPD for more details.</i></p>
LIFE INSURANCE/ACCIDENTAL DEATH AND DISMEMBERMENT	
<ul style="list-style-type: none">• Life insurance amount of \$1,250	<p><i>See Section IV of this SPD for more details.</i></p>

DISABILITY

- The Benefit Fund does not provide Disability Benefits. This benefit may be provided by your Employer. *See Section III of this SPD for more details.*
 - Member must submit proof to the Benefit Fund that Disability Benefits have been received to maintain health coverage for up to 26 weeks within a 52-week period
 - Follow the same procedure if you are receiving Workers' Compensation Benefits
-

HOSPITAL INDEMNITY PAYMENTS

- Up to \$200 (less applicable taxes) for each day you are an inpatient in a hospital as defined in Section IX of this SPD
 - Up to a maximum of 10 days per hospital stay
 - You must be billed for a room and board charge on your hospital bill
-

SOCIAL SERVICES

- Member Assistance Program
 - Citizenship Program
 - Earned Income Tax Credit Assistance Program
 - Home Mortgage and Financial Wellness Program
 - Weekly Legal Clinics
-



SECTION I – ELIGIBILITY

- A. Who Is Eligible
- B. When Your Coverage Begins
- C. Enrolling in the Benefit Fund
- D. How to Determine Your Level of Benefits
- E. Your ID Cards
- F. Coordinating Your Benefits
- G. When Others Are Responsible for Your Illness or Injury
- H. When You Are on Workers' Compensation Leave
- I. When Your Benefits Stop
- J. Continuing Your Coverage
 - While Receiving Disability Benefits from Your Employer
 - While Participating in Training Programs
 - While Covered by the Job Security Fund (JSF)
 - While on Workers' Compensation Leave
 - While Taking Family and Medical Leave (FMLA)
 - While Taking Uniformed Services Leave
- K. Your COBRA Rights

WHERE TO CALL

Member Services Department
(646) 473-9200
www.1199SEIUBenefits.org

Call Member Services to:

- Check whether you are eligible to receive benefits;
- Find out your benefit level;
- Request any forms;
- Update the information on your **Enrollment Form** (address, phone number, dependents, etc.);
- Notify the Benefit Fund when you change Employers;
- Report any errors on your ID cards;
- Notify the Benefit Fund when you're on Workers' Compensation, Disability or FMLA leave; or
- Get the answers to any of your questions.

COBRA Department
(646) 473-6815

Call the COBRA Department to:

- Apply for COBRA continuation coverage; or
- Get more information on COBRA.

NO PRE-EXISTING CONDITION EXCLUSIONS

The Benefit Fund has no pre-existing condition exclusions. A pre-existing condition is a medical condition, illness or health problem that existed before you enrolled in the Fund.

REMINDERS

- You must enroll in the Benefit Fund to be eligible for benefits.
- If electing optional spousal coverage, complete the **Spouse Coverage and Paycheck Deduction Authorization Form** with your Employer.
- Check the information on your ID cards and notify the Benefit Fund of any incorrect information immediately.
- Fill out all forms completely and attach all the documents required. Otherwise, your claim may be delayed or your benefits denied.
- Notify the Benefit Fund of any change of address, phone number, dependents, etc.
- Notify the Benefit Fund when you change Employers in order for your coverage to continue.
- File a **Disability Certification Form** every year if your child is disabled and eligible to receive benefits after age 26 (see Section I.A).
- To protect your benefits, contact the Benefit Fund immediately if you are not working due to a Workers' Compensation, Disability or FMLA leave.
- Notify the Benefit Fund of any change that will affect your right to COBRA continuation coverage.
- Call the Benefit Fund if you want to continue your life insurance after your coverage ends.

SECTION I. A

WHO IS ELIGIBLE

YOU

You are eligible to participate in the 1199SEIU Greater New York Benefit Fund if:

- You work for a Contributing Employer who is making contributions to the Benefit Fund on your behalf based on your employment, for the benefits in this SPD; and
- You have completed the waiting period specific to your Employer's Collective Bargaining Agreement (which cannot exceed the limit permitted by the Affordable Care Act).

You may also be eligible for benefits if:

- You are eligible to receive COBRA continuation coverage and you comply with the notice requirements and make the monthly payments required to keep this coverage (see Section I.K); or
- You are a retiree eligible for specified Retiree Health Benefits (see Section VI).

1199SEIU members employed by New Jersey Contributing Employers are not eligible for Health Benefits described in this SPD.

YOUR SPOUSE

Your **spouse** may be eligible if:

- You and your spouse are legally married;
- You are eligible for family coverage, based on your Eligibility Class (see Section I.D);
- You enroll your spouse during an open enrollment or special enrollment period;
- You pay a weekly premium for your spouse through a payroll deduction; and
- You have provided documents as requested by the Benefit Fund.

The Plan Administrator reserves the right, in its sole and absolute discretion, to determine all questions relating to the eligibility of spouses.

NOTE: Generally, whenever the term “your spouse” is used in this SPD, it is intended to refer to your enrolled spouse, for whom you are paying the weekly premium. You must be eligible for Eligibility Class I or Eligibility Class II Benefits for your spouse to be eligible for Fund benefits.

You must complete the **Spouse Coverage and Paycheck Deduction Authorization Form**, and give it to your Employer. This form acknowledges your election for spousal coverage and

authorizes your Employer to deduct the weekly premium payment. Effective January 1, 2016, the deduction is \$25 per week for all members. If you are employed by more than one GNY Contributing Employer, you should elect coverage and authorize the payroll deduction from only one Employer.

Open enrollment for spouses is held twice a year, in January for coverage effective March 1, and in July for coverage effective September 1. New members and members that are recently married do not have to wait for the next enrollment period to enroll their spouse. You must elect to enroll your spouse for coverage within the first 90 days of marriage or wait for the next open enrollment period. If you decline to enroll your spouse, you may be able to request enrollment within 30 days of your spouse losing eligibility for other health plan coverage he or she is enrolled in (not including a loss for failure to pay premiums), or within 60 days of your spouse losing coverage under Medicaid.

To terminate spousal coverage, you must notify your Employer to end the coverage and stop the authorized payroll deductions.

Benefit Fund coverage of a spouse ends upon legal separation or divorce except to the extent your spouse timely elects and pays for COBRA continuation coverage (see Section I.K).

YOUR CHILDREN

Your **children** are eligible up to their 26th birthday if all the following conditions are met:

- They're your biological children; or
- They're your legally adopted children (coverage for legally adopted children starts from placement); or
- You are their legal parent identified on their birth certificate; and
- You have provided updated information about your child's coverage under other benefit plans as requested by the Fund; and
- You are eligible for family coverage, based on your Eligibility Class (see Section I.D).

Your stepchildren, foster children and grandchildren are **not covered** by the Benefit Fund. Children of your spouse cannot be covered by the Benefit Fund unless you are their legally recognized parent or they are legally adopted by or placed for adoption with you.

CHILDREN WITH DISABILITIES

If your child is disabled, as described below, coverage for your child may continue after age 26 if all of the following additional conditions are met:

- There is no other coverage available from either a government agency or through a special organization; and
- Your child is not married; and

- Your child became disabled before age 19; and
- You file a properly completed **Disability Certification Form** with the Benefit Fund each year after your child reaches age 26.

Your child is considered disabled if the Trustees determine in their discretion that your child lacks the ability to engage in any substantial gainful activity due to any physical or mental impairment that is verified by a physician, and the physical or mental impairment is expected to last for a continuous period of no less than 12 months or to result in death.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Benefit Fund will comply with the terms of any Qualified Medical Child Support Order (QMCSO), as the term is defined in the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended.

The Plan Administrator will determine the qualified status of a medical child support order in accordance with the Benefit Fund’s written procedures. A copy of these procedures is available, without charge, from the Benefit Fund.

SECTION I. B

WHEN YOUR COVERAGE BEGINS

IF YOU ARE A NEW EMPLOYEE

You can start receiving benefits from the Benefit Fund after:

- You are hired by a Contributing Employer already participating in the Benefit Fund;
- You have enrolled in the Benefit Fund; and
- You have completed the waiting period specific to your Employer and your Employer has been obligated to make contributions to the Benefit Fund based upon your employment for at least 30 consecutive days (however, in no event can the waiting period exceed the limit permitted by the Affordable Care Act).

IF YOU ARE A NEWLY ORGANIZED EMPLOYEE

Your coverage begins after:

- Your Employer becomes a Contributing Employer participating in the Benefit Fund;
- You have enrolled in the Benefit Fund; and
- Your Employer has made at least 30 consecutive days of contributions to the Benefit Fund based on your employment.

IF YOU CHANGE JOBS OR RETURN TO WORK AFTER A LEAVE

If you stop working for one Contributing Employer and begin working for another Contributing Employer, or return to work for a Contributing Employer:

- **Within 45 days**, you will have no break in your coverage;
- **After 45 days but within six months**, your benefits will start 30 days after you have been working for your new Contributing Employer; or
- **After six months**, you must meet the same requirements as a new employee.

NOTE: You must let the Benefit Fund know that you have changed Employers or returned to work from a leave in order for your coverage to begin again.

IF YOU HAVE FAMILY COVERAGE

Coverage for your spouse and/or your children starts at the same time your coverage begins if:

- Your benefit level is Eligibility Class I or Eligibility Class II (see Section I.D);
- They're eligible to receive benefits; and
- You elect spousal coverage and pay the weekly premium.

SECTION I. C

ENROLLING IN THE BENEFIT FUND

TO GET YOUR BENEFITS, YOU MUST FIRST ENROLL

You must fill out an **Enrollment Form** and send it to the 1199SEIU Family of Funds' Eligibility Department before you will be eligible for benefits.

To enroll in the Benefit Fund:

1. Get an **Enrollment Form** and a **Spouse Coverage and Paycheck Deduction Authorization Form** (if electing spousal coverage) from the Benefit Fund, by calling the Member Services Department at (646) 473-9200, or by clicking on "My Account" when visiting our website at **www.1199SEIUBenefits.org**; and
2. Completely fill out the form(s) (including the life insurance beneficiary section).

The Enrollment Form will ask for information about you and your family, including:

- Your name;
- Your address;
- Your Social Security number;
- Your birth date;
- Your marital status;
- The names, birth dates and Social Security numbers of each member of your family;

- The name and address of your designated life insurance beneficiary;
- Your spouse's Employer; and
- Information on other insurance coverage.

Sign and date the Enrollment Form, and:

1. Include copies of a birth certificate for you, your spouse and your eligible children to be covered, and a marriage certificate if you are enrolling your spouse.
2. Send the Enrollment Form and any related documents to the 1199SEIU Family of Funds' Eligibility Department immediately.

The Benefit Fund will not be able to process your Enrollment Form if you do not include all the information and documents required. That means you will not be eligible to receive benefits.

LET THE BENEFIT FUND KNOW OF ANY CHANGES

Your claims will be processed faster — and you will receive your benefits more quickly — if the Benefit Fund has up-to-date information on you and your family.

You must notify the Benefit Fund no more than 30 days from the date of the event when:

- You move;
- You get married;
- You are divorced or legally separated;
- You have a new baby;
- Your child reaches age 26;
- A family member covered by the Benefit Fund dies;
- You want to change your beneficiary;
- You change Employers; or
- You stop working for a Contributing Employer.

Fill out an **Enrollment Change Form**

and send it to the 1199SEIU Family of Funds' Eligibility Department so that your records can be updated. You must notify the Fund **within 60 days** if you stop working or you get divorced, or you or your spouse (if you get divorced) risk losing your rights to continued coverage. See Sections I.J and I.K.

Remember to send copies of all the documents needed by the Benefit Fund, including:

- Birth certificate(s) if you are adding your child(ren);
- Adoption papers if you are adding your child(ren);
- A marriage certificate if you are adding your spouse;

- Your separation or divorce papers if you are separated or divorced; and
- Any other documents required by the Benefit Fund.

An English translation certified to be accurate must accompany all foreign documents.

NOTE: If you have designated your spouse as your life insurance beneficiary, your divorce will automatically revoke that designation upon notification of your divorce to the Fund.

NOTE ABOUT NEWBORNS: To expedite payment of claims for your newborn child, you must provide the Fund with a birth certificate, Social Security number and Coordination of Benefits (other health insurance) information if requested.

SECTION I. D

HOW TO DETERMINE YOUR LEVEL OF BENEFITS

THE BENEFITS YOU RECEIVE ARE BASED ON THE HOURS YOU WORK EACH WEEK

The Benefit Fund has three levels of benefits called “Eligibility Classes.” Your Eligibility Class is based on the average hours you work each week (Average Weekly Hours).

Eligibility Class I – Family Coverage

If you work full time, your benefit level is generally Eligibility Class I. If you are in Eligibility Class I, you are eligible for family coverage. This means that you, your spouse and your children, if eligible, can receive benefits from the Benefit Fund.

If you work part time, your benefit level is either:

Eligibility Class II – Family Coverage

If you work on average more than 60%, but less than 100%, of a full-time schedule (**generally three or four days per week**) your benefit level is generally Eligibility Class II. If you are in Eligibility Class II, you are eligible for family coverage. This means that you, your spouse and your children, if eligible, can receive benefits from the Fund.

OR

Eligibility Class III – Member-Only Coverage

If you work on average more than 20%, but less than 60%, of a full-time schedule (**generally one or two days per week**), your benefit level is generally Eligibility Class III. If you are in Eligibility Class III, only you (the member) can receive limited benefits. Your spouse and your children are not eligible for coverage from the Benefit Fund.

See page 12 for an Overview of Eligibility Class I and Eligibility Class II Benefits. See page 22 for an Overview of Eligibility Class III Benefits.

IF YOU WORK FOR MORE THAN ONE CONTRIBUTING EMPLOYER

Your hours from all Contributing Employers are combined to determine your Eligibility Class. However, you can receive no more than the maximum benefit allowed by the Benefit Fund’s Schedule of Allowances.

HOW YOUR HOURS WORKED IS CALCULATED TO DETERMINE YOUR ELIGIBILITY CLASS

Your Employer reports the hours for which you are paid each week (including paid sick leave, vacation, holidays and other *paid* leave) to the Benefit Fund. To determine your Eligibility Class, the Benefit Fund averages your weekly

hours over a 16-week testing period. Your Average Weekly Hours are then compared to the Eligibility Class levels listed on the previous page.

If there is a change in your Average Weekly Hours over the 16-week testing period, your Eligibility Class will be adjusted, retroactive to the first day of the last monthly payroll report during the 16-week testing period.

However, your coverage will be extended for an additional 30 days for Eligibility Class I and Eligibility Class II members who, due to a reduction in hours, would otherwise be reduced to Eligibility Class III Benefits.

SECTION I. E

YOUR ID CARDS

If you are eligible for benefits and have enrolled in the Benefit Fund, you will receive one or more ID cards:

- **An 1199SEIU Health Benefits ID card** to use when accessing Health and Prescription Benefits; and/or
- **A Member Choice ID card**, if you are participating in the 1199SEIU Member Choice Program, to indicate what program you are enrolled in and who your primary care doctor is.

Call the Benefit Fund's Member Services Department at (646) 473-9200 if you have any problems with your ID card(s), including if:

- You do not receive your card(s);
- Your card is lost or stolen;
- Your name is not listed correctly; or
- Your spouse's and/or children's name(s) are not listed correctly.

NOTE: If you are no longer eligible for benefits, you may not use any ID card from the Benefit Fund. If you do, you will be personally responsible for all charges.

Your ID card(s) are for use by you and your eligible dependents only. To help safeguard your identity, please use the unique ID number that is included on your card(s) rather than your Social Security number when communicating with the Fund. You should not allow anyone else to use your ID card(s) to obtain Benefit Fund benefits. If you do, the Benefit Fund will deny payment and you may be personally responsible to the provider for the charges. If the Benefit Fund has already paid for these benefits, you will have to reimburse the Benefit Fund. The Benefit Fund may deny benefits to you and your eligible dependents and/or may initiate civil or criminal actions against you until you repay the Benefit Fund.

If you suspect that someone is using a Health Benefits ID card or Member Choice ID card fraudulently, call the Benefit Fund's Fraud and Abuse Hotline at (646) 473-6148.

SECTION I. F

COORDINATING YOUR BENEFITS

When you, your spouse or your children are covered by more than one group health plan, the two plans share the cost of your family's health coverage by "coordinating" benefits.

Here's how it works:

- One plan is determined to be **primary**. It makes the first payment on your claim; and
- The other plan is **secondary**. It may pay an additional amount, according to the terms of that plan.

If the Benefit Fund is:

- **Primary**, it will pay your claim in accordance with its Schedule of Allowances and the rules set forth in this SPD.
- **Secondary**, it will pay the balance of your claim up to its Schedule of Allowances in accordance with the rules set forth in this SPD after you have submitted a statement from the other insurer which indicates what it has paid. In no event will the Benefit Fund pay more than its Schedule of Allowances.

WHEN YOU ARE COVERED AS AN EMPLOYEE BY MORE THAN ONE PLAN

The coverage that has been in place the longest will be your primary payer. However, if you are enrolled in a plan where coverage is limited to services provided by in-network providers only, **you must use that coverage first.**

The Benefit Fund may provide benefits for charges related to a deductible, co-payment or co-insurance. The Benefit Fund will not provide benefits for services denied by that payer solely based upon your failure to use in-network providers.

WHEN YOU ARE COVERED BY MORE THAN ONE EMPLOYER PARTICIPATING IN THE BENEFIT FUND OR WHEN YOU AND YOUR SPOUSE ARE BOTH COVERED BY THE BENEFIT FUND

Each of you may claim the other and your children as dependents.

WHEN YOU AND YOUR SPOUSE OR CHILD ARE COVERED BY DIFFERENT PLANS

When your spouse or child is covered by another plan, or benefit coverage is available through your spouse's Employer, the Benefit Fund will coordinate payment of your benefits with that plan.

For your care:

- The Benefit Fund is the **primary** payer. It makes the first payment on your claim.
- Your spouse's plan is your **secondary** payer. It may cover any remaining balance, according to the terms of that plan.

For your spouse's care:

- Your spouse's plan is the **primary** payer.
- The Benefit Fund is your spouse's **secondary** payer.

For your child's care:

- When your child is covered by another Employer-sponsored plan (excluding parent coverage), your child's plan is the **primary** payer.

When submitting a claim for your spouse's care or your child's care, you must include a statement from your spouse's or child's plan showing what action it has taken.

IF BENEFIT COVERAGE CAN BE OBTAINED THROUGH YOUR SPOUSE'S EMPLOYER OR IF YOUR SPOUSE IS SELF-EMPLOYED

Your spouse must:

- Enroll in that Employer's benefit plan; or
- Purchase health coverage if self-employed, as defined by the Plan Administrator; and
- Pay any premiums required by that plan to maintain this coverage.

WHEN CHILDREN ARE COVERED BY BOTH PARENTS

If you and your spouse both have dependent coverage, benefits for your children are coordinated as follows:

- The **primary** payer is your child's Employer-sponsored coverage through his or her employment or through his or her spouse's employment, if any;
- The **secondary** payer is the plan of the **parent whose birthday is earliest in the year**; and
- The other parent's plan is the next payer.

If your child has no coverage, then the birthday rule would work as follows: The mother's birthday is March 11 and the father's birthday is July 10. Since the mother's birthday is earlier than the father's birthday, her plan is the primary payer for her children's benefits.

In the case of a divorce or separation, these rules will continue to apply except where a court order requires otherwise.

WHEN COVERED BY AN IN-NETWORK ONLY PLAN

If your spouse and/or your children are enrolled in a plan where coverage is limited to services provided by in-network providers only, **they must use that coverage first.**

The Benefit Fund may provide benefits for charges related to a deductible, co-payment or co-insurance. The Benefit Fund will not provide benefits for services denied by that payer solely based upon your failure to use in-network providers.

WHEN YOU ARE COVERED BY MEDICARE

The Benefit Fund is the primary payer for working members and their spouses age 65 and over who may be covered by Medicare. You will be eligible for the same coverage as any other working member or spouse.

However, you or your spouse may want to sign up for Medicare Part A and Part B as well. That way, Medicare will become your secondary payer.

This means that after the Benefit Fund pays benefits for your covered expenses, you may submit a claim for any unpaid balances to Medicare to be considered.

MEDICARE AND END STAGE RENAL DISEASE (ESRD)

A person with end stage renal disease (ESRD) will be entitled to Medicare Benefits. Initially, during the Medicare Coordination Period, the Benefit Fund will be the primary payer of benefits. Thereafter, the Benefit Fund will be secondary to Medicare. To protect your benefits, you must be enrolled in Medicare Part A and Part B immediately upon completion of the Medicare Coordination Period, and you must maintain Medicare coverage prior to and after your transplant as required by law unless you have verified that the Fund is your primary insurer. The Fund will provide reimbursement for 50% of the standard Medicare Part B premium for months where the Fund is secondary to Medicare. You are not eligible for this reimbursement for any month in which the Fund is providing primary coverage. To get this benefit, you must file a claim form with the Benefit Fund once each quarter but no later than two years after the premium payment.

NOTE OF CAUTION: Members or spouses who enroll only in Medicare Part A while they are in their Medicare Coordination Period may encounter Medicare penalties and delays in acquiring Medicare Part B upon completion of the Medicare Coordination Period.

SECTION I. G

WHEN OTHERS ARE RESPONSIBLE FOR YOUR ILLNESS OR INJURY

If someone else is responsible for your illness or injury, for example because of an accident or medical malpractice, you may be able to recover money from that person or entity, his or her insurance company, an uninsured motorist fund, a no-fault insurance carrier or a Workers' Compensation insurance carrier. **Expenses such as disability, hospital, medical, prescription or other services resulting from such an illness or injury caused by the conduct of a third party are *not covered by the Plan.***

However, the Plan Administrator recognizes that often the responsibility for injuries or illness is disputed. Therefore, in certain cases, as a service to you and if you follow the required procedures, the Benefit Fund may advance benefit payments to you, or on your behalf, before the dispute is resolved. You must notify the Benefit Fund of any accident or injury for which someone else may be responsible. Further, the Benefit Fund must be notified of initiation of any lawsuit arising out of the accident or incident. You are required to provide the Benefit Fund with any and all information and to execute and deliver all necessary documents, including a fully completed Accident Questionnaire,

as the Plan Administrator may require to enforce the Benefit Fund's rights.

When another party is responsible for an illness or injury, the Plan Administrator has the right to recovery and reimbursement of the full amount it has paid or will pay, for expenses related to any claims that you may have against any person or entity as a result of the illness or injury. By accepting the Benefit Fund's health benefits in payment for such expenses, you are assigning your rights in any recovery to the Benefit Fund, and you are agreeing to hold such proceeds in trust for the Benefit Fund and to repay the Benefit Fund from those proceeds immediately, as soon as you receive them, up to the amount of the payments that the Benefit Fund advanced to you or on your behalf. This means that the Benefit Fund has an equitable lien by agreement on the proceeds of any verdict or settlement reached in a lawsuit that you bring against someone for causing the illness or injury, up to the amount the Benefit Fund has paid for costs arising from that person's actions. This also means the Benefit Fund has an independent right to bring a lawsuit in connection with such an injury or illness in your

name and also has a right to intervene in any such action brought by you.

If you receive payments from or on behalf of the party responsible for an illness or injury, you agree that the Benefit Fund must be repaid immediately, up to the amount of the payments that the Benefit Fund has advanced to you or on your behalf. The Benefit Fund's right to recover its advanced benefit payments comes before you can recover any payments you may have made. You must repay the Benefit Fund regardless of whether the total amount of the recovery is less than the actual loss and even if the party does not admit responsibility, itemize the payments or identify payments as medical expenses. You cannot reduce the amount of the Benefit Fund's payments to pay for attorneys' fees incurred to obtain payments from the responsible party. The Benefit Fund's rights provide the Benefit Fund with first priority to any and all recovery in connection with the injury or illness. The Benefit Fund has these rights without regard to whether you have been "made-whole."

Once the Benefit Fund learns that another party may be responsible, you must sign a Lien Acknowledgment affirming the Benefit Fund's rights with respect to benefit payments and claims. If the Benefit Fund has advanced benefit payments to you and you fail or refuse to sign a Lien Acknowledgment or to comply with these terms, or dispute the

Fund's entitlement to a lien, the Plan Administrator may suspend your eligibility for benefits or bring a court action against you to enforce the terms of the Plan.

In the event you comply with the Fund's terms and acknowledge the Fund's rights, but you dispute the Fund's Lien Determination, in whole or in part, you may request an Administrative Review of the Lien Determination by writing to the Liens Department, provided that any proceeds you receive from a settlement, verdict or agreement for compensation from or on behalf of the party responsible for the illness or injury, up to the amount of the lien, are not disbursed for the duration of the appeal. The Fund will notify you in writing of the appeal decision and rationale within 30 days of receipt of the written appeal. If the Administrative Review results in a denial of your appeal, you have the right to request a final Administrative Review by the Chief Medical Officer or his or her designee in writing no later than 60 days after the receipt of the appeal denial. If your appeal is denied by the Chief Medical Officer or his or her designee, you have the right to file a suit under the Employee Retirement Income Security Act of 1974 ("ERISA") only in a federal court in New York City.

WHEN MOTOR VEHICLE OR NO-FAULT INSURANCE PROVIDES COVERAGE

This provision is expressly intended to avoid the possibility that the Plan will be primary to coverage that is available under motor vehicle or no-fault insurance.

The Plan is *secondary* to:

- Coverage provided under any “no-fault” provision of any motor vehicle insurance statute or similar statute; and
- Coverage provided under motor vehicle insurance, which provides for health insurance protection, even if you (your spouse or your covered children) select coverage under the motor vehicle insurance as secondary.

NOTE: All remedies and appeals must be exhausted through your no-fault carrier before the Benefit Fund will consider any payments on a primary basis.

In the event that the Benefit Fund pays benefits that should have been paid by the no-fault insurer, you are obligated to reimburse the Benefit Fund for the amount advanced on your behalf from any monetary recovery from any person or entity responsible for the injury or illness.

WHEN MOTOR VEHICLE OR NO-FAULT INSURANCE DENIES COVERAGE

Before the Benefit Fund will provide benefits, you must exhaust all of your benefits under your no-fault insurance.

If the no-fault insurer denies your claim for benefits, you are required to appeal this denial to your no-fault carrier. You must provide proof to the Benefit Fund that you have exhausted the no-fault appeals process before the Benefit Fund will consider payment in accordance with its Schedule of Allowances.

SECTION I. H

WHEN YOU ARE ON WORKERS' COMPENSATION LEAVE

If you are injured at work or suffer from a work-related illness, you are covered by Workers' Compensation, which is provided by your Employer. This includes coverage for healthcare costs, loss of wages and lump-sum payments for permanent injuries.

NOTE: You must file a Workers' Compensation claim with your Employer. Otherwise, you will jeopardize your rights to Workers' Compensation and your benefits from the Benefit Fund for yourself and your eligible family. If you need help or advice concerning your Workers' Compensation claim, call the Benefit Fund at (646) 473-9200.

WHAT WORKERS' COMPENSATION COVERS

You are covered for Workers' Compensation when you have an injury or illness as a result of your job, which:

- Prevents you from working for more than 14 days; and
- Causes a permanent defect, whether or not you lose time from work.

Workers' Compensation Benefits include:

- Weekly disability payments;
- Lump-sum payments for permanent injuries;

- Medical expenses;
- Coverage for drugs and appliances; and
- Carfare to and from the doctor's office or hospital.

Remember to get receipts for all services and send them to your Employer's Workers' Compensation insurer.

WHAT THE BENEFIT FUND COVERS

In most cases, the Benefit Fund will not cover any healthcare costs due to a work-related illness or injury.

However, the Benefit Fund will continue to cover you and your family for benefits **not related to the job injury or illness** while you are receiving Workers' Compensation Benefits, up to a maximum of 26 weeks.

If you can't go back to work after 26 weeks, your coverage through the Benefit Fund will end. However, you may be eligible to receive certain benefits under COBRA continuation coverage (see Section I.K).

PROTECT YOUR BENEFITS WHILE ON WORKERS' COMPENSATION

File a Claim with Workers' Compensation

1. Report your accident or work-related incident to your Employer immediately.
2. Get a **Workers' Compensation Incident Form** from your Employer and file a Workers' Compensation claim.
3. Submit proof to the Benefit Fund that you are receiving Workers' Compensation Benefits. Forms of proof that are acceptable include a copy of a Workers' Compensation check stub or a statement from your insurance carrier showing the period of coverage and amount paid. The Benefit Fund determines your eligibility for benefits based on your hours worked, which is reported by your Employer. If no hours have been reported for you, your coverage may be suspended because the Benefit Fund does not know that you are on Workers' Compensation.
4. Continue to send copies of all correspondence you receive in connection with your Workers' Compensation claim, including any electronic communications you receive from Workers' Compensation, to the 1199SEIU Family of Funds' Eligibility Department. This electronic communication may be a **First Report of Injury (FROI) Form**,

which indicates that your benefits have begun, or a **Supplementary Report of Injury (SROI) Form**, which indicates that your benefits have been stopped or modified. This will help the Benefit Fund keep up to date on the status of your Workers' Compensation claim.

5. If your Workers' Compensation claim is denied or disputed, notify the Benefit Fund immediately at (646) 473-9200.

Within 18 days after your claim is filed, your Employer's insurance company must, by law, either:

- Send you a check; or
- Notify you that your claim is being questioned or contested.

Call the Benefit Fund at (646) 473-9200 if:

- You do not hear from the insurance company within 21 days;
- You are called for an examination or hearing;
- Your claim is rejected or disputed;
- You need help filing your claim; or
- You need a referral to a qualified attorney.

SECTION I. I

WHEN YOUR BENEFITS STOP

If you are no longer employed by a Contributing Employer, if you stop working or if your Employer is not obligated to make payments to the Benefit Fund on your behalf:

All benefits end 30 days after the last day on which your Employer is required to make contributions to the Benefit Fund* on your behalf, unless your benefits are continued as described in Sections I.D and I.J or in Section VI – Retiree Health Benefits. However, if you or your spouse are covered by Medicare as of the last day that your Employer is required to make contributions to the Benefit Fund on your behalf, then there shall be no 30-day extension for active member benefits that are otherwise covered by Medicare, and therefore, such benefits end immediately on that last day.

** This may include contributions based on severance or other wages paid to you, such as vacation, etc.*

If your Employer fails to make contributions and is delinquent in making contributions on your behalf, the Trustees have the right to terminate coverage. If this occurs, you will be notified and your Employer may be liable in a civil action for the full amount of the benefits you lose, along with court costs.

If the Collective Bargaining Agreement between your Employer and 1199SEIU expires and if 1199SEIU and your Employer reach an impasse in negotiations, your benefits may also be terminated if your Employer stops making contributions on your behalf.

NOTE: If you stop making premium payments on behalf of your spouse, your spouse's benefits will end seven days after the last day you are required to pay premiums on his or her behalf.

NOTE: If you are no longer eligible for benefits, you may not use benefits from the Benefit Fund. If you do, you will be personally responsible for all charges from the date your coverage ended.

IF YOU ARE ON DISABILITY OR WORKERS' COMPENSATION LEAVE

Unless you return to work *immediately*, all of your Benefit Fund benefits will end:

- On the last day of your Disability Benefits, up to a maximum of 26 weeks within a 52-week period; or
- On the last day of your Workers' Compensation Benefits, up to a maximum of 26 weeks within a 52-week period.

If you are unable to return to work after your Disability leave or after 26

weeks of Workers' Compensation leave, call the Benefit Fund's COBRA Department at (646) 473-6815. See Section I.K for more information on COBRA continuation coverage.

OTHER COVERAGE OPTIONS FOR YOU AND YOUR FAMILY

There may be other coverage options for you and your family when you lose group coverage under the Benefit Fund. Under the Affordable Care Act, within 60 days from the date your coverage ended or during any open enrollment period, you and your family can buy health coverage through the Health Insurance Marketplace, **which could be a lower-cost option.** In the Marketplace, you could be eligible for a tax subsidy that lowers your monthly premiums right away, and you can see what your premiums, deductibles and out-of-pocket costs will be before you make a decision to enroll. You may also be eligible for COBRA continuation coverage. Being eligible for COBRA does not limit your eligibility for coverage or for a tax subsidy through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days from the date when your coverage ended.

WHEN YOU RETURN TO WORK

If you stop working for one Contributing Employer and begin working for another Contributing Employer, or return to work for a Contributing Employer:

- **Within 45 days**, you will have no break in your coverage;
- **After 45 days but within six months**, your benefits will start 30 days after you have been working for your new Contributing Employer; or
- **After six months**, you must meet the same requirements as a new employee.

You must let the Benefit Fund know that you have returned to work in order for your coverage to continue.

UPON YOUR DEATH

Upon your death, your spouse and eligible children will continue to receive benefits:

- While you are in the hospital; or
- For 30 days immediately following the date of your death.

The benefits they may receive are the same as would have been provided on the day before your death.

SECTION I. J

CONTINUING YOUR COVERAGE

WHILE RECEIVING DISABILITY BENEFITS FROM YOUR EMPLOYER

You need to contact the Benefit Fund **within 30 days** when you are not working due to a Disability, Workers' Compensation, Family Medical Leave (FMLA) or Uniformed Services leave. Call the Benefit Fund's Member Services Department at (646) 473-9200, to find out which forms need to be filed with the Benefit Fund.

Here's why: The Benefit Fund determines your eligibility for benefits based on hours reported by your Employer. If you have not worked any hours, then your coverage may be put in jeopardy because the Benefit Fund does not know that you are on an authorized leave.

Protect Your Disability and Health Benefits

While you are receiving Disability Benefits from your Employer, you and your family are still eligible for the same Benefit Fund coverage you had before your Disability. This coverage continues for a maximum of 26 weeks within a 52-week period.

It is important that you notify the Benefit Fund **within 30 days** of your illness or injury. Otherwise, you may jeopardize your Health Benefits.

CALL THE BENEFIT FUND

When You Return to Work

You must let the Benefit Fund know when you go back to work after being on Disability leave. This way, the Benefit Fund can update its records and determine your eligibility for benefits.

If Your Disability Continues

If your Disability continues beyond the maximum 26-week period, your coverage through the Benefit Fund will stop immediately. (See COBRA continuation coverage, Section I.K.)

However, you may be eligible for other benefits provided by governmental agencies. Call the Benefit Fund at (646) 473-9200 for more information and advice on how to file a claim for this aid.

NOTE: The Benefit Fund does not provide Disability Benefits, including payment for your lost wages.

WHILE PARTICIPATING IN TRAINING PROGRAMS

You may continue to be covered by the Benefit Fund when you participate in a training program through the 1199SEIU Greater New York Education Fund.

For more information on the various programs offered by the 1199SEIU Greater New York Education Fund, call (212) 494-0534, or visit our website at www.1199SEIUBenefits.org.

WHILE COVERED BY THE JOB SECURITY FUND (JSF)

You may continue to be covered by the Benefit Fund if you receive benefits from the 1199SEIU Greater New York Job Security Fund (JSF), which makes contributions on your behalf.

WHILE ON WORKERS' COMPENSATION LEAVE

If you are injured at work or suffer from a work-related illness, you are covered by Workers' Compensation, which is provided by your Employer. This includes coverage for healthcare costs and loss of wages.

In most cases, the Benefit Fund will not provide any coverage for a work-related illness or injury.

However, the Benefit Fund will continue to cover you and your family for benefits **not related to the job injury or illness** while you are receiving Workers' Compensation Benefits, up to a maximum of 26 weeks.

If you can't go back to work after 26 weeks, your coverage through the Fund will end. However, you can continue to receive Health Benefits under COBRA continuation coverage (see Section I.K).

WHILE TAKING FAMILY AND MEDICAL LEAVE (FMLA)

The Family and Medical Leave Act of 1993 ("FMLA") provides that the Benefit Fund — upon proper notification from your Employer — will extend eligibility for you and your dependents for up to 12 weeks, under certain conditions.

You are entitled to an FMLA extension if you are a member and experience an FMLA "qualifying event," defined as:

- The birth of your child and to care for the baby within one year of birth;
- When you adopt a child or become a foster parent within one year of placement;
- When you need to care for your spouse, your child or your parent who has a serious health condition (but not your mother-in-law or father-in-law);
- When you have a serious health condition that keeps you from doing your job; or
- When your spouse, son, daughter or parent is a military service member and is on or has been called to active duty in support of a contingency operation, in cases of "any qualifying exigency."

FMLA defines a “serious health condition” to include an injury, illness, impairment, or physical or mental condition that involves inpatient hospital care or continuing treatment by a healthcare provider.

If you are eligible for FMLA leave for one of the qualifying family and medical reasons listed in Section I.J, you may receive up to 12 workweeks of unpaid leave during a 12-month period.

If you need to care for your spouse, son, daughter, parent or “next of kin” in the Armed Forces (current service members or certain veterans) who has a serious injury or illness incurred or aggravated in the line of active duty, you are eligible for up to 26 workweeks of unpaid FMLA leave in a 12-month period. You are also eligible for up to 15 calendar days to spend with your military family member during his or her Rest and Recuperation leave.

During this FMLA leave, you are entitled to receive continued health coverage under the Benefit Fund under the same terms and conditions as if you had continued to work.

If you return to work with the required number of hours or more hours in your first full month after your FMLA leave ends, there is no lapse in coverage.

To be eligible for continued benefit coverage during your FMLA leave, your Employer must notify the Benefit Fund that you have been approved for FMLA leave.

NOTE: Your Employer — not the Benefit Fund — has the sole responsibility for determining whether you are granted leave under FMLA.

FMLA legislation was enacted to provide for temporary leave in situations where an employee intends to return to work when his or her FMLA leave ends. If you do not return to work, you may owe your Employer for the costs that were paid on your behalf over any period of time where coverage was extended solely on the basis of your FMLA leave.

WHILE TAKING UNIFORMED SERVICES LEAVE

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), if your coverage under the Benefit Fund ends because of your service in the U.S. uniformed services, your medical coverage will be reinstated for you, your spouse and your children when you return to work with your Employer without any waiting periods.

If you take a leave of absence under USERRA, healthcare coverage under the Plan will be continued for up to 30 days of active duty. If active duty continues for 31 days or more, coverage may be continued at your election and expense for up to 24 months (or such other period of time required by law). See Section I.K for a full explanation of the COBRA coverage provisions.

When you are discharged from service in the uniformed services (not less than honorably), your full eligibility will be reinstated on the day you return to work with a Contributing Employer, provided that you return to work within 90 days from the date of discharge if the period of military service was more than 181 days, or within 14 days from the date of discharge if service was more than 30 days but less than 180 days, or at the beginning of the first full regularly scheduled working period on the first calendar day following discharge if the period of service was less than 31 days. If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended for up to two years. Contact the Benefit Fund at (646) 473-9200 if you have any questions regarding coverage during a military leave.

The Benefit Fund may apply exclusions and/or waiting periods permitted by law, including for any disabilities that the Veterans Administration (“VA”) has determined to be service-related. This includes any injury or illness found by the VA to have been incurred in, or aggravated during, the performance of service in uniformed service.

SPECIAL NOTE: To continue your spousal coverage while you are receiving benefits during a Disability or Workers’ Compensation leave or through any of the programs or leaves described above, you must submit timely premium

payments directly to the Fund to maintain your spouse’s coverage. All payments should be sent to: 1199SEIU GNY Benefit Fund, Spousal Premium Payments, PO Box 796, New York, NY 10108-0796 or through the Fund’s electronic member portal.

SECTION I. K

YOUR COBRA RIGHTS

Under the federal law commonly known as COBRA, you, your spouse and your eligible children have the option of extending your **group health coverage** for a limited period of time in certain instances where group health coverage under the Benefit Fund would otherwise end (called a **qualifying event**). A qualified beneficiary is someone who will lose group health coverage under the Benefit Fund because of a qualifying event.

Continuation coverage is available on a **self-pay** basis. This means that you, your spouse and your children **pay monthly premiums** directly to the Benefit Fund to continue your group health coverage.

This section summarizes your rights and obligations regarding COBRA continuation coverage. You and your spouse should read it carefully. For more information, contact the Benefit Fund's COBRA Department at (646) 473-6815.

If you elect to continue your coverage, you, your spouse and/or your eligible children will receive the same health coverage that you were receiving right before you lost your coverage.

This may include hospital, medical, surgical, dental, vision and prescription drug coverage. However, note that Life Insurance, Accidental Death and Dismemberment Insurance and Burial Benefits are not covered by COBRA

continuation coverage. A child born to you or placed for adoption with you while you are receiving COBRA continuation coverage will also be covered for benefits by the Benefit Fund. 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).

WHEN AND HOW LONG YOU'RE COVERED

How long you, your spouse and your children can extend health coverage will depend upon the nature of the qualifying event.

18 MONTHS COVERAGE — YOU, YOUR SPOUSE, YOUR ELIGIBLE CHILDREN

You, your spouse and your eligible children may have the right to elect COBRA continuation coverage for a **maximum of 18 months** if coverage is lost as a result of one of the following qualifying events:

- The number of hours you work is reduced, resulting in a change in your Eligibility Class; or
- Your employment terminates for reasons other than gross misconduct on your part.

When the qualifying event is the end of employment or reduction of your hours of employment, and you became entitled to Medicare Benefits less than 18 months before the qualifying event, COBRA continuation coverage for your spouse and eligible children can last up to 36 months after the date of Medicare entitlement.

Being on a Family and Medical Leave of Absence (see Section I.J) is not a qualifying event for COBRA. If you do not return to work, you will be considered to have left your job, which may lead to a qualifying event.

You may be eligible for COBRA continuation coverage if you lose your Benefit Fund coverage because your Employer has filed a Title 11 bankruptcy proceeding. Please contact the Plan Administrator if this occurs.

36 MONTHS COVERAGE — YOUR SPOUSE

Under certain circumstances, your spouse may have the right to elect COBRA continuation coverage for a **maximum of 36 months**. These include a loss of coverage because:

- You die;
- You and your spouse become divorced or legally separated; or
- You become entitled to Medicare.

Under federal law, you or your spouse is responsible for notifying the Benefit

Fund within 60 days after the date your spouse loses (or would lose) coverage.

36 MONTHS COVERAGE — YOUR ELIGIBLE CHILDREN

Under certain circumstances, your eligible children may have the right to elect COBRA continuation coverage for a **maximum of 36 months**.

These include loss of coverage because:

- You die;
- Your child ceases to be an eligible dependent; or
- You become entitled to Medicare.

Under federal law, you or your child is responsible for notifying the Benefit Fund within 60 days after the date your child loses (or would lose) coverage.

EXTENDED COVERAGE

Second Qualifying Event Extension

Additional qualifying events can occur while COBRA continuation coverage is in effect. If your family experiences another qualifying event while receiving 18 months (or in the case of a Disability extension, 29 months) of COBRA continuation coverage, your spouse and children receiving COBRA continuation coverage 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 Benefit Fund.

This extension may be available to your spouse and any children receiving COBRA continuation coverage if:

- You die;
- You become entitled to Medicare;
- You get divorced or legally separated; or
- Your child stops being eligible as a dependent child;

but only if the additional qualifying event would have caused a loss of coverage had the initial qualifying event not occurred.

This extension due to a second qualifying event is available only if you notify the Benefit Fund of the second qualifying event within 60 days after the later of:

- The date of the second qualifying event;
- The date on which the qualified beneficiary would have lost coverage as a result of the second qualifying event if it had occurred while the qualified beneficiary was still covered; or
- The date on which the qualified beneficiary is informed of COBRA's requirements of both the responsibility to provide and the procedures for providing notice of the second qualifying event.

Disability Extension

If you, your spouse or a child covered under the Benefit Fund is determined

by the Social Security Administration to be disabled and you notify the Benefit Fund in a timely fashion, you, your spouse and your eligible children may be entitled to an additional 11 months of COBRA continuation coverage, for a **total maximum of 29 months**. The disability must have started at some time before the 60th day of the initial 18-month COBRA or Job Security Fund (JSF) continuation period, whichever is sooner, and must last at least until the end of the 18-month period of continuation coverage.

NOTE: If the disabled qualified beneficiary is a child born to you or adopted by you during the initial 18-month continuation period, the child must be determined to be disabled during the first 60 days after the child was born or adopted.

The Disability extension is available only if you notify the Benefit Fund of the Social Security Disability determination **within 60 days** after the later of:

- The date of the Social Security Disability determination;
- The date of the qualifying event;
- The date on which the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event; or
- The date on which the qualified beneficiary is informed of both the responsibility to provide and the procedures for providing notice of the Social Security Disability determination, but before the end

of the first 18 months of COBRA continuation coverage.

YOU MUST NOTIFY THE BENEFIT FUND TO OBTAIN COBRA CONTINUATION COVERAGE

Under the law, you, your spouse or your children are responsible for notifying the Benefit Fund **within 60 days** if:

- You and your spouse become divorced or legally separated; or
- Your child is no longer an eligible dependent.

You must notify the Benefit Fund at (646) 473-6815 or at PO Box 1036, New York, NY 10108-1036 **within 60 days** after the later of:

- The date of the qualifying event;
- The date on which the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event; or
- The date on which the qualified beneficiary is informed of both the responsibility to provide and the procedures for providing notice of a qualifying event.

Your Employer is responsible for notifying the Benefit Fund **within 30 days** if coverage is lost because:

- Your hours or days are reduced;
- Your employment terminates;
- You become entitled to Medicare; or
- You die.

INFORMING YOU OF YOUR RIGHTS

After the Benefit Fund is notified of your qualifying event, you will receive information on your COBRA rights. 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 decide to elect COBRA coverage, you, your spouse or your children have to notify the Benefit Fund of your decision **within 60 days** of the date (whichever is later) that:

- You would have lost your Benefit Fund coverage, including extensions; or
- You are notified by the Fund of your right to elect COBRA coverage.

In order for your election to be timely and valid, your **COBRA Election Form** must be:

- Actually received by the Benefit Fund on or before the 60-day period noted in Section I.K; or
- Mailed to the Benefit Fund at PO Box 1036, New York, NY 10108-1036 and postmarked on or before the 60-day period noted in Section I.K.

If you or your spouse or dependent children do not choose COBRA continuation coverage in a timely manner, your group health coverage

under the Fund will end as described in Section I.I, and you will lose your right to elect continuation coverage.

Even if you decide not to elect COBRA coverage when you qualify, your spouse and each of your children, if eligible, have a right to elect this coverage. Once your spouse elects COBRA, spousal premium payments will end and your spouse will be billed directly for the full cost of COBRA.

There may be other coverage options for you and your family when you lose group coverage under the Benefit Fund. Under the Affordable Care Act, within 60 days from the date your coverage ended or during any open enrollment period, you and your family can buy health coverage through the Health Insurance Marketplace, **which could be a lower-cost option**. In the Marketplace, you could be eligible for a tax subsidy that lowers your monthly premiums right away, and you can see what your premiums, deductibles and out-of-pocket costs will be before you make a decision to enroll. You may also be eligible for COBRA continuation coverage. Being eligible for COBRA does not limit your eligibility for coverage or for a tax subsidy through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days from the date when your coverage ended.

COST OF COBRA COVERAGE

Each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage.

WHEN COBRA COVERAGE ENDS

Your COBRA continuation coverage may end before the end of the applicable 18-, 29- or 36-month coverage period when:

- Your Employer ceases to be a Contributing Employer to the Benefit Fund, except under circumstances giving rise to a qualifying event for active employees;
- The Benefit Fund is terminated;
- Your premium for your coverage is not paid on time (within any applicable grace period);
- You, your spouse or your children get coverage under another group health plan;
- A qualified beneficiary becomes entitled to Medicare; or
- Coverage had been extended for up to 29 months due to a disability and there has been a final determination that the qualified beneficiary is no longer disabled.

Continuation coverage may also be terminated for any reason the Benefit Fund would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud or changes in the Plan's eligibility requirements). The Plan Administrator reserves the right to end your COBRA

continuation coverage retroactively if you are found to be ineligible for coverage.

Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event.

If the Social Security Administration (“SSA”) determines that the individual is no longer disabled, this extended period of COBRA coverage will end as of the last day of the month that begins more than 30 days after the SSA has determined that the individual is no longer disabled. The disabled individual or a family member is required to notify the Benefit Fund within 30 days of any such determination.

Once your COBRA coverage has stopped for any reason, it can’t be reinstated.

Claims incurred by you will not be paid unless you have elected COBRA coverage and pay the premiums, as required by the Plan Administrator.

This description of your COBRA rights is only a general summary of the law. The law itself must be consulted to determine how the law would apply in any particular circumstance.

If you have any questions about COBRA continuation coverage, please call the Benefit Fund at (646) 473-6815.

Remember to notify the Benefit Fund immediately if:

- You get married;
- You get divorced or legally separated;
- You or your spouse move; or

- Your child is no longer an eligible dependent.

CONTINUING YOUR LIFE INSURANCE

Life insurance is not covered by COBRA continuation coverage.

To continue your life insurance coverage, you may make payments directly if:

- You have been eligible for this coverage for at least one year; and
- You apply **within 30 days** after your Fund coverage ends.



SECTION II – HEALTH BENEFITS

- A. Participating Providers
 - Member Choice Providers
- B. Using Your Benefits Wisely
 - 1199SEIU CareReview Program
 - Program for Behavioral Health
 - Emergency Departments Are for Emergencies
 - Care Management Program
 - Prenatal Program
 - Wellness and Disease Management Programs
- C. Hospital Care and Hospice Care
- D. Emergency Department Visits
- E. Program for Behavioral Health: Mental Health and Alcohol/ Substance Abuse
- F. Surgery and Anesthesia
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- H. Medical Services
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 - What Is Not Covered
- I. Services Requiring Prior Authorization
- J. Vision Care and Hearing Aids
- K. Dental Benefits
- L. Prescription Drugs

HEALTH BENEFITS RESOURCE GUIDE

HOW TO REACH THE FUND

You can visit our website at www.1199SEIUBenefits.org for forms, directories and other information. From our website, you can also click on “My Account” to access information about your eligibility and claims history or to make simple updates to your information.

WHERE TO CALL

For Member Services

Call the Member Services Department at **(646) 473-9200** if you have any questions about your benefits, the programs or services offered by the Benefit Fund, or any procedures that need to be followed. The staff will either give you the information you need or refer you to someone who can provide you with the necessary information.

Also call for:

- A list of Participating Providers in your area;
- A list of Member Choice network hospitals;
- A Schedule of Allowances for non-Participating Providers;
- A list of Participating Dentists in your area;
- A list of Participating Pharmacies in your area; or
- A list of preferred drugs, also known as a Preferred Drug List (PDL).

For Ambulatory/Outpatient Surgery Pre-certification

You must call the **1199SEIU CareReview Program at (800) 227-9360** to pre-certify your surgery if your surgery is going to be performed in the outpatient department of a hospital or in a doctor's office.

For Prior Authorization

You must call **(646) 473-9200** for Prior Authorization if:

- You have questions about the treatment your doctor is recommending;
- You require home care services;
- You require certain diagnostic tests; or
- You need Prior Authorization for certain medications, including specialty drugs.
- You must call Care Continuum at **(877) 273-2122** if you require certain home infusion drugs administered on an outpatient basis.

You can also visit our website at www.1199SEIUBenefits.org for forms, directories and other information.

HEALTH BENEFITS RESOURCE GUIDE

For the Prenatal Program

Call **(646) 473-8962** to register with the Benefit Fund's Prenatal Program.

For the Program for Behavioral Health (Mental Health or Alcohol/Substance Abuse)

Call **(646) 473-6900** to get help with a mental health or alcohol/substance abuse problem.

For Inpatient Hospital Stays (including Behavioral Health)

You must call the 1199SEIU CareReview Program at (800) 227-9360:

- To pre-certify your hospital stay **before** going to the hospital for non-Emergency care;
- To notify the Benefit Fund **within two business days** of an Emergency admission; or
- To pre-certify inpatient behavioral health treatment (mental health or alcohol/substance abuse).

You can also visit our website at www.1199SEIUBenefits.org for forms, directories and other information.

HEALTH BENEFITS RESOURCE GUIDE

REMINDERS

- If you use a non-Participating Provider, you can be billed the difference between the Benefit Fund's allowance and whatever the provider normally charges, which could result in a significant cost to you. Also, a non-Participating Provider who appeals a benefit denial cannot file a lawsuit on your behalf more than five years from the date of service.
- You must call 1199SEIU CareReview **before** your hospital stay for non-Emergency care, or **within two business days** of an Emergency admission.
- Use the Emergency Department only in the case of a **legitimate medical Emergency**. If it is an Emergency, your Emergency Department visit must be **within 72 hours of an accident/injury or the onset of a sudden and serious illness**. A \$75 co-payment may apply if you are not admitted to the hospital.
- Show your Health Benefits ID card when you go to the Emergency Department or when you are admitted to the hospital. The Benefit Fund will pay the hospital directly.
- Register with the Benefit Fund's Prenatal Program.
- Call the Benefit Fund for services and supplies requiring Prior Authorization.
- If your dental treatment will cost more than \$300, you must get approval from the Benefit Fund **before** the work is done.
- Show your Health Benefits ID card to the pharmacist when you have a prescription filled.

Eligibility Class I and II have an annual restriction on out-of-pocket co-payments as established under the Affordable Care Act.

You can also visit our website at www.1199SEIUBenefits.org for forms, directories and other information.

QUALITY CARE ASSESSMENT

Your Benefit Fund is concerned about the quality of the care you and your family receive. If our medical or dental advisor has questions about your claim, the Benefit Fund may send it to an independent specialist to review. In some cases, the Benefit Fund may require that you be examined by a specialist chosen by the Benefit Fund. There is no cost to you for this consultation.

The Benefit Fund will pay only for Medically Necessary services. If the Benefit Fund determines that services provided to you were not Medically Necessary, the Fund will not pay the charges and you may be responsible for such charges.

SECTION II. A

PARTICIPATING PROVIDERS

GETTING THE CARE YOU NEED

Your Benefit Fund contracts with thousands of doctors, hospitals, diagnostic facilities, pharmacies, medical equipment suppliers and other healthcare professionals that provide comprehensive healthcare services. In addition, the Benefit Fund has designated certain laboratory facilities (including your Member Choice hospital-based lab), certain radiology (X-ray) facilities and certain durable medical equipment vendors as “preferred.” These “Participating Providers” accept the Benefit Fund’s payment as payment in full, beyond your co-payment, for most services. You must use these providers to avoid out-of-pocket expenses beyond your co-payment and to help control costs.

Participating Providers:

- Accept the Benefit Fund’s payment as payment in full for most services beyond your co-payments;
- Are conveniently located near where you work or where you live;
- Are licensed physicians and practitioners, in almost all cases, board-certified or board-eligible in their area of specialty; and
- Are affiliated with highly regarded institutions throughout the area.

For the names of Participating Doctors and other healthcare providers in your area, call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

HOW IT WORKS

You can choose any Participating Doctor, Hospital or other healthcare provider that you want for your family’s care. For children, you may designate a pediatrician as the primary care provider. You and your family can receive comprehensive care at no cost to you, except for your co-payments. And, there are no claim forms for you to file.

You should go to see your primary care doctor (including pediatricians for children) for regular checkups, vaccinations and other preventive care, and whenever you are sick.

If you have a special medical problem, talk to your primary care doctor first. Your doctor can determine whether you need to be referred to a specialist. If you see a specialist, make sure the specialist is also a Participating Provider. This is important because if the specialist is a non-Participating Provider, you cannot be sure that the specialist will accept the Benefit Fund’s allowances as payment in full. You may face a high out-of-pocket cost when using non-Participating Providers.

You do not need a referral in order to obtain access to obstetrical or gynecological care from a healthcare professional who specializes in obstetrics or gynecology.

THE BENEFIT FUND PAYS FOR YOUR BENEFITS, YOUR DOCTORS PROVIDE YOUR CARE

You make the decision about which physician or healthcare provider you and your family use.

The Benefit Fund's Participating Providers are independent practitioners who do not provide services as agents or employees of the Benefit Fund. The Benefit Fund does not provide medical care. It pays for benefits.

The Benefit Fund reviews providers' practice patterns and credentials. However, the Benefit Fund is not responsible for the decisions and actions of individual providers.

MEMBER CHOICE PROVIDERS

Access to Comprehensive Care

Member Choice combines the benefits of a patient-doctor relationship with the wide variety of medical specialties and patient services available at many hospitals.

You can choose a network of Participating Providers at a hospital that's conveniently located near your work or your home. You and your family can receive comprehensive care at no cost to you, except for your co-payments. And, there are no claim forms for you to file.

With Member Choice, all your doctors and healthcare providers work together in the same hospital network. Your primary care doctor coordinates your healthcare needs with specialists, diagnostic facilities and other healthcare services provided in the same Member Choice hospital network.

All of the Covered Services provided in that hospital network by Participating Providers, are covered in full by the Benefit Fund — including referrals, tests, anesthesia, outpatient treatment or inpatient hospital care.

You must be in Eligibility Class I or Eligibility Class II to enroll in Member Choice.

How to Join

To join Member Choice:

1. Call the Benefit Fund's Member Services Department at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org for the list of hospitals participating in Member Choice.
2. Pick the Member Choice network hospital that is most convenient for you and your family — you can choose any network, regardless of where you live or work.
3. Choose a primary care doctor for yourself and each member of your family from the list of doctors affiliated with that network hospital.
4. Fill out a **Member Choice Enrollment Form**, listing the

network hospital and primary care doctor(s) you have chosen.

5. Send your Member Choice Enrollment Form to the Benefit Fund.

You, your spouse and your children will each receive a Member Choice ID card to show that you're a member of the network at that hospital. This card will also show whom you have chosen as your primary care doctor.

You can choose one Member Choice hospital for your care (near where you work) and another Member Choice hospital for your spouse and your children (near where they live). Or, you can choose the same Member Choice hospital for all your family's care. But, you can choose only one hospital for each person.

You can change doctors at your Member Choice hospital at any time. If you want to change your doctor, change your Member Choice network or drop out of the Member Choice Program, you must call the Benefit Fund first.

The Benefit Fund will send you a new Member Choice ID card.

PREFERRED LABORATORY FACILITIES, RADIOLOGY (X-RAY) FACILITIES AND DURABLE MEDICAL EQUIPMENT (DME) VENDORS

The Benefit Fund has designated certain labs (including your Member Choice hospital-based lab), certain radiology facilities and certain DME vendors as "preferred." You must use these providers to avoid out-of-pocket costs beyond your co-payments. If your doctor wants you to have lab or radiological tests, please contact the Benefit Fund at (646) 473-9200 or visit our website at **www.1199SEIUBenefits.org** for the lists and locations of these laboratory and radiology facilities.

SECTION II. B

USING YOUR BENEFITS WISELY

Certain benefits described in this SPD are subject to co-payments. Please see the individual sections of this SPD for more details.

In order to avoid out-of-pocket costs, you must comply with the following:

1199SEIU CAREREVIEW PROGRAM (800) 227-9360

If you or a member of your family needs to go to the hospital or requires ambulatory or outpatient surgery, you must contact the **1199SEIU CareReview Program**:

- To pre-certify your hospital stay **before** going to the hospital for non-Emergency care;
- To certify your hospital stay **within two business days** of an Emergency admission;
- To pre-certify inpatient mental health or alcohol/substance abuse treatment;
- To pre-certify inpatient physical rehabilitation in an acute care facility; or
- To pre-certify outpatient or ambulatory surgical procedures.

Pre-certification is a review of Medical Necessity of Covered Services only. Pre-certification of the above services **does not** mean you are eligible on the date of service or that a

non-Participating Provider will accept the Benefit Fund's payment as payment in full.

WHEN YOU USE NON-PARTICIPATING PROVIDERS

You can go to any doctor or hospital you choose. But if you use a non-Participating (or non-Panel) Provider, you can be billed the difference between the Benefit Fund's allowance and whatever the provider normally charges. You may have to pay any cost over the Benefit Fund's allowance, **which could result in a significant cost to you**. Also, a non-Participating Provider who appeals a benefit denial cannot file a lawsuit on your behalf more than five years from the date of service.

Before you receive services from a non-Participating Provider, **you should ask the provider to find out the total Benefit Fund allowance for the planned service** by calling (646) 473-7160, and to notify you of what your out-of-pocket expenses will be.

PROTECT YOUR BENEFITS

If You Use an Emergency Department for Non-Emergency Care

The cost of non-Emergency treatment in an Emergency Department is much higher than non-Emergency treatment in your doctor's office, a clinic or through the use of an urgent care center which may be conveniently located near where you live. These centers are generally open seven days per week and have extended hours.

You will be responsible for the difference between some of the Benefit Fund's payment and the actual cost of the care you receive in the Emergency Department — resulting in a high out-of-pocket cost to you.

Questions?

If you have any questions, call the Benefit Fund's Member Services Department at (646) 473-9200. The staff can help you understand what procedures you need to follow in order to protect your benefits and to find out the Benefit Fund's allowance for the planned service.

PROGRAM FOR BEHAVIORAL HEALTH

Mental Health and Alcohol/ Substance Abuse

The Benefit Fund has a special program to help you, your spouse or your children get behavioral healthcare.

All calls and treatment information are kept strictly confidential. To pre-certify Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) services, you must call the Benefit Fund at (646) 473-6868.

You must call 1199SEIU CareReview at (800) 227-9360 before going to the hospital for inpatient care.

EMERGENCY DEPARTMENTS ARE FOR EMERGENCIES

A hospital Emergency Department should be used only in case of a **legitimate medical Emergency**.

To be considered an Emergency, your Emergency Department visit must occur **within 72 hours of an accident/injury or the onset of a sudden and serious illness**.

The Plan Administrator reserves the sole discretion to determine whether a legitimate Emergency existed, and benefits will only be provided in the event such a determination has been made. A \$75 co-payment for each Emergency Department visit will apply if you are not admitted to the hospital.

CARE MANAGEMENT PROGRAM

This is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services required to meet a member's health needs.

If you require ongoing medical treatment from a catastrophic or severe illness or injury, including after-hospital care, the Care Management ("CM") staff may consult with the doctor or hospital during the planning of Medically Necessary and appropriate care. CM aims to coordinate your care under the terms of our Plan to help ensure utilization of Covered Services by Participating Providers to minimize out-of-pocket costs. Information related to CM is strictly confidential.

UTILIZATION REVIEW

Utilization Review is a process for evaluating the Medical Necessity, appropriateness and efficiency of healthcare services provided to a member or eligible dependent. This will help ensure that requested services are the most appropriate for the illness or injury and provided at the most cost-effective level of care.

The review process can be:

- Prior Authorization (or prospective) — review before services are provided;
- Concurrent — review as services are being provided; or
- Retrospective — review after services have been rendered.

PRENATAL PROGRAM — HAVING A HEALTHY BABY

Complications can occur during your pregnancy that could lead to premature birth, low birth weight, birth defects or possibly even death for your baby.

With regular prenatal care, which includes the visits to your doctor and medical care you receive while you are pregnant, complications can be detected early and treated to reduce the risk of harming your baby.

Through the Prenatal Program, you can get important information, take part in practical workshops and receive supportive advice. You'll also learn about making healthier choices and get tips on what to expect during your pregnancy and caring for your baby.

Call the Benefit Fund's Prenatal Program at (646) 473-8962 to register.

WELLNESS AND DISEASE MANAGEMENT PROGRAMS

The Benefit Fund's wellness and disease management programs teach you ways to keep you and your family healthy and can work with you to help you manage existing medical conditions.

For more information or to find worksite programs, health fairs, workshops or other wellness events near you provided by Worksite Medical Services P.C., call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

PREFERRED LABORATORY FACILITIES

The Benefit Fund has contracted with certain freestanding labs in addition to your Member Choice hospital-based lab. You must use these providers to avoid additional out-of-pocket costs. If you require lab work:

- Make sure that your doctor sends your lab samples to a preferred lab; or
- If you need to have your lab work done outside of your doctor's office, take your referral slip from your doctor to a Patient Care (Drawing) Center from one of the preferred labs.

Contact the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org for the listing and locations of these facilities.

PREFERRED RADIOLOGY (X-RAY) FACILITIES

Prior Authorization and a \$15 co-payment are required for certain high-end imaging tests, such as MRI, MRA, PET scans, CAT scans and certain nuclear cardiology tests. If your doctor prescribes one of these tests, you or your doctor must call (888) 910-1199 for Prior Approval.

The Benefit Fund has entered into an agreement with a preferred network of radiology facilities. By using these facilities, you will avoid additional out-of-pocket costs. Call (888) 910-1199 for a referral to a preferred radiology facility. All radiological tests must be

performed by a radiologist or a non-radiology provider within the specialty for your particular test.

PREFERRED DURABLE MEDICAL EQUIPMENT (DME) VENDORS

The Plan covers rental of standard durable medical equipment such as hospital beds, wheelchairs and breast pumps. By using these vendors, you will avoid out-of-pocket costs. You must call for Prior Authorization at (646) 473-9200.

CERTAIN OUTPATIENT MOLECULAR AND GENOMIC LABORATORY PROCEDURES (GENETIC TESTING)

A list of outpatient laboratory genetic tests that require Prior Approval can be found on the Benefit Fund's website at www.1199SEIUBenefits.org under the "For Providers" tab. If your doctor prescribes one of these tests, your doctor or the laboratory must call (888) 910-1199 for Prior Approval. In addition, Prior Approval may be requested by your provider by logging onto the "Ordering Provider Login" at www.CareCoreNational.com.

See Section II.I — Services Requiring Prior Authorization. Other benefits may also require Prior Authorization. Please refer to the sections describing those specific benefits for more information.

SECTION II. C

HOSPITAL CARE AND HOSPICE CARE

BENEFIT BRIEF

Inpatient Hospital Care

This benefit is for the hospital's charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered, as described in Section II.H of this SPD. Coverage includes:

- Up to 365 days per year
- Acute care that is Medically Necessary
- Semi-private room and board
- Up to 30 days per year for inpatient physical rehabilitation in an acute care facility
- Benefits are not provided for care in a sub-acute nursing home or skilled nursing facility
- Observation care and services

You must call the 1199SEIU CareReview Program at (800) 227-9360 before going to the hospital or within two days of an Emergency admission to avoid out-of-pocket costs.

Eligibility Class I: Family

Eligibility Class II: Family

If you are in Eligibility Class I or Eligibility Class II, you, your spouse and your children are covered if you need to go to the hospital.

NOTE: Hospital Benefits will not be provided for any hospitalization that began prior to the date of your eligibility.

WHEN YOU NEED TO GO TO THE HOSPITAL

You are covered for acute inpatient hospital care for up to 365 days during a calendar year, in a semi-private room in a hospital, if Medically Necessary to treat your medical condition.

If you need hospital care:

- You must call the 1199SEIU CareReview Program at (800) 227-9360; and
- Show your Health Benefits ID card when you get to the hospital.

Even though you are covered for up to 365 days per year, most people do not have to stay in the hospital for more than a few days.

The Benefit Fund reviews hospital admissions. Based on this review, the Plan Administrator determines the number of days the Benefit Fund will pay for a given admission based upon the diagnosis when you are admitted and discharged. Your doctor may consult

with the Benefit Fund's Medical Advisor or 1199SEIU CareReview if your doctor feels a longer hospital stay is needed.

If you choose a private room, you will have to pay the difference between the charges for a private room and the average charges for a semi-private room.

If you require services from a surgeon or an anesthesiologist, check to make sure they are Participating Providers. Even when you go to a Participating Hospital, the doctors and anesthesiologists that provide services in the facility may not be participating and may charge above the Benefit Fund's allowance.

CARE COVERED

Inpatient Hospital Benefits cover reasonable payments billed by the hospital for the Medically Necessary care customarily provided to patients with your medical condition. These may include:

- Room and board, including special diets;
- Use of operating and cystoscopic rooms and equipment;
- Lab work that is needed for the diagnosis and treatment of the condition for which you are in the hospital, including pre-admission testing within seven days of the admission;
- X-rays that are needed for the diagnosis and treatment of the condition for which you are in the hospital, including pre-admission testing within seven days of admission;

- Use of cardiographic equipment;
- Use of physiotherapeutic and X-ray therapy equipment;
- Oxygen, and use of equipment for administering oxygen;
- A fee for administration of blood for each hospital stay; or
- Recovery room charges for care immediately following an operation.

INPATIENT ACUTE REHABILITATION

You are covered for up to **30 days per calendar year** in a hospital for Medically Necessary, acute inpatient treatment. Benefits are not provided for care in a sub-acute setting such as a nursing home or skilled nursing facility (SNF).

Your doctor must provide the Benefit Fund with a detailed written treatment plan. The plan must be reviewed and approved by 1199SEIU CareReview before the Benefit Fund will agree to provide benefits for any rehabilitation care.

ELECTIVE/SCHEDULED ADMISSIONS

Before you go to the hospital, you must call the 1199SEIU CareReview Program at (800) 227-9360.

OUTPATIENT OBSERVATION CARE AND SERVICES

Observation Care Benefits cover Medically Necessary services before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient or if he or she is able to be discharged from the

hospital. Generally, observation services are for a period of less than 48 hours.

HOSPITAL CARE OUTSIDE OF THE COUNTRY

The Fund will reimburse the member directly for reasonable costs of Medically Necessary services rendered outside of the country. The member must provide proof of payment, an itemized bill and other pertinent information, which may include a copy of the member's passport or airline tickets, and a certified translation, if requested by the Fund.

NOTE: For coverage of behavioral health partial hospitalization and intensive outpatient services, see Section II.E. For a description of the Eligibility Class III Hospital Indemnity Benefit, see Section V.B.

WHAT IS NOT COVERED

The Benefit Fund does not cover:

- Admissions for cosmetic services;
- Blood for transfusions;
- Care or service in a nursing home, skilled nursing facility, rest home or convalescent home;
- Custodial care or sub-acute care in a hospital or any other institution;
- Hospitalization covered under federal, state or other laws, except where otherwise required by law;
- Personal or comfort items;
- Private rooms;
- Rest cures;

- Services related to a claim filed under Workers' Compensation;
- Services that are not Medically Necessary;
- Services that are not pre-approved in accordance with the terms of the Plan; and
- All general exclusions listed in Section VII.D.

Some benefits may require Prior Authorization. Please refer to the sections describing those specific benefits for more information.

PAYMENT TO A HOSPITAL

The Benefit Fund has negotiated rates with many hospitals in the New York area. These are called "Participating Hospitals." Some Participating Hospitals have agreed to provide a Member Choice option as well.

As a Member Choice participant, when you go to your Member Choice hospital for Medically Necessary care, the Benefit Fund will pay the hospital directly for all services.

If you go to a hospital that is not a Participating Hospital for an elective admission, the Benefit Fund will pay only what it determines is the Schedule of Allowances at a comparable Participating Hospital for the services provided. You may be responsible for large out-of-pocket costs for the balance of the hospital bill.

BENEFIT BRIEF

Inpatient and Outpatient Hospice Care

- Coverage for a combined total of up to 210 days per lifetime in a Medicare-certified hospice program in a hospice center, hospital, skilled nursing facility or at home
- Life expectancy is estimated to be six months or less

Eligibility Class I: Family

Eligibility Class II: Family

HOSPICE CARE

Hospice care is a type of care and a philosophy of care that focuses on bridging comfort and relief of symptoms to patients nearing the end of life. The Fund pays for inpatient and outpatient charges made by a Hospice Care Agency and may include, but is not limited to:

- Room and board and other services and supplies received during a stay for pain control and other acute and chronic symptom management;
- Services and supplies given to you on an outpatient basis;
- Part-time or intermittent nursing care by an RN (Registered Nurse) or LPN (Licensed Practical Nurse) for up to eight hours a day;
- Part-time or intermittent home health aide services for up to eight hours a day;

- Physical and occupational therapy;
- Consultation or case management services by a physician;
- Psychological counseling; or
- Respite care. This is care received during a period of time when your family or usual caretaker cannot attend to your needs.

LIMITATIONS

Unless specified above, **not covered** under this benefit are charges for:

- Daily room and board charges over the semi-private room rate;
- Bereavement counseling;
- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling, including estate planning and the drafting of a will;
- Services that were not pre-authorized (see Section II.I for details); and
- Homemaker or caretaker services. These are services that are not solely related to your care. These include, but are not limited to, sitter or companion services, transportation or maintenance of your residence.

SECTION II. D

EMERGENCY DEPARTMENT VISITS

BENEFIT BRIEF

Emergency Department Visits

- This benefit is for the hospital's charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered as described in Section II.H of this SPD.
- Use of the Emergency Department must be within 72 hours of an accident/injury or the onset of a sudden and serious illness
- Benefit Fund pays negotiated rate at Participating Hospital or reasonable charge at non-Participating Hospital

Eligibility Class I: Family

Eligibility Class II: Family

If you are in Eligibility Class I or Eligibility Class II, you, your spouse and your children are covered for Emergency Department care.

The Benefit Fund has negotiated Emergency Department rates with many hospitals in the New York area. If you go to the Emergency Department of a Participating Hospital, you will have no out-of-pocket costs for the hospital's charge for the use of the facility, except for a \$75 co-payment if you are not admitted to the hospital.

EMERGENCY DEPARTMENTS ARE FOR EMERGENCIES

A hospital Emergency Department should be used only in the case of a **legitimate medical Emergency**. To be considered an Emergency, your Emergency Department visit must meet the definition of Emergency (see Section IX) and must occur **within 72 hours of an accident/injury or the onset of a sudden and serious illness**.

When you go the Emergency Department:

- Show your Health Benefits ID card. The Benefit Fund will pay the hospital directly.
- You must call the 1199SEIU CareReview Program at (800) 227-9360 **within two business days** if you are admitted.

- Pay the required \$75 co-payment if you are not admitted to the hospital.

If you go to the Emergency Department in a hospital with which the Benefit Fund does not have an Emergency Department contract, you may incur additional out-of-pocket costs. If you have any questions about a bill for Emergency Department treatment, call the Benefit Fund's Member Services Department at (646) 473-9200.

NON-EMERGENCY TREATMENT CAN BE COSTLY TO YOU

The cost of non-Emergency treatment in an Emergency Department is much higher than non-Emergency treatment in your doctor's office, a clinic or through the use of an urgent care center, which may be conveniently located near where you live. These centers are generally open seven days per week and have extended hours.

For non-Emergency treatment, you will be responsible for the difference between some of the Benefit Fund's payments and the actual cost of the care you receive in the Emergency Department — resulting in a high out-of-pocket cost to you.

CALL YOUR DOCTOR FIRST

If you aren't sure whether you need to go to the Emergency Department:

1. Call your doctor first. Your doctor may be able to recommend treatment over the phone, have you go to the doctor's office or go to the hospital.
2. If your doctor's office is closed, call your doctor's Emergency (after hours) number.

If you do not have a primary care doctor or cannot reach your doctor, call (646) 473-9200 during the Benefit Fund's normal working hours for a referral to a Participating Provider.

Some benefits may require Prior Authorization. Please refer to the sections describing those specific benefits for more information.

SECTION II. E

PROGRAM FOR BEHAVIORAL HEALTH: MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE

BENEFIT BRIEF

Inpatient Mental Health

- Medically Necessary services, which may include inpatient days and Partial Hospitalization Programs (PHP)

Eligibility Class I: Family

Eligibility Class II: Family

Inpatient Alcohol/Substance Abuse

- Medically Necessary services for inpatient detoxification and rehabilitation

Eligibility Class I: Family

Eligibility Class II: Family

Outpatient Mental Health and Alcohol/Substance Abuse

- Outpatient visits – \$5 co-payment
- Intensive Outpatient Programs (IOP)

Eligibility Class I: Family

Eligibility Class II: Family

If you are in Eligibility Class I or Eligibility Class II, you, your spouse and your children are covered for inpatient and outpatient mental health, alcohol or substance abuse treatment.

Benefits are paid according to the Benefit Fund's Schedule of Allowances.

GET THE HELP YOU NEED

The Fund offers a Member Assistance Program to help you and your family receive confidential treatment for alcohol, substance abuse or mental health problems.

If you need help, call the Program at (646) 473-6900. The Benefit Fund's social workers will discuss your problems or concerns with you and refer you to appropriate resources as needed.

MENTAL HEALTH BENEFITS

Outpatient Care

- Outpatient visits – \$5 co-payment
- Intensive Outpatient Programs (IOP)

Inpatient Care

- Medically Necessary mental health admissions in a hospital
- Partial Hospitalization Programs (PHP)

ALCOHOL/SUBSTANCE ABUSE BENEFITS

When Medically Necessary, you are covered for diagnosis and treatment of alcoholism or substance abuse.

Outpatient Care

- Outpatient visits – \$5 co-payment
- Intensive Outpatient Programs (IOP)

Inpatient Care

- Medically Necessary services for inpatient detoxification and rehabilitation

PARTIAL HOSPITALIZATION PROGRAMS FOR MENTAL HEALTH AND INTENSIVE OUTPATIENT PROGRAMS FOR MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE

Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP) provide intermediate levels of coordinated care and can prevent hospitalizations and help to restore maximum function in a clinically appropriate setting.

To pre-certify these services, call the Fund at (646) 473-6868.

IF YOU NEED TO GO TO THE HOSPITAL

If you or a member of your family need to go to the hospital, you must call 1199SEIU CareReview at (800) 227-9360:

- **Before** going to the hospital if it's not an Emergency; or
- **Within two business days** of an Emergency admission.

If you need hospital care, the 1199SEIU CareReview staff will authorize your hospital stay and may refer you to the Benefit Fund for additional follow-up. In the case of an Emergency admission, you or a member of your family must call 1199SEIU CareReview **within two business days**.

YOUR RIGHTS UNDER THE MENTAL HEALTH PARITY ACT

The Benefit Fund complies with federal law, which generally requires group health plans to ensure that financial requirements and treatment limitations applicable to Mental Health or Substance Use Disorder Benefits are no more restrictive than the predominant requirements or limitations applied to Medical/Surgical Benefits.

Some benefits may require Prior Authorization. Please refer to the sections describing those specific benefits for more information.

SECTION II. F

SURGERY AND ANESTHESIA

BENEFIT BRIEF

Surgery and Anesthesia

- Inpatient or outpatient (ambulatory) surgery
- Anesthesia

Eligibility Class I: Family

Eligibility Class II: Family

If you are in Eligibility Class I or Eligibility Class II, you, your spouse and your children are covered if you have surgery and need anesthesia.

Benefits are paid according to the Benefit Fund's Schedule of Allowances.

SURGERY

You are covered for surgery when performed:

- By a licensed physician or surgeon; and
- In an accredited hospital, ambulatory surgical center or office-based surgery suite.

If you need to go to the hospital, you must **call 1199SEIU CareReview at (800) 227-9360, before** your hospital stay. See Section II.B for more information.

YOUR BENEFIT IS DETERMINED BY THE TYPE OF SURGERY YOU NEED

The Benefit Fund can only pay up to a certain amount for each type of surgical procedure. Your benefit is the Benefit Fund's allowance for your type of surgery, or the doctor's charge, whichever is less.

If you need two or more related operations at the same time, the total Benefit Fund allowance for all your procedures will be determined based upon the Benefit Fund's allowance and its claims processing rules for multiple or related operations.

If you use a non-Participating Provider, you could face high out-of-pocket costs. Before you receive services from a non-Participating Provider, you should ask the provider to find out the total Benefit Fund allowance for the planned service by calling (646) 473-7160, and to notify you of what your out-of-pocket expenses will be.

For the names of Participating Surgeons in your area, call the Benefit Fund's Member Services Department at (646) 473-9200.

Assistant Surgeon

The Benefit Fund will pay 20% of its allowance for your surgery for an assistant surgeon if:

- No surgical residents were available; and
- The assistant surgeon was Medically Necessary.

ANESTHESIA

The amount of reimbursement for anesthesia under the Schedule of Allowances varies depending upon:

- The type of anesthesia provided; and
- The length of time anesthesia is given.

Coverage includes:

- Supplies;
- Use of anesthesia equipment; and
- Anesthesiologist charges.

Payment for local anesthesia is normally included in the Benefit Fund's surgical allowance.

AMBULATORY SURGERY

You no longer need to stay in the hospital for many surgical procedures that can be safely performed in the outpatient center of a hospital, surgical center or ambulatory care center. If your procedure can be safely performed in one of these settings, you must have it performed on an ambulatory or outpatient basis.

The Benefit Fund pays for:

- Operating room charges; and
- Ancillary hospital or ambulatory surgical center charges.

You must call 1199SEIU CareReview at (800) 227-9360 before having outpatient or ambulatory surgery.

YOUR RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Benefit Fund complies with federal law related to mastectomies.

If a member or dependent has a mastectomy and then chooses to have breast reconstruction, the Benefit Fund (in consultation with the patient and doctor) will provide coverage based upon the Benefit Fund's Schedule of Allowances for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy (including lymphedemas).

WHAT IS NOT COVERED

The Benefit Fund will not pay Surgical or Anesthesia Benefits if your surgery was:

- Covered by Workers' Compensation (see Section I.H);
- Not Medically Necessary;
- Performed primarily for cosmetic purposes, except when needed to correct gross disfigurement resulting from surgery, an illness or an accidental injury;
- Related to infertility treatment including, but not limited to, in vitro fertilization, artificial insemination, embryo storage, cryosterilization and reversal of sterilization;
- Services by an assistant to the surgeon performing the operation unless Medically Necessary;
- Services of a type usually performed by a dentist, except certain oral surgical procedures; and
- All general exclusions listed in Section VII.D.

Some benefits may require Prior Authorization. Please refer to the sections describing those specific benefits for more information.

SECTION II. G

MATERNITY CARE

BENEFIT BRIEF

Maternity Care

- An allowance which includes all prenatal and postnatal visits and delivery charges
- Disability Benefit through your Employer for you, if you are the mother
- Hospital Benefit for the mother
- Hospital Benefit for the newborn if the mother is you or your spouse
- Other benefits as required under the Affordable Care Act

Eligibility Class I: Family

Eligibility Class II: Family

If you are in Eligibility Class I or Eligibility Class II, Surgical and Hospital Benefits are available for maternity care.

Disability Benefits may be available through your Employer to replace a part of your lost wages, but this is not a benefit provided by the Benefit Fund. You may also be eligible to continue your Health Benefits through the Benefit Fund as long as you are receiving Disability Benefits from your Employer. See Section III – Disability Benefits for more information. Benefits are paid according to the Benefit Fund's Schedule of Allowances.

FOR YOU AND YOUR SPOUSE

If you or your spouse is the expectant mother, your Maternity Benefit includes:

- An allowance for all prenatal and postnatal visits and delivery charges;
- Anesthesia allowance;
- A Hospital Benefit for the mother and newborn;
- Lactation consulting by a certified provider (up to three consultations per calendar year); and
- Rental of hospital-grade breast pump (Prior Approval required. For details, call the Benefit Fund at [646] 473-9200.); or
- Reimbursement for one electric or manual retail breast pump. (Prescription required. For details, call the Benefit Fund at [646] 473-9200.)

FOR YOUR DEPENDENT CHILD

If your dependent child is the expectant mother, your Maternity Benefit includes:

- An allowance for all prenatal and postnatal visits and delivery charges;
- Anesthesia allowance;
- Lactation consulting by a certified provider (up to three consultations per calendar year); and

- Rental of hospital-grade breast pump (Prior Approval required. For details, call the Benefit Fund at [646] 473-9200.); or
- Reimbursement for one electric or manual retail breast pump. (Prescription required. For details, call the Benefit Fund at [646] 473-9200.)

**YOUR RIGHTS UNDER
THE NEWBORNS' AND
MOTHERS' HEALTH
PROTECTION ACT OF 1996**

The Benefit Fund complies with federal law in that:

- A mother and her newborn child are allowed to stay in the hospital for at least 48 hours after delivery (or 96 hours after cesarean section); and
- A provider is not required to obtain authorization for prescribing these minimum lengths of stay.

However, the mother and her provider may still decide that the mother and newborn should be discharged before 48 (or 96) hours.

PRENATAL PROGRAM

Having a Healthy Baby

With regular prenatal care, complications that may occur during your pregnancy can be detected early and treated to reduce the risk of harming your baby. Prenatal care includes the visits to your doctor and medical care you receive while you are pregnant. **To participate in the Benefit Fund's Prenatal Program, register by calling (646) 473-8962 or register online at www.1199SEIUBenefits.org.**

Some benefits may require Prior Authorization. Please refer to the sections describing those specific benefits for more information.

SECTION II. H

MEDICAL SERVICES

BENEFIT BRIEF

Medical Services

- Treatment in a doctor's office, clinic, hospital, Emergency Department or your home
- Well-child care for dependent children
- Immunizations
- Dermatology: up to 20 treatments per year
- Chiropractic: up to 12 treatments per year
- Podiatry: up to 15 treatments per year for routine care
- Allergy: up to 20 treatments per year, including diagnostic testing
- Physical/Occupational/Speech therapy up to 25 visits per discipline per year
- X-rays and laboratory tests
- Ambulance services

Eligibility Class I: Family

Eligibility Class II: Family

If you are in Eligibility Class I or Eligibility Class II, you, your spouse and your children are covered for Medical Benefits.

Benefits are paid according to the Benefit Fund's Schedule of Allowances.

NOTE: Behavioral Health Benefits are only provided as described in Section II. E.

PARTICIPATING PROVIDERS

Doctors, labs and other health providers who are part of the **Benefit Fund's Participating Provider programs accept your co-payment and the Benefit Fund's allowance as payment in full.** For more information, see Section II.A.

If you use a **non-Participating Provider**, you could face high out-of-pocket costs. You may have to pay the difference between the Benefit Fund's allowance and whatever the provider normally charges. Before you receive services from a non-Participating Provider, **you should ask the provider to find out the total Benefit Fund allowance for the planned service** by calling (646) 473-7160, and to notify you of what your out-of-pocket expenses will be.

DOCTOR VISITS

You and your family are covered for medical services provided in a doctor's office, clinic, hospital, Emergency Department or at home.

A licensed medical provider must provide your care. Specialists must be board-certified or board-eligible in their area of specialty.

A \$5 co-payment applies to regular doctor visits, and a \$10 co-payment applies to specialist office visits. However, no co-payment applies to preventive services as defined by the Affordable Care Act.

MAKING SURE YOU GET THE CARE YOU NEED

The Benefit Fund will pay its allowance for the following Medically Necessary services up to the maximums indicated below:

- **Dermatology:** up to 20 treatments per calendar year;
- **Chiropractic:** up to 12 treatments per calendar year;
- **Podiatry:** up to 15 treatments per calendar year for routine care;
- **Allergy:** up to 20 treatments per calendar year, including diagnostic testing; and
- **Physical/Occupational/Speech therapy:** up to 25 visits per discipline per year. Prior approval is required for additional visits. Habilitation therapies are not covered to the extent there is other

coverage available from either a government agency or program through a special organization.

If it is determined that additional treatment is Medically Necessary and in compliance with the Benefit Fund's clinical guidelines, policies, protocols and procedures, the Benefit Fund may provide benefits for additional treatment. To be covered, these treatments must be approved **in advance** by the Plan Administrator.

PREVENTIVE CARE

Regular medical check-ups help to keep you and your family healthy.

Some benefits are provided for preventive care services with no co-payments, as mandated by the Affordable Care Act, including:

- **Periodic check-ups**
Through regular exams, your doctor can detect any problems early, when they are easier to treat.
- **Immunizations**
Immunizations help protect your children against disease and are required for entrance to the public school system.
- **Well-child care**
Your dependent children are covered for regular exams.

X-RAY AND LABORATORY SERVICES

Benefits are provided for X-rays and lab services needed for your medical condition when performed:

- In your doctor's office (for a limited number of routine tests only);
- By an outside laboratory; or
- By a hospital outpatient department.

In order to avoid out-of-pocket costs, contact the Benefit Fund or visit our website at www.1199SEIUBenefits.org for the listing and locations of Participating Providers.

PREFERRED LABORATORY FACILITIES

The Benefit Fund has contracted with certain freestanding labs in addition to your Member Choice hospital-based lab. You must use these providers to avoid out-of-pocket costs. If you require lab work:

- Make sure that your doctor sends your lab samples to a preferred lab; or
- If you need to have your lab work done outside of your doctor's office, take your referral slip from your doctor to a Patient Care (Drawing) Center from one of the preferred labs.

Contact the Benefit Fund or visit our website at www.1199SEIUBenefits.org for the listing and locations of these facilities.

PREFERRED RADIOLOGY (X-RAY) FACILITIES

Prior Authorization is required for certain high-end imaging tests, such as MRI, MRA, PET scans, CAT scans and certain nuclear cardiology tests. If your doctor prescribes one of these tests, you or your doctor must call (888) 910-1199 for Prior Approval.

The Benefit Fund has entered into an agreement with a preferred network of radiology facilities. By using these facilities, you will avoid out-of-pocket costs other than your co-payments. Call (888) 910-1199 for a referral to a preferred radiology facility. All radiological tests must be performed by a radiologist or a non-radiology provider within the specialty for your particular test.

PREFERRED DURABLE MEDICAL EQUIPMENT (DME) VENDORS

The Plan covers rental of standard durable medical equipment such as hospital beds, wheelchairs and breast pumps. By using these vendors, you will avoid out-of-pocket costs. Call for Prior Authorization at (646) 473-9200.

HOSPICE CARE

Coverage for a combined total of up to 210 days per lifetime in a Medicare-certified hospice program in a hospice center, hospital, skilled nursing facility or at home. See Section II.C for details. For Prior Approval of hospice care, call (646) 473-9200. See Section II.I for details.

CHOOSE A PRIMARY CARE DOCTOR FOR COMPREHENSIVE CARE

A primary care doctor is an internist, family physician or pediatrician who coordinates your care or care needed by your spouse or children. Your primary care doctor gets to know you and your medical history, sees you when you're sick and provides regular check-ups and immunizations.

This way, he or she is aware of your overall health and minor problems can be detected before they become serious illnesses. If you have a chronic condition such as diabetes, hypertension or heart disease, your primary care doctor can oversee your care and help you manage your condition.

AMBULANCE SERVICES

Emergency transportation and services to the closest hospital where you can be treated in the case of an accident/injury or the onset of a sudden and serious illness. The Fund also covers transportation between hospitals if you need specialized care that the first hospital cannot provide.

WHAT IS NOT COVERED

The Benefit Fund does not cover:

- Acupuncture when administered by anyone other than a licensed medical physician or licensed acupuncturist;
- Charges for your co-payments;
- Charges in excess of the Benefit Fund's Schedule of Allowances;
- Charges related to refractions when performed by an ophthalmologist;
- Employment or return-to-work physicals;
- Experimental, unproven or non-FDA-approved treatments, procedures, facilities, equipment, drugs, devices or supplies (see definition of "Experimental" and exceptions for clinical trials in Section IX);
- Habilitation therapies to the extent there is other coverage available from either a government agency or program through a special organization;
- Infertility treatment, including, but not limited to, in vitro fertilization, artificial insemination, embryo storage, cryosterilization and reversal of sterilization;
- Laboratory tests that are not FDA-approved;
- Private physicians when care is given in a governmental or municipal hospital;
- Treatment for illness or injury covered by Workers' Compensation;

- Treatment that is cosmetic in nature;
- Treatment that is custodial in nature;
- Treatments determined to be not Medically Necessary;
- Venipuncture; and
- All general exclusions listed in Section VII.D.

Some benefits may require Prior Authorization. Please refer to the sections describing those specific benefits for more information.

SECTION II. I

SERVICES REQUIRING PRIOR AUTHORIZATION

BENEFIT BRIEF

Services Requiring Prior Authorization

- Home health care
- Non-Emergency ambulance services
- Durable medical equipment and appliances
- Medical supplies
- Specific medications, including specialty drugs (Eligibility Class II not covered)
- Certain diagnostic and radiological tests
- Certain outpatient molecular and genomic laboratory procedures (genetic testing)
- Radiation therapy
- Medical oncology services
- Hospice care
- Ambulatory surgery or inpatient admissions
- Certain mental health and alcohol/substance abuse services
- Certain home infusion drugs administered on an outpatient basis

Eligibility Class I: Family

Eligibility Class II: Family

If you are in Eligibility Class I or Eligibility Class II, you, your spouse and your children are covered for Medical Benefits as described in this section. Doctors and health professionals that are part of the **Benefit Fund's Participating Provider programs accept the Benefit Fund's allowance as payment in full.**

If you use a **non-Participating Provider**, you could face high out-of-pocket costs. You have to pay the difference between the Benefit Fund's allowance and whatever the provider normally charges.

Prior Authorization reviews Medical Necessity of Covered Services only. Authorization of services **does not** mean a non-Participating Provider will accept the Benefit Fund's payment as payment in full. Before you receive services from a non-Participating Provider, **you should ask the provider to find out the total Benefit Fund allowance for the planned service** by calling (646) 473-7160, and to notify you of what your out-of-pocket expenses will be.

WHAT IS COVERED

To be covered, services must be:

- Ordered by your physician;
- Medically Necessary to treat your condition in compliance with the Benefit Fund's clinical guidelines, policies, protocols and procedures; and
- Approved **in advance** by the Benefit Fund's Prior Authorization Department.

PRIOR APPROVAL NEEDED

Call the Prior Authorization Department at (646) 473-9200. The Benefit Fund's professional staff will:

- Review your medical records;
- Determine if the service or supply will be covered by the Plan as Medically Necessary for your condition and appropriate for your treatment; and
- Contact you if there are any Participating Providers who can provide the course of treatment or equipment you need.

Prior Authorization reviews Medical Necessity of Covered Services only. Authorization of services **does not** mean a non-Participating Provider will accept the Benefit Fund's payment as payment in full.

If you do not get approval from the Prior Authorization Department before starting the service or using the supplies, you are not covered for these benefits.

HOME HEALTH CARE

Home health care services will be covered if they are authorized by the Benefit Fund in advance, Medically Necessary and in compliance with the Benefit Fund's protocols. Benefits are payable in accordance with the Benefit Fund's Schedule of Allowances up to the maximum benefits available.

This includes a combined total of up to 60 visits per calendar year for:

- Intermittent skilled nursing care;
- Intermittent non-skilled care; and
- Physical, occupational or speech therapy.

Coverage may be provided for private-duty skilled nursing care for up to an additional 120 hours per calendar year when authorized by the Fund in advance, Medically Necessary and in compliance with the Fund's protocols.

NON-EMERGENCY AMBULANCE SERVICE

Transportation between hospitals is covered if you need specialized care that the first hospital cannot provide.

NOTE: Emergency transportation and services to the closest hospital where you can be treated in the case of an accident/injury or the onset of a sudden and serious illness do not require Prior Authorization.

DURABLE MEDICAL EQUIPMENT AND APPLIANCES

The Plan covers rental of standard durable medical equipment such as hospital beds, wheelchairs and breast pumps.

Equipment may be bought only if:

- It is cheaper than the expected long-term rental cost; or
- A rental is not available.

MEDICAL SUPPLIES

The Plan covers services and supplies medically needed to treat your illness and which are approved by the Food and Drug Administration (FDA), such as:

- Prostheses;
- Blood and blood processing;
- Dressings;
- Catheters; and
- Oxygen.

SPECIFIC MEDICATIONS

You must get Prior Approval before benefits can be provided for certain prescriptions, including specialty drugs.

Call Care Continuum at (877) 273-2122 if you require certain home infusion drugs administered on an outpatient basis.

The Benefit Fund will periodically publish an updated listing of drugs that require Prior Authorization.

For a list of these drugs, contact the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

Those in Eligibility Class II have limited prescription drug coverage, which excludes specialty drugs. See Section II.L for further details.

NOTE: You may have to pay the entire cost of the prescription if you don't get Prior Approval from the Benefit Fund.

AMBULATORY SURGERY OR INPATIENT ADMISSIONS

You must get Prior Approval for hospital and surgery. See Section II.B.

CERTAIN DIAGNOSTIC AND RADIOLOGICAL TESTS

Prior Authorization is required for certain high-end imaging tests, such as MRI, MRA, PET scans, CAT scans and certain nuclear cardiology tests. If your doctor prescribes one of these tests, you or your doctor must call (888) 910-1199 for Prior Approval.

The Benefit Fund has entered into an agreement with a preferred network of radiology facilities. By using these facilities, you will avoid out-of-pocket costs. Call (888) 910-1199 for a referral to a preferred radiology facility. All radiological tests must be performed by a radiologist or a non-radiology provider within the specialty for your particular test.

MENTAL HEALTH AND ALCOHOL/ SUBSTANCE ABUSE TREATMENT

Prior Authorization is required for Partial Hospitalization Programs (PHP) and transcranial magnetic stimulation (TMS) for mental health. Prior Authorization is also required for Intensive Outpatient Programs (IOP) and inpatient admissions for mental health and alcohol/substance abuse. PHPs and IOPs provide intermediate levels of coordinated care and can prevent hospitalizations and help to restore maximum function in a clinically appropriate setting. To pre-certify these services, call the Fund at (646) 473-6868.

GENETIC TESTING

A list of certain outpatient molecular and genomic laboratory procedures and tests that require Prior Approval can be found on the Benefit Fund's website at www.1199SEIUBenefits.org under the "For Providers" tab. If your doctor prescribes one of these tests, your doctor or the laboratory must call (888) 910-1199 for Prior Approval. In addition, Prior Approval may be requested by your provider by logging onto the "Ordering Provider Login" at www.CareCoreNational.com.

Other benefits may require Prior Authorization. Please refer to the sections describing those specific benefits for more information.

RADIATION THERAPY AND MEDICAL ONCOLOGY SERVICES

Prior Authorization is required for radiation therapy and medical oncology services. If your doctor prescribes these services, your doctor must call (888) 910-1199 for Prior Approval. In addition, Prior Approval may be requested by your provider by logging onto the "Ordering Provider Login" at www.CareCoreNational.com.

HOSPICE CARE

Coverage for a combined total of up to 210 days per lifetime in a Medicare-certified hospice program in a hospice center, hospital, skilled nursing facility or at home, if they are Medically Necessary and approved by the Benefit Fund in advance. See Section II.C for details.

For Prior Approval of inpatient hospice care, call 1199SEIU CareReview at (800) 227-9360. For Prior Approval of outpatient hospice care, call the Benefit Fund's Prior Authorization Department at (646) 473-9200.

SECTION II. J

VISION CARE AND HEARING AIDS

BENEFIT BRIEF

Vision Care

- One eye exam every two years
- One pair of glasses or one order of contact lenses every two years

Eligibility Class I: Family

Eligibility Class II: Family

Hearing Aids

- Once every three years
- Call for referrals
- Co-payments when using Participating Providers may apply

Eligibility Class I: Family

Eligibility Class II: Family

If you are in Eligibility Class I or Eligibility Class II, you, your spouse and your children are covered for vision care and hearing aids.

Benefits are paid according to the Benefit Fund's Schedule of Allowances. Co-payments may apply when you use Participating Providers.

If you use a non-Participating Provider, you can be billed the difference between the Benefit Fund's allowance and whatever the provider normally charges. You may have to pay any cost over the Benefit Fund's allowance.

Call the Benefit Fund's Member Services Department at (646) 473-9200 to check your entitlement for benefits or for a referral to a Participating Provider.

VISION CARE

This Vision Benefit is not to be confused with medical treatment for diseases of the eye. You are covered for:

- One eye exam every two years; and
- One pair of glasses or one order of contact lenses every two years.

The following items are available from a Participating Optical Provider with no co-payment:

- Large selection of contemporary frames; and
- Plastic or glass lenses, including single vision, bifocals, safety and oversize.

Co-payment required for:

- Most contact lenses; and
- Progressive lenses.

FILING FOR BENEFITS

Participating Optometrists and Opticians bill the Benefit Fund directly.

If you select frames, lenses or other services that are not included in the Benefit Fund's program with your provider, you will receive a credit equal to the Benefit Fund's allowance and you may incur out-of-pocket costs.

If you use a Participating Optometrist or Optician, and you incur a large out-of-pocket cost, call the Benefit Fund at (646) 473-9200 before you pay for your exam, glasses or contact lenses.

Certain Participating Vision Care Providers also provide hearing aids.

If You Use a Non-Participating Provider

1. Obtain an itemized bill from your provider on his or her letterhead.
2. Request a **Member Reimbursement Medical Claim Form** from the Benefit Fund and fill it out.
3. Send the claim form with the paid itemized bill to the Benefit Fund.
4. You will be reimbursed up to the Benefit Fund's allowance.

WHAT IS NOT COVERED

The Benefit Fund does not cover:

- Non-prescription sunglasses;
- Lens coatings (scratch resistant and/or ultraviolet treatment);
- Visual training; and
- All general exclusions listed in Section VII.D.

HEARING AIDS

If you are in Eligibility Class I or Eligibility Class II, you, your spouse and your children are covered for hearing aids once every three years.

Call the Benefit Fund's Member Services Department at (646) 473-9200 for a referral to a Participating Provider. Co-payments may apply when you use Participating Providers.

If you use a non-Participating Provider, you can be billed the difference between the Benefit Fund's allowance and whatever the provider normally charges. You may have to pay any cost over the Benefit Fund's allowance.

SECTION II. K

DENTAL BENEFITS

BENEFIT BRIEF

Dental Benefits

Payments made in accordance with the Benefit Fund's Schedule of Allowances.

Coverage includes:

- Basic, preventive, major restorative and orthodontic services
- Maximum benefit of \$1,200 per calendar year (excluding essential oral pediatric services)

Eligibility Class I: Family

Eligibility Class II: Not Covered

If you are in Eligibility Class I, you, your spouse and your children are covered for Dental Benefits. If you are in Eligibility Class II, you, your spouse and your children are not covered for Dental Benefits.

Contact the Benefit Fund's Member Services Department at (646) 473-9200 or (800) 575-7771 (outside the New York City area) to verify your eligibility for this Dental Benefit. Dental coverage ends with the last day of your employment.

The maximum benefit is per calendar year, based on the date of *treatment* — not the date of the Benefit Fund's payment or when you filed your claim.

NOTES:

- Members who work or live north of Westchester County may be eligible to enroll in an upstate dental provider program.
- If you are currently enrolled in the American Dental Centers plan, you and/or your family members are not eligible to use the preferred panel of DDS dentists or non-Participating Dentists. Please call the Benefit Fund's Member Services Department at (646) 473-9200 for additional information or if you want to change your dental plan from the American Dental Centers to the dental plan administered by DDS.

All dental work must be performed by a licensed dentist.

- Certain surgical procedures will be covered only when performed by a board-certified or board-eligible oral surgeon, or a board-certified or board-eligible periodontist. You should contact the Benefit Fund in this regard before undergoing any oral surgical procedure.
- Comprehensive orthodontic treatment will be covered only when performed by a board-certified or board-eligible orthodontist.
- Cleanings may be performed by a licensed dental hygienist supervised by a licensed dentist.

BASIC AND PREVENTIVE CARE

You, your spouse and your children are covered for the following to the annual maximum benefit indicated in Section II.K:

- Examinations twice per year;
- Prophylaxis (cleaning) twice per year;
- Fluoride treatments twice per year;
- One complete set of diagnostic X-rays in a three-year period;
- X-rays needed to diagnose a specific disease or injury;
- Extractions;
- Fillings;
- Oral surgery;
- Periodontics (treatment of gum diseases); periosealing is limited to two quadrants every six months

and is not covered on the same day as a cleaning; and

- Endodontics (treatment of the inner part of the tooth).

MAJOR RESTORATIVE CARE

You, your spouse and your children are covered for the following, up to the annual maximum benefit indicated in Section II.K:

- Removable prosthetics (partial and complete dentures) subject to a five-year limitation;
- Crown and bridgework, including replacement of any existing denture, bridgework, crown or gold restoration, subject to a five-year limitation;
- Orthodontics (treatment and appliances to correct tooth misalignment) once in a lifetime for children. Benefits start when the appliances are inserted and continue for a maximum of **24 consecutive months** for active treatment and a maximum of **eight months** of retention visits during the 12-month period following active treatment.

ANNUAL MAXIMUM PAYMENTS

Benefits are paid according to the actual charges or the Benefit Fund's Schedule of Allowances, whichever is less, up to the maximum benefit of \$1,200 per eligible person per calendar year. There is no limit on essential oral pediatric services to the

extent required by the Affordable Care Act. Therefore, reference to a \$1,200 maximum in this section excludes essential oral pediatric services.

The lifetime maximum for orthodontics is \$1,000 for each eligible child.

WHEN TREATMENT COSTS MORE THAN \$300

All services above \$300 and all orthodontic services for eligible children under the age of 19 must be pre-certified by DDS's dental consultant. This protects you from unnecessary or inappropriate treatment. You should not begin treatment until your dentist receives the necessary Prior Authorization.

To have your dental treatment pre-certified, you or the dentist must submit the X-ray(s) of the treatment area and a description of treatment plan.

You and your dentist will receive a pre-determination form which will indicate:

- What treatment will be covered, if any; and
- What the Benefit Fund will pay.

If the Benefit Fund authorizes the procedure, it will be covered up to your annual maximum benefit, based upon your continued eligibility throughout the period of treatment. If the cost of the service exceeds your annual maximum benefit, you will be responsible for the balance.

IN CASE OF EMERGENCY

If you need Emergency treatment, call DDS at (800) 255-5681 and you will be referred to a Participating Dentist within 24 hours. If the DDS office is closed, visit the nearest dentist or your regular Participating Preferred Panel Dentist. You will be reimbursed up to the limits of the Plan.

You must file the following information with the Benefit Fund **within 30 days** of the date of your treatment:

- A completed claim form; and
- The appropriate X-rays.

EMERGENCY TREATMENT OF NON-EMERGENCY CONDITIONS CAN BE COSTLY TO YOU

If you use the Emergency Department for *non-Emergency treatment*, the Benefit Fund will not pay any more than it would for non-Emergency treatment in your dentist's office.

The Benefit Fund's allowance for non-Emergency treatment is much lower than the cost of an Emergency Department visit, resulting in a **large out-of-pocket** cost to you.

GETTING YOUR BENEFITS

When Using Your Preferred Panel of Dental Providers

DDS is a Preferred Panel of Providers with a network of over 800 Participating Dentists in the tri-state area that accept full or partial assignment for Covered Services up to the limits of the Plan.

When receiving your dental care from a Participating Dentist, there is coverage in full with no co-payment for covered preventive or basic services. There are some co-payments for major services as described in this section.

Participating Dentists are independent neighborhood dentists in a private or group practice. This means a preferred dental provider may be a single dentist practicing alone or a number of dentists practicing as a group.

You are not required to bring a claim form when you use a Participating DDS Dentist. Participating Dentists will bill DDS directly.

When Using a Non-Participating Dentist

If you use a non-Participating Dentist, you or your dentist will be reimbursed up to the Benefit Fund's Schedule of Allowances for non-Participating Providers. The Benefit Fund pays no more than its allowance or the provider's charge, whichever is less. You are responsible for the balance. Before you receive services from a non-Participating Dentist, you should make sure that the provider submits a

form for Prior Authorization, if required, so the provider can notify you of what your out-of-pocket expenses will be.

If you use a non-Participating Dentist, you should obtain a dental claim form from the Benefit Fund, or by calling DDS at (800) 255-5681 prior to seeing a dentist. You or your dentist can send in a completed claim form to DDS for processing.

Remember, it is likely you will have large out-of-pocket expenses.

Multiple Services or Multiple Dentists

Your care is paid according to the Schedule of Allowances, unless a maximum amount is specified for a particular combination of dental services.

The Benefit Fund will make payments as if your treatment were performed by a single dentist if:

- You use more than one dentist during the course of your treatment; or
- More than one dentist provides services for the same procedure.

DENTAL EVALUATIONS

Before, during or after your dental treatment, you may be required to be examined by the Fund's dental consultant.

This evaluation protects both you and the Benefit Fund and is provided at no cost to you. If you do not agree to the exam, your benefits may be reduced or denied.

WHAT IS NOT COVERED

Benefits are not provided for:

- Any dental procedures which are undertaken primarily for dental care to treat accidental injuries, congenital or developmental malformations;
- Deep or intravenous conscious sedation and general anesthesia services which are not performed by a board-certified or board-eligible oral surgeon, or a dental anesthesiologist;
- Implants and services, supplies, appliances or restorations incurred in connection with implants are usually not covered by the Benefit Fund unless they meet the Benefit Fund's clinical guidelines and approved protocols;
- Replacement of an existing crown, bridge or denture which can be repaired and made serviceable according to accepted dental standards;
- Services not listed in the above sections;
- Services performed in foreign countries, unless there was an Emergency (services must be clearly described, and performed by a licensed dentist);
- Services, supplies or appliances incurred in connection with periodontal splinting or precision attachments, other than personalized restorations or specialized techniques;
- Services, supplies or appliances which are not Medically Necessary;
- Services that are cosmetic in nature;
- Temporary services, including, but not limited to, crowns, restorations, dentures or fixed bridgework, and night guards;
- The start of orthodontic treatment for individuals who are 19 years of age or over;
- Treatment of temporomandibular joint (TMJ) disorder;
- Treatment provided by someone other than a dentist (except for cleanings performed by a licensed dental hygienist under the supervision of a dentist); and
- All general exclusions listed in Section VII.D.

Some benefits may require Prior Authorization. Please refer to the sections describing those specific benefits for more information.

SECTION II. L

PRESCRIPTION DRUGS

BENEFIT BRIEF

Prescription Drugs

- Coverage of FDA-approved prescription medications for FDA-approved indications, except Plan exclusions
- No co-payments, no deductible when you use generic and preferred drugs where available
- Use Participating Pharmacies
- Mandatory Maintenance Drug Access Program
- You must comply with the Benefit Fund’s prescription programs, including Prior Authorization where required. For a complete list of these programs, please call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

Eligibility Class I: Family

Eligibility Class II: Limited Coverage
(mandated by the Affordable Care Act)

If you are in Eligibility Class I, you, your spouse and your children are covered for prescription drugs.

If you are in Eligibility Class II, you, your spouse and your children are eligible for a Prescription Benefit which is limited to contraceptive medication, Medically Necessary aspirin, certain vaccines, certain smoking cessation products and for the following preventive supplements when Medically Necessary and prescribed by a licensed prescriber: iron, folic acid, oral fluoride and prenatal vitamins.

WHAT IS COVERED

The Benefit Fund covers drugs approved by the Food and Drug Administration (“FDA”) that:

- Have been approved for treating your specific condition;
- Have been prescribed by a licensed prescriber; and
- Are filled by a licensed pharmacist.

The Benefit Fund also covers the following preventive drugs and supplements when Medically Necessary and if prescribed by a licensed prescriber:

- Contraceptive medication, aspirin, certain vaccines, certain smoking cessation products, iron, folic acid, oral fluoride and prenatal vitamins.

USING YOUR BENEFITS

To get your prescription:

- Ask your doctor to prescribe only covered medications and generics whenever possible, as per the Benefit Fund's prescription programs;
- Use Participating Pharmacies for short-term medications; and
- Show your Health Benefits ID card to the pharmacist when you give him or her your prescription.

There is no out-of-pocket cost for your prescriptions if you comply with the Benefit Fund's prescription programs:

- Mandatory Generic Drug Program;
- Preferred Drug List;
- Mandatory Maintenance Drug Access Program;
- Prior Authorization for specified medications;
- Quantity and day supply limitations;
- Step therapy; and
- Use the Specialty Care Pharmacy for injectables and other drugs that require special handling.

PRESCRIPTION DRUG PROGRAMS

For a complete list of these programs, please call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

GENERIC DRUGS

Generic drugs are therapeutic alternatives to brand-name drugs. The only major difference is the cost.

By law, a generic drug must contain the same active ingredients in the same quantities and be the same strength as the corresponding brand-name drug.

When the doctor gives you a prescription:

- If there is a generic equivalent for a brand-name drug, you must get the generic drug. Otherwise, you will have to pay the difference in cost between the brand-name drug and the generic equivalent.
- If there is no generic equivalent, your prescription will be filled with the brand-name drug.
- In rare situations, your doctor may specify the brand-name drug. In this case, your doctor must submit detailed medical information and supporting documentation to the Benefit Fund's Prescription Review Department to evaluate the clinical reasons why the brand-name drug is necessary.

PREFERRED DRUGS

The Benefit Fund and its Pharmacy Benefit Manager have developed a list of preferred drugs known as a **Preferred Drug List (PDL)**.

Drugs are selected based on how well they work and their safety. All Participating Providers are provided with a copy of the PDL. It should be used when prescription medication is required. If your doctor prescribes a brand-name drug that is not preferred, you will have to pay the difference in cost between the preferred drug and the non-preferred drug. If you would like a copy of the PDL, please call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

PREScription DRUG PROGRAMS

PRIOR AUTHORIZATION FOR SPECIFIED MEDICATIONS

You must get Prior Approval before benefits can be provided for prescriptions filled with certain medications. The Benefit Fund will periodically publish an updated listing of which drugs require Prior Authorization.

If your doctor prescribes any of those drugs, contact the Benefit Fund at (646) 473-9200. Some drugs require Prior Authorization from the Pharmacy Benefit Manager. Visit our website at www.1199SEIUBenefits.org for a comprehensive list and the correct phone number to call.

NOTE: You may have to pay the entire cost of the prescription if you don't get Prior Approval from the Benefit Fund. These claims will not be reimbursed.

QUANTITY AND DAY SUPPLY LIMITS

These prescription programs are intended to monitor clinical appropriateness of utilization based upon FDA guidelines. Examples of these programs are:

Proton Pump Inhibitors – You must get Prior Approval if your doctor prescribes one of these drugs for more than a 90-day period.

Migraine Medications – Coverage is limited to a specific quantity.

Prescriptions for these medications must be in compliance with the standards and criteria established by the FDA and accepted clinical guidelines for standard of care.

Dose Optimization – A program to help members have a more convenient “once per day” prescription dosing regimen whereby prescriptions written for twice-a-day dosing may be changed to once-a-day dosing.

Personalized Medicine – A voluntary program for members to help physicians determine which drug and dosage are clinically appropriate.

Quantity Duration – Based on FDA-recommended prescribing and safety information, the quantity duration rules help members receive the most clinically effective dosages of medication.

SPECIALTY CARE

Members must use the Specialty Care Pharmacy Program for injectables and other drugs that require special handling. Call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org for a listing of drugs included in this program. Specialty care drugs are available only through mail delivery service.

PRESCRIPTION DRUG PROGRAMS

STEP THERAPY

Step therapy is designed to provide safe, effective treatment while controlling prescription costs. With step therapy, you are required to try established, lower-cost, clinically appropriate alternatives before progressing to other, more costly medications, such as preferred brand names.

PROTECT YOUR CARD

Your 1199SEIU Health Benefits ID card is for your use only. Do not leave your card with your pharmacist. Show it to the pharmacist when ordering your prescription and make sure it is returned to you before you leave the store.

If your card is lost or stolen, immediately report it to the Benefit Fund at (646) 473-9200. If you think someone is fraudulently using your card, call the Benefit Fund's Fraud and Abuse Hotline at (646) 473-6148 or visit our website at www.1199SEIUBenefits.org.

USE A PARTICIPATING PHARMACY

For a list of Participating Pharmacies, call the Benefit Fund's Member Services Department at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

If you use a non-Participating Pharmacy or purchase covered supplements over-the-counter at any pharmacy, you will have to:

1. Pay for your prescription when it is filled;
2. Then visit the Fund's website at www.1199SEIUBenefits.org or

call the Benefit Fund's Member Services Department at (646) 473-9200 for a **Prescription Drug Reimbursement Claim Form (Direct Claim Form)**; and

3. Complete this form and send it along with an itemized paid receipt for your prescription to the address indicated on the form.

You will only be reimbursed up to the Benefit Fund's Schedule of Allowances.

FILLING YOUR PRESCRIPTIONS

For Short-term Illnesses:

If you need medication for a short period of time, such as an antibiotic, go to your local Participating Pharmacy to have your prescription filled.

For Chronic Conditions:

The Benefit Fund's Mandatory Maintenance Drug Access Program — *The 1199SEIU 90-Day Rx Solution*

If you have a chronic condition and are required to take the same medication on a long-term basis, you must fill your prescription through the Benefit Fund's Mandatory Maintenance Drug Access Program, *The 1199SEIU 90-Day Rx Solution*.

This program requires that you order medications you take on an ongoing basis in 90-day supplies. For your convenience, your medication will be delivered directly to you at your choice of address or you may choose to order and pick up your 90-day supply at a designated Participating Pharmacy.

If you are currently taking a maintenance medication, ask your doctor for a 90-day prescription (with three refills) and fill it either by:

- Mailing the prescription to the Benefit Fund's mail-order pharmacy, where it will normally be delivered within eight days; or
- Taking it to one of the designated Participating Pharmacies where it will be filled at the pharmacy.

For new maintenance medications, ask your doctor for two prescriptions: one for a 30-day supply (with one refill) and another for a 90-day supply (with three refills) that can be filled through the Mandatory Maintenance Drug Access Program once you know that the medication works for you.

Call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org for the locations of pharmacies that participate in the Mandatory Maintenance Drug Access Program, for a mail-order form or to determine if the drug you are taking is a maintenance medication.

COORDINATING PRESCRIPTION DRUG BENEFITS

If your spouse is covered for prescription medication under another healthcare plan, that plan is **primary**. The Benefit Fund is the **secondary** plan for your spouse and may provide coverage for any co-payments or deductibles that your spouse may incur up to the Benefit Fund's Schedule of Allowances.

Although your spouse's name will appear on your Health Benefits ID card, your spouse must use his or her primary prescription insurer first.

WHAT IS NOT COVERED

The Benefit Fund does not cover:

- Cold and cough prescription products;
- Compound drugs (except reformulations for injection or administration);
- Cost differentials for drugs that are not approved through the Benefit Fund's Prescription Drug Program;
- Experimental drugs;
- Medications for cosmetic purposes;
- Migraine medication in excess of FDA guidelines for strength, quantity and duration;
- Non-prescription items such as bandages or heating pads — even if your physician recommends them;
- Non-sedating antihistamines;
- Oral erectile dysfunction agents (except for penile functional rehabilitative therapy for up to

six months immediately following prostatic surgery);

- Over-the-counter drugs (except diabetic supplies or prescribed aspirin);
- Over-the-counter supplements (except Medically Necessary prescribed iron, folic acid or oral fluoride);
- Prescriptions for drugs not approved by the FDA for the treatment of your condition;
- Proton pump inhibitors in excess of a 90-day supply for FDA-approved indications by diagnosis; and
- All general exclusions listed in Section VII.D.

Some benefits may require Prior Authorization. Please refer to the sections describing those specific benefits for more information.



SECTION III – DISABILITY BENEFITS

DISABILITY BENEFITS

Disability Benefits may be provided through your Employer to replace a part of your lost wages, but it is not a benefit provided by the Benefit Fund.

You must notify the Benefit Fund when you apply for Disability Benefits through your Employer and submit copies of your disability payment stubs to the 1199SEIU Family of Funds' Eligibility Department as proof of your continued disability.

Your health coverage through the Benefit Fund will continue for up to a maximum of 26 weeks within a 52-week period while you are receiving Disability Benefits.

Follow the same procedure if you are receiving Workers' Compensation. If you need help or advice in filing a Workers' Compensation claim, call the Benefit Fund at (646) 473-9200.

NOTE: You cannot receive Disability Benefits for any period in which you receive any other compensation, such as a pension (except for active members age 70.5 or older who are receiving a Pension Benefit), payments from the Social Security Administration as a result of a Disability Award, sick leave or wages from any other Employer.

WHEN YOU RETURN TO WORK

Remember to let the Benefit Fund know when you return to work after being out on a Disability or Workers' Compensation leave. This will allow the Fund to update its records to reflect that you are once again an active member. You must also notify the Fund if you do not return to work following a leave.



SECTION IV – LIFE INSURANCE BENEFIT

- A. Life Insurance Eligibility
- B. Life Insurance Benefit
- C. Accidental Death and Dismemberment
- D. Burial

LIFE INSURANCE BENEFIT RESOURCE GUIDE

WHERE TO CALL

**Member Services Department
(646) 473-9200**

Call Member Services to:

- Request an **Enrollment Form** or an **Enrollment Change Form**; or
- Request a claim form for life insurance.

REMINDERS

- Complete your **Enrollment Form** and select a beneficiary.
- You may change your beneficiary at any time.
- You or your beneficiary need to file a claim for Accidental Death and Dismemberment Benefits **within 31 days** of your death or dismemberment.

You can also visit our website at www.1199SEIUBenefits.org.

SECTION IV. A

LIFE INSURANCE ELIGIBILITY

WHO IS COVERED

Once you're enrolled in the Benefit Fund and eligible for benefits, you are covered for:

- Life insurance; and
- Accidental death and dismemberment.

If you are in Eligibility Class I or II, you and your spouse are eligible for the Burial Benefit (if available).

Your children are not covered for these benefits.

CHOOSING YOUR BENEFICIARY

Your beneficiary is the person(s) you choose to receive your Life Insurance Benefit when you die.

When you fill out your **Enrollment Form**, list at least one person as your beneficiary.

You may change your beneficiary at any time. To change your beneficiary:

1. Call the Benefit Fund's Member Services Department at (646) 473-9200 and ask for an Enrollment Change Form, or visit our website at **www.1199SEIUBenefits.org**;
2. Fill out the form; and
3. Return it to the Benefit Fund.

The change of beneficiary will not be effective until it is received by the Benefit Fund.

NOTE: If you have designated your spouse as your beneficiary and you later get divorced, your divorce will automatically revoke that designation upon notification of your divorce to the Fund. If you do not designate or change your beneficiary after your divorce, your Life Insurance Benefit will be paid as if there is no beneficiary (see "If There Is No Beneficiary" below).

HOW YOUR BENEFICIARY APPLIES FOR BENEFITS

After your death, your beneficiary must, as soon as reasonably possible:

1. Notify the Benefit Fund's Member Services Department; and
2. Submit a certified original copy of your death certificate and a completed claim form to the Benefit Fund.

IF THERE IS NO BENEFICIARY

If you do not list a beneficiary, your beneficiary dies before your death or the Benefit Fund cannot locate your beneficiary after reasonable efforts, your Life Insurance Benefit is paid to the administrator or executor of your estate. If the total amount of your Life

Insurance and Accidental Death and Dismemberment Benefit is less than \$20,000 and no estate exists, your Life Insurance Benefit is paid to your survivors in the following order:

- Your spouse;
- Your children, shared equally;
- Your parents, shared equally;
- Your brothers and sisters, shared equally; or
- If none of the above survive, to your estate after it has been established.

If the total amount of your Life Insurance and Accidental Death and Dismemberment Benefit is \$20,000 or more, benefits will be paid to the administrator or executor of your estate.

IF THERE IS A DISPUTE

If there is a dispute as to who is entitled to receive your Life Insurance Benefit, no payment will be made until the dispute is resolved.

The disputed funds will be deposited into a court-monitored account if necessary.

IF YOU BECOME PERMANENTLY DISABLED

Before age 60, you will continue to be covered for life insurance if all of the following conditions are met:

- You have been covered by the Benefit Fund for at least 12 months;
- You become permanently disabled at the time you stopped working

and receive a Disability Award from the Social Security Administration;

- Your medical condition is certified no later than nine months after the time you stop working; and
- Your condition is recertified by your doctor three months before each anniversary of the start of the disability.

After age 60, you will be eligible for life insurance for a **maximum of 12 months** from the date your disability began if all of the following conditions are met:

- You have been covered by the Benefit Fund for at least 12 months;
- You become permanently disabled at the time you stopped working and receive a Disability Award from the Social Security Administration; and
- Your medical condition is certified no later than nine months after you stop working.

ASSIGNMENTS

Proceeds of a Life Insurance Benefit may be assigned, by you or your beneficiary, to pay the costs of your funeral. If your beneficiary chooses to assign his or her benefit after your death, that assignment shall be considered irrevocable.

SECTION IV. B

LIFE INSURANCE BENEFIT

BENEFIT BRIEF

Life Insurance

- Based on your Eligibility Class, years of service and earnings
- Death from any cause

Eligibility Class I: Member Only

Eligibility Class II: Member Only

Retirees are **not eligible** for this benefit.

See “Continuing Your Life Insurance” in Section I.K.

WHO IS COVERED

Once you are enrolled in the Benefit Fund and eligible for benefits, you are covered for:

- Life insurance; and
- Accidental death and dismemberment.

If you are in **Eligibility Class I**, your life insurance is based on your years of service and your annual rate of pay, up to a maximum benefit of \$25,000 (see chart on next page).

Eligible Members in Class I (Full-time Employees)	Life Insurance Amount
Less than 1 year of service	\$2,000
1 year or more but less than 4 years of service	\$4,000
4 years or more but less than 5 years of service	\$5,000
5 years or more but less than 6 years of service	\$6,000
6 years or more but less than 7 years of service	\$7,500
7 years or more but less than 8 years of service	\$8,500
8 years or more but less than 9 years of service	\$9,500
9 years or more but less than 10 years of service	\$10,000
10 years or more of service	An amount equal to 100% of the employee's annual earnings, taken to the next higher multiple of \$100 if not already a multiple thereof, but in no event less than \$10,000 or more than \$25,000.

If you are in **Eligibility Class II**, your maximum life insurance amount is \$2,500; however, your life insurance is \$1,250 during your first year of employment with a Contributing Employer.

Retirees are **not eligible** for this benefit.

SECTION IV. C

ACCIDENTAL DEATH AND DISMEMBERMENT

BENEFIT BRIEF

Accidental Death and Dismemberment

- Accidental death or injury
- Equal to, or one-half of, your life insurance, depending on the loss suffered

Eligibility Class I: Member Only

Eligibility Class II: Member Only

Retirees are **not eligible** for this benefit.

Accidental Death and Dismemberment (AD&D) Benefits are paid only if your death or accident/injury:

- Is caused directly and exclusively by external and accidental means, independent of all other causes;
- Occurs within 90 days from the date of your accident/injury; and
- Occurs while you are employed and covered by the Benefit Fund.

Retirees are **not eligible** for this benefit.

Your **Accidental Death Benefit** is equal to your life insurance amount. It is paid **in addition** to your life insurance. Proof of the cause of death is required.

Your **Accidental Dismemberment Benefit** is:

- **Half your life insurance amount** for loss of one hand, one foot or the sight in one eye;
- **Equal to your life insurance amount** for loss of both hands, both feet or sight in both eyes; or
- **Equal to your life insurance amount** for any combined loss of hands, feet and eyesight.

Loss means:

- Dismemberment at or above the wrist for hands;
- Dismemberment at or above the ankle for feet; or
- Total and irrecoverable loss of sight for eyes.

Your Accidental Death and Dismemberment Benefit will be no more than an amount equal to your life insurance amount. If you have more than one loss as a result of the same accident, payment will be made only for one of the combinations listed in Section IV.C.

FILING YOUR CLAIM

You or your beneficiary must complete a claim form and return it to the Benefit Fund **within 31 days** of your death or dismemberment.

Your eligibility for this benefit is the same as your eligibility for life insurance (see Section IV.A).

WHAT IS NOT COVERED

Accidental Death and Dismemberment Benefits are not available for losses resulting from:

- Acts of war;
- Bacterial infection (except pyogenic infections resulting solely from injury);
- Bodily or mental infirmity;
- Committing or participating in a crime or act that can be prosecuted as a crime;
- Disease or illness of any kind;
- Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft, except while as a fare-paying passenger in any aircraft that is licensed to carry passengers;
- Intentionally self-inflicted injury;
- Medical or surgical treatment (except where necessary solely by injury);
- Suicide or any attempt thereof; or
- The use of alcohol, or substance abuse.

SECTION IV. D

BURIAL

BENEFIT BRIEF

Burial

- If available, a free burial plot with permanent care

Eligibility Class I: Member & Spouse

Eligibility Class II: Member & Spouse

Retirees are **not eligible** for this benefit.

If available, a free non-sectarian burial plot with permanent care is available for you and your spouse, if you are in Eligibility Class I or Eligibility Class II. Plots are located in New York and New Jersey.

To receive information on a burial plot, call the Benefit Fund at (646) 473-9200.



SECTION V – OTHER BENEFITS

- A. Social Services
- B. Eligibility Class III Benefits

OTHER BENEFITS RESOURCE GUIDE

WHERE TO CALL

Member Assistance Program

(646) 473-6900

Call Member Assistance to:

- Make an appointment to confidentially discuss a personal or family problem; or
- Reach the Program for Behavioral Health.

Citizenship Program

(646) 473-9200

- Call the Citizenship Program to learn about assistance available in applying for United States citizenship.

Earned Income Tax Credit Assistance Program

(646) 473-9200

- Call the Earned Income Tax Credit Assistance Program for tax preparation help.

Home Mortgage and Financial Wellness Program

- For information on the Home Mortgage and Financial Wellness Program, visit our website at **www.1199SEIUBenefits.org** or refer to the 1199SEIU Greater New York Pension Fund Summary Plan Description.

Eligibility Class III Benefits **(646) 473-9200**

- Call the Fund's Member Services Department for information on Eligibility Class III Benefits.

You can also visit our website at www.1199SEIUBenefits.org.

SECTION V. A

SOCIAL SERVICES

BENEFIT BRIEF

Member Assistance Program

- Help and referral for personal and family problems for you, your spouse or your children

Citizenship Program

- Assistance in applying for United States citizenship

Earned Income Tax

Credit Assistance Program

- Tax preparation help

Home Mortgage and Financial Wellness Program

- Help with home ownership and managing credit and financial wellness

Weekly Legal Clinics

- Access to attorneys for free legal consultations regarding various legal matters

Eligibility Class I: Family

Eligibility Class II: Family

MEMBER ASSISTANCE PROGRAM

The Benefit Fund's Member Assistance Program offers assistance with personal and family problems.

If you are having a problem, speak to one of the Benefit Fund's social workers or other staff. They can work with you to try to get you information on community resources or the help you need to cope with a broad range of problems, including:

- Getting help for an alcohol or substance abuse problem;
- Getting decent housing;
- Dealing with pressure from creditors;
- Dealing with domestic violence; and
- Many more problems.

Call the Member Assistance Program at (646) 473-6900 for an appointment or to reach the Program for Behavioral Health.

All information is kept strictly confidential. Your confidence and privacy are respected. You don't have to worry about someone else finding out about your problem or concern.

CITIZENSHIP PROGRAM

A program is available to assist eligible members in applying for United States citizenship. For more information on the Citizenship Program, call (646) 473-9200.

EARNED INCOME TAX CREDIT ASSISTANCE PROGRAM

The Benefit Fund can connect members with certified tax preparers to help determine if they are eligible for the Earned Income Tax Credit and to file tax returns at a discounted rate. For more information, call (646) 473-9200.

HOME MORTGAGE AND FINANCIAL WELLNESS PROGRAM

For information on the Home Mortgage and Financial Wellness Program, please visit our website at www.1199SEIUBenefits.org or refer to the 1199SEIU Greater New York Pension Fund Summary Plan Description.

WEEKLY LEGAL CLINICS

Provides to eligible members access to attorneys for free legal consultations regarding various legal matters, including Workers' Compensation claims. For information on the legal clinics, visit our website at www.1199SEIUBenefits.org or call (646) 473-6488.

SECTION V. B

ELIGIBILITY CLASS III BENEFITS

BENEFIT BRIEF

Eligibility Class III Benefits

Eligibility Class III working members are eligible for a member-only package of benefits which includes:

- A Dental Benefit
- Vision care
- Life insurance and accidental death and dismemberment
- Hospital indemnity payments
- Social services

Effective April 1, 2014, members in Eligibility Class III are eligible only for a package of benefits which includes the Fund's Dental Benefit, vision care, life insurance, accidental death and dismemberment, a program to provide hospital indemnity payments if you are hospitalized and social services.

These benefits are briefly described below and in greater detail throughout this SPD:

DENTAL BENEFIT

- Maximum benefit of \$1,200 per year
- Coverage includes basic, preventive, major restorative and orthodontic services

- Payments based upon non-Participating Schedule of Allowances if you use a non-Participating Dentist

For additional information, call the Benefit Fund's Dental Department at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

See Section II.K for a summary of what is covered and a listing of additional limitations and what is not covered.

VISION CARE

- One eye exam every two years; and
- One pair of glasses or one order of contact lenses every two years.

See Section II.J for a summary of what is covered and a listing of what is not covered.

LIFE INSURANCE/ACCIDENTAL DEATH AND DISMEMBERMENT

- Maximum life insurance amount of \$1,250

See Section IV – Life Insurance Benefit for additional information and for a listing of what is not covered.

HOSPITAL INDEMNITY PAYMENTS

- The Benefit Fund will pay you up to \$200 (less applicable taxes) for each day you are an inpatient in a hospital as defined in Section IX of this SPD
- Up to a maximum of 10 days per hospital stay
- You must be billed for a room and board charge on your hospital bill

This benefit is payable to you upon receipt by the Fund of a completed claim form with a copy of a hospital bill showing the number of days that you were hospitalized.

Hospital indemnity payments are considered taxable earnings. They will be included in a W-2 tax form that you will receive at the end of the year.

SOCIAL SERVICES

- Member Assistance Program
- Citizenship Program
- Earned Income Tax Credit Assistance Program
- Home Mortgage and Financial Wellness Program
- Weekly Legal Clinics

See Section V.A for more information on the Benefit Fund's social services programs.



SECTION VI – RETIREE HEALTH BENEFITS

- A. Retiree Health Benefits
- B. Using Your Benefits Wisely
- C. If You Retire at or After Age 65 and Live in New York City, Nassau, Suffolk or Westchester Counties (with at Least 25 Pension Fund Credits)
- D. If You Retire at or After Age 65 and Live Outside New York City, Nassau, Suffolk or Westchester Counties (with at Least 25 Pension Fund Credits)
- E. If You Retire Between Ages 62 Through 64 (with at Least 25 Pension Fund Credits)
- F. If You Retire with a Disability Pension at Any Age (with at least 25 Pension Fund Credits)
- G. Retired Members Programs

RETIREE HEALTH BENEFITS RESOURCE GUIDE

WHERE TO CALL

Retiree Services Department (646) 473-8666

Call Retiree Services:

- For general questions about your Retiree Health Benefits;
- For more information on continuing the coverage you had as a working member after you retire through COBRA;
- For a list of Participating Pharmacies; or
- For questions about the Benefit Fund's Medicare Program.

1199SEIU CareReview (800) 227-9360

If you are not covered by Medicare:

- Call to pre-certify your hospital stay **before** going to the hospital for non-Emergency care; or
- Call **within two business days** of an Emergency admission.

Retired Members Department (646) 473-8666

- Call the Retired Members Department for information on retiree programs.

Please refer to Section II – Health Benefits for detailed information on each Health Benefit and the procedures that need to be followed.

You can also visit our website at www.1199SEIUBenefits.org.

REMINDERS

- Retiree Health Benefits differ by Eligibility Class.
- Your benefits as a retired member cannot exceed the coverage you had just before you retired.
- Your benefits must be coordinated with Medicare.
- You must register for Medicare at a local Social Security office **at least 90 days before** you retire, if you are age 65 or older.
- You must comply with the Benefit Fund's prescription programs, including the Benefit Fund's Medicare Part D Prescription Drug Program.

SECTION VI. A

RETIREE HEALTH BENEFITS

The Benefit Fund offers several Health Benefit packages for 1199SEIU retirees, each with specific rules for eligibility, which are explained in greater detail on the following pages.

Benefits are for retired members only; there is no coverage for spouses or dependents.

The benefits for which you are eligible depend on your age and your Pension Fund Credits. These benefits will be different than the benefits you were eligible for as a working member.

To determine what package of Retiree Health Benefits you are eligible for, refer to the appropriate section:

- If you retire at or after age 65 with at least 25 Pension Fund Credits (Sections VI.C and VI.D)
- If you retire between ages 62 through 64 with at least 25 Pension Fund Credits (Section VI.E)
- If you retire with a Disability Pension at any age with at least 25 Pension Fund Credits (Section VI.F)

Coverage is available if:

- You retired and began receiving your pension prior to January 1, 1992; or

- You retired from active Covered Employment on or after January 1, 2002.

There is **no** retiree health coverage if you retired between January 1, 1992, and December 31, 2001.

In most cases, Retiree Health Benefits start 30 days after you retire and stop if you go back to work.

In order to be eligible for Retiree Health Benefits, you must be retired, which means receiving a pension from the 1199SEIU Greater New York Pension Fund. If your Pension Benefit is suspended or stops for any reason (including your return to work or your loss of entitlement to a Social Security Disability Award), you will no longer be eligible for Retiree Health Benefits from the Benefit Fund.

Your benefits as a retired member cannot exceed the coverage you had just before you retired. For example, if you did not have prescription drug coverage right before you retired, you are not covered for Prescription Drug Benefits after you retire.

Retiree Health Benefits are available for the member only. Your spouse and dependent children are not covered for these benefits, regardless of their age.

The Board of Trustees reserves the right, within its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason, in such manner as may be duly authorized by the Board of Trustees.

Neither you, nor your beneficiaries or any other person, have or will have a vested or non-forfeitable right to receive benefits under the Plan.

SPECIAL RULE FOR MEMBERS WHO RETIRED WITH ELIGIBILITY CLASS III BENEFITS

If you meet the eligibility criteria as set forth in Section VI.C, VI.D, VI.E or VI.F, retire after January 1, 2015, and were eligible for Eligibility Class III Benefits as a working member, you are eligible for Vision Benefits only.

SECTION VI. B

USING YOUR BENEFITS WISELY

REGISTER FOR MEDICARE

Your Retiree Health Benefits are coordinated with Medicare Part A (hospital) and Medicare Part B (medical) if:

- You are age 65 or over; or
- You are eligible for Medicare as a result of receiving a Disability Pension through Social Security (which normally occurs when you reach age 65 or two years from the effective date of your Disability Award from Social Security, whichever comes first).

Medicare is the primary insurer for your care. The Benefit Fund's benefits supplement some of the coverage provided by Medicare, which you are eligible to receive.

You must register for Medicare Part A and Part B at a local Social Security office at least 90 days before you retire if you are Medicare-eligible or when you become Medicare-eligible (normally when you reach age 65) after you retire.

A delay in registering may:

- Delay your Medicare coverage;
- Result in a financial penalty charged by Medicare; or
- Result in out-of-pocket costs to you for care, which Medicare does

not pay. You must also enroll in either the Benefit Fund's Medicare Program, as described in Section VI.C, or the Benefit Fund's Medicare Part D Prescription Drug Program, as described in Section VI.D.

If you live in New York City, Nassau, Suffolk or Westchester Counties and are eligible for Medicare, you must also enroll in the Benefit Fund's Medicare Program unless you meet the exceptions described in Section VI. C. See Section VI.C for details on this program.

If you do not live in New York City, Nassau, Suffolk or Westchester Counties or if you have received a waiver from the Benefit Fund's Medicare Program:

You will receive prescription coverage as a part of your Retiree Health Benefits from the Benefit Fund only if you enroll in the Fund's Medicare Part D Prescription Program, which is an Employer Group Waiver Program (EGWP) sponsored by the Fund and its Pharmacy Benefit Manager.

The Benefit Fund's Medicare Part D Prescription Drug Program will provide you with a basic Prescription Drug Benefit which has been approved by Medicare, with little or no out-of-pocket cost. Under this program, the Benefit Fund supplements your

Medicare Prescription Drug Benefit up until you reach what is known as the “coverage gap.” While in the gap, the Benefit Fund stops supplementing your benefits and you can receive your prescriptions for both brand-name and generic drugs at significant discounts. After you have completed the gap, your benefits are further increased, whereby Medicare will pay up to 95% of the cost.

If you are not yet eligible for Medicare, when you become Medicare-eligible, you will automatically be enrolled in this prescription program if you live outside of New York City, Nassau, Suffolk or Westchester County. Once you receive your new ID card, simply continue to use Participating Pharmacies and comply with the program by using preferred drugs, generics and mail order to minimize your out-of-pocket cost.

If you choose not to maintain your coverage through this Medicare Part D Prescription Drug Program, you will not be eligible for prescription drug coverage through the Benefit Fund.

IF YOU NEED PRESCRIPTION DRUGS

For Participants in the Benefit Fund’s Medicare Program or Medicare Part D Prescription Program:

If you are enrolled in either of these programs, you will receive your medication, including mail-order prescriptions for chronic or maintenance medications, through these programs. See Section VI.C or VI.D.

For All Other Retirees:

Filling Your Prescriptions for Short-term Illnesses

If you need medication for a short period of time, such as an antibiotic, go to your local Participating Pharmacy to have your prescription filled.

Filling Your Prescriptions for Chronic Conditions

The Benefit Fund’s Mandatory Maintenance Drug Access Program — *The 1199SEIU 90-Day Rx Solution*

If you have a chronic condition and are required to take the same medication on a long-term basis, you must fill your prescription through the Benefit Fund’s Mandatory Maintenance Drug Access Program, *The 1199SEIU 90-Day Rx Solution*.

This program requires that you order medications you take on an ongoing basis in 90-day supplies. For your convenience, your medication will be delivered directly to you at your choice of address, or you may choose to order and pick up your 90-day supply at a designated Participating Pharmacy.

If you are currently taking a maintenance medication, ask your doctor for a 90-day prescription (with three refills) and fill it either by:

- Mailing the prescription to the Benefit Fund’s mail-order pharmacy, where it will normally be delivered within eight days; or

- Taking it to one of the designated Participating Pharmacies where it will be filled at the pharmacy.

For new maintenance medications, ask your doctor for two prescriptions: One for a 30-day supply (with one refill) and another for a 90-day supply (with three refills) that can be filled through the Mandatory Maintenance Drug Access Program once you know that the medication works for you.

Call the Benefit Fund at (646) 473-8666 or visit our website at **www.1199SEIUBenefits.org** for the locations of pharmacies that participate in the Mandatory Maintenance Drug Access Program, for a mail-order form or to determine if the drug you are taking is a maintenance medication.

SECTION VI. C

IF YOU RETIRE AT OR AFTER AGE 65 AND LIVE IN NEW YORK CITY, NASSAU, SUFFOLK OR WESTCHESTER COUNTIES (WITH AT LEAST 25 PENSION FUND CREDITS)

If you live in New York City, Nassau, Suffolk or Westchester Counties, you are eligible for the benefits described in this section when you retire at or after age 65 with Eligibility Class I Benefits and at least 25 Pension Fund Credits.

Your Benefit Fund coordinates your health coverage with Medicare. If you are eligible for Medicare, you must enroll in Medicare Part A, Medicare Part B and the Benefit Fund's Medicare Program in order to receive your supplemental Retiree Health Benefits from the Fund.

If you are eligible for Medicare and live in New York City, Nassau, Suffolk or Westchester Counties, you will only be able to receive Retiree Health Benefits from the Benefit Fund through the Medicare Advantage Plan with which the Benefit Fund has negotiated a special package of benefits for Benefit Fund retirees ("Benefit Fund's Medicare Program") after you have enrolled in Medicare Part A and Part B.

If you retire with Eligibility Class II or Eligibility Class III Benefits, you are not eligible to enroll in the Benefit Fund's Medicare Program. Please see Section VI.D for a description of your benefits.

The Benefit Fund's Medicare Program will provide you with a basic Prescription Drug Benefit as well as Hospital, Medical, Dental, Podiatry, Chiropractic, Vision and Hearing Aid Benefits. In addition, eligible members will receive an enhanced Prescription Drug Benefit.

If you are required to enroll in the Benefit Fund's Medicare Program and choose to "opt out" for any reason, you will no longer be eligible to receive Retiree Health Benefits from the Benefit Fund as described in the following sections of this SPD.

You may request a waiver of this requirement by calling the Benefit Fund at (646) 473-8666, only if you meet the following criteria as determined by the Plan Administrator:

- You are currently under treatment for a serious and/or chronic condition; **and**

- Your doctor does not participate in the Benefit Fund’s Medicare Program; **and**
- A change in physician would put your health in serious jeopardy.

Members who receive a waiver will be eligible for the benefits described in Section VI.D.

ELIGIBILITY

To receive the benefits described in this section from the Benefit Fund, you must have left covered service with Benefit Fund coverage and either (I) meet the eligibility conditions listed below within one year of the date (a) your Employer was no longer obligated to make contributions on your behalf; or (b) your Employer was terminated as a Contributing Employer to the Benefit Fund; or (II) be receiving Benefit Fund Disability or an award of permanent partial disability or permanent total disability from Workers’ Compensation from a disabling condition or event that commenced or occurred while you were actively employed by a Contributing Employer to the Benefit Fund.

Members who retire with Eligibility Class II Benefits will receive coverage as described in Section VI.D, except for Prescription Drug Benefits.

Members who retire with Eligibility Class III Benefits will receive vision-only coverage, as described in Section VI.D.

In addition, you must meet all of the following conditions:

- Retire at or after age 65; **and**

- Have at least 25 Pension Fund Credits certified by a Pension Fund that is recognized by the Trustees of the 1199SEIU Greater New York Pension Fund (or if you are not covered by a Pension Fund, 25 years of service recognized by the Trustees); **and**
- Be receiving a pension from the 1199SEIU Greater New York Pension Fund or have your application in process.

YOUR BENEFITS

Benefit Fund’s Medicare Program

When you enroll in the Benefit Fund’s Medicare Program, your Health Benefits, including a basic Prescription Drug Benefit, will be provided through the Benefit Fund’s Medicare Program.

Your basic Health Benefits are provided through the Benefit Fund’s Medicare Program, including:

- Hospital;
- Medical;
- Prescription drugs;
- Dental care;
- Home health care;
- Podiatry;
- Chiropractic;
- Vision care; and
- Hearing aids.

Remember to use physicians that participate in the Benefit Fund’s Medicare Program to avoid out-of-pocket costs.

For detailed information on these benefits, call the Benefit Fund's Retiree Health Benefits Department at (646) 473-8666.

SUPPLEMENTAL BENEFITS

Eligible members also receive supplemental benefits, including an enhanced Prescription Drug Benefit beyond that provided by the Benefit Fund's Medicare Program.

Prescription Drugs

When you enroll in the Benefit Fund's Medicare Program, the Plan will also provide Medicare Part D prescription coverage. You are also covered for an enhanced Prescription Drug Benefit, based upon an amount established by the Trustees, beyond the basic benefit provided through the Benefit Fund's Medicare Program and Medicare Part D. For more information on your enhanced Prescription Drug Benefit, contact the Retiree Health Benefits Department at (646) 473-8666.

NOTE: You may not enroll in any other Medicare Part D Plan while you are enrolled in the Benefit Fund's Medicare Program, or you will lose your supplemental Retiree Health Benefits through the Benefit Fund.

SECTION VI. D

IF YOU RETIRE AT OR AFTER AGE 65 AND LIVE OUTSIDE NEW YORK CITY, NASSAU, SUFFOLK OR WESTCHESTER COUNTIES (WITH AT LEAST 25 PENSION FUND CREDITS)

If you live outside New York City, Nassau, Suffolk or Westchester Counties, you are eligible for the benefits described in this section when you retire at or after age 65 with Eligibility Class I Benefits and at least 25 Pension Fund Credits.

Members who retire with Eligibility Class II Benefits will receive all of the benefits described in this section except for Prescription Drug Benefits.

Your Benefit Fund coordinates your health coverage with Medicare. If you are eligible for Medicare, you must enroll in Medicare Part A, Medicare Part B and the Benefit Fund's Medicare Part D Prescription Drug Program in order to receive your supplemental Retiree Health Benefits from the Fund.

If you are eligible for Medicare and live outside New York City, Nassau, Suffolk or Westchester Counties, you will only be able to receive Retiree Health Benefits from the Benefit Fund if you are enrolled in Medicare Part A, Medicare Part B and the Benefit Fund's Medicare Part D Prescription Drug Program, which is an Employer Group Waiver Program (EGWP) sponsored by the Fund and its Pharmacy Benefit Manager.

The Benefit Fund's Medicare Part D Prescription Drug Program will provide you with a basic Prescription Drug Benefit which has been approved by Medicare with little or no out-of-pocket cost. Under this program, the Benefit Fund supplements your Medicare Prescription Drug Benefit up until you reach what is known as the "coverage gap." While in the gap, the Benefit Fund stops supplementing your benefits and you can receive your prescriptions for both brand-name and generic drugs at significant discounts. After you have completed the gap, your benefits are further increased, whereby Medicare will pay up to 95% of the cost.

The Benefit Fund may not require that you enroll in the Medicare Part D Prescription Drug Program if you have already enrolled in another Medicare Part D Plan. Please note that you will be responsible for the full cost of your Medicare Part D premium, if any.

ELIGIBILITY

To receive the benefits described in this section from the Benefit Fund, you must have left covered service

with Benefit Fund coverage and either (I) meet the eligibility conditions listed below within one year of the date (a) your Employer was no longer obligated to make contributions on your behalf; or (b) your Employer was terminated as a Contributing Employer to the Benefit Fund; or (II) be receiving Benefit Fund Disability or an award of permanent partial disability or permanent total disability from Workers' Compensation from a disabling condition or event that commenced or occurred while you were actively employed by a Contributing Employer to the Benefit Fund.

Members who retire with Eligibility Class III Benefits will receive vision-only coverage, as described in this section.

In addition, you must meet all of the following conditions:

- Retire at or after age 65; **and**
- Have at least 25 Pension Fund Credits under the 1199SEIU Greater New York Pension Fund (or if you are not covered by a Pension Fund, 25 years of service recognized by the Trustees); **and**
- Be receiving a pension from the 1199SEIU Greater New York Pension Fund or have your application in process.

YOUR BENEFITS

When you are enrolled in the Benefit Fund's Medicare Part D Prescription Drug Program or if you are not required to enroll in the Benefit Fund's Medicare Program, for instance, if you have received a waiver, then you are entitled to receive the following benefits.

Hospital – Inpatient

Medicare is your primary insurer and must pay for your care first.

The Benefit Fund covers reasonable payments for the following inpatient hospital care customarily provided to patients with your medical condition, if Medically Necessary:

- Your Medicare Part A first-day deductible; and
- Your Medicare Part A co-insurance and reserve days.

NOTE: The Benefit Fund does not provide benefits for services rendered in a nursing home or skilled nursing facility.

Vision Care

You are covered for the following services once every two years when performed by an optometrist or optician:

- An eye exam; and
- A pair of glasses or an order of contact lenses.

The Vision Benefit does not include services rendered by an ophthalmologist.

Benefits are paid according to the Benefit Fund's Schedule of Allowances.

There are no out-of-pocket costs when you use Participating Optometrists and Opticians, unless you order glasses or other services that are not included in the Benefit Fund's program.

Prescription Drugs

The Benefit Fund's Medicare Part D Prescription Drug Program will provide you with a basic Prescription Drug Benefit with little or no out-of-pocket costs. Under this program, the Benefit Fund supplements your Medicare Prescription Drug Benefit up until you reach what is known as the "coverage gap." While in the gap, the Benefit Fund stops supplementing your benefits and you can receive your prescriptions for both brand-name and generic drugs at significant discounts. After you have completed the gap, your benefits are further increased, whereby Medicare will pay up to 95% of the cost.

To get your prescription:

- Ask your doctor to prescribe only covered medications and generics whenever possible;
- Use Participating Pharmacies for short-term medications; and
- Show your Health Benefits ID card to the pharmacist when you give him or her your prescription.

If you have any questions about your Prescription Drug Benefits, contact the Retiree Health Benefits Department at (646) 473-8666.

SECTION VI. E

IF YOU RETIRE BETWEEN AGES 62 THROUGH 64 (WITH AT LEAST 25 PENSION FUND CREDITS)

Effective January 1, 2015, if you retire at or after age 62 and before age 65 with Eligibility Class I Benefits and at least 25 Pension Fund Credits, you will be eligible for the Early Retiree Dental Plus Plan, as described in this section, unless you select, on a **one-time only** basis, coverage for the Early Retiree Prescription Plan, as described in this section, consisting of Vision Care and Prescription Drug Benefits only.

When you become eligible for Medicare, you will receive the benefit package given to members who retired at or after age 65 with at least 25 Pension Fund Credits as described in Section VI.C or VI.D.

ELIGIBILITY

To receive the benefits described in this section from the Benefit Fund, you must have left covered service with Benefit Fund coverage and either (I) meet the eligibility conditions listed below within one year of the date (a) your Employer was no longer obligated to make contributions on your behalf; or (b) your Employer was terminated as a Contributing Employer to the Benefit Fund; or (II) be receiving Benefit Fund Disability or an award of permanent partial disability or permanent total disability

from Workers' Compensation from a disabling condition or event that commenced or occurred while you were actively employed by a Contributing Employer to the Benefit Fund.

Members who retire with Eligibility Class II or Eligibility Class III Benefits will receive vision-only coverage, as described in this section.

In addition, you must meet all of the following conditions:

- Retire between the ages of 62 through 64; **and**
- Have at least 25 Pension Fund Credits under the 1199SEIU Greater New York Pension Fund (or if you are not covered by a Pension Fund, 25 years of service recognized by the Trustees); **and**
- Be receiving a pension from the 1199SEIU Greater New York Pension Fund or have your application in process.

YOUR BENEFITS

Early Retiree Dental Plus Plan

If you meet the above eligibility requirements, you will be eligible for the benefits described here unless you select, on a **one-time only** basis, coverage for the Early Retiree Prescription Plan described later on in this section.

- **Dental Benefit**

- » Maximum benefit of \$1,200 per year
- » Coverage includes basic, preventive and major restorative services when you use Participating Dentists
- » Payments based upon non-Participating Schedule of Allowances if you use a non-Participating Dentist

Call the Benefit Fund's Dental Department at (646) 473-9200 or visit our website at

www.1199SEIUBenefits.org.

See Section II.K for a summary of what is covered and a listing of additional limitations and what is not covered.

- **Vision Care**

You are covered for the following services once every two years when performed by an optometrist or optician:

- » An eye exam; and
- » A pair of glasses or an order of contact lenses.

The Vision Benefit does not include services rendered by an ophthalmologist.

Benefits are paid according to the Benefit Fund's Schedule of Allowances. There are no out-of-pocket costs when you use Participating Optometrists and Opticians, unless you order glasses

or other services that are not included in the Benefit Fund's program.

- **Hospital Indemnity Payments**

- » The Fund will pay you up to \$200 (less applicable taxes) for each day you are an inpatient in a hospital as defined in Section IX of this SPD
- » Up to a maximum of 10 days per hospital stay
- » You must be billed for a room and board charge on your hospital bill

This benefit is payable to you upon receipt by the Fund of a completed claim form with a copy of a hospital bill showing the number of days that you were hospitalized.

Hospital indemnity payments are considered taxable earnings. They will be included in a W-2 tax form that you will receive at the end of the year.

- **Early Retiree Prescription Plan**

If you select to be covered for the Early Retirement Prescription Plan, your coverage will include:

- **Vision Care**

You are covered for the following services once every two years when performed by an optometrist or optician:

- » An eye exam; and
- » A pair of glasses or an order of contact lenses.

The Vision Benefit does not include services rendered by an ophthalmologist.

Benefits are paid according to the Benefit Fund's Schedule of Allowances. There are no out-of-pocket costs when you use Participating Optometrists and Opticians, unless you order glasses or other services that are not included in the Benefit Fund's program.

- **Prescription Drugs**

To get your prescription:

- » Ask your doctor to prescribe only covered medications and generics whenever possible;
- » Use Participating Pharmacies for short term medications; and
- » Show your Health Benefits ID card to the pharmacist when you give him or her your prescription.

There is no out-of-pocket cost for your prescriptions if you comply with the Benefit Fund's prescription programs as described in Section II.L of this SPD:

- » Mandatory Generic Drug Program;
- » Preferred Drug List;
- » Mandatory Maintenance Drug Access Program;
- » Prior Authorization for specified medications;
- » Quantity and day supply limitations;

- » Step therapy; and
- » Use the Specialty Care Pharmacy for injectables and other drugs that require special handling.

Please refer to the Prescription Drug provision (Section II.L) for other procedures you need to follow to help ensure reimbursement for covered prescription drugs.

SECTION VI. F

IF YOU RETIRE WITH A DISABILITY PENSION AT ANY AGE (WITH AT LEAST 25 PENSION FUND CREDITS)

Effective January 1, 2015, if you retire with a Disability Pension at any age from the 1199SEIU Greater New York Pension Fund with Eligibility Class I Benefits and at least 25 Pension Fund Credits, you will be eligible for the Early Retiree Dental Plus Plan, as described in this section, unless you select, on a **one-time only** basis, coverage for the Early Retiree Prescription Plan, as described in this section, consisting of Vision Care and Prescription Drug Benefits only.

When you become eligible for Medicare, (which normally occurs when you reach age 65 or two years from the effective date of your Disability Award from Social Security, whichever comes first), you will receive the benefit package given to members who retired at or after age 65 with at least 25 Pension Fund Credits as described in Section VI.C or VI.D.

ELIGIBILITY

To receive the benefits described in this section from the Benefit Fund, you must have left covered service with Benefit Fund coverage and either (I) meet the eligibility conditions listed below within one year of the date (a) your Employer was no longer obligated to make contributions on

your behalf; or (b) your Employer was terminated as a Contributing Employer to the Benefit Fund; or (II) be receiving Benefit Fund Disability or an award of permanent partial disability or permanent total disability from Workers' Compensation from a disabling condition or event that commenced or occurred while you were actively employed by a Contributing Employer to the Benefit Fund.

Members who retire with Eligibility Class II or Eligibility Class III Benefits will receive vision-only coverage, as described in this section.

In addition, you must meet all of the following conditions:

- Have at least 25 Pension Fund Credits under the 1199SEIU Greater New York Pension Fund (or if you are not covered by a Pension Fund, 25 years of service recognized by the Trustees); **and**
- Be receiving a Disability Pension from the 1199SEIU Greater New York Pension Fund or have your application in process.

YOUR BENEFITS

Early Retiree Dental Plus Plan

If you meet the above eligibility requirements, you will be eligible for the benefits described here unless you select, on a **one-time only** basis, coverage for the Early Retiree Prescription Plan described later on in this section.

- **Dental Benefits**

- » Maximum benefit of \$1,200 per year
- » Coverage includes basic, preventive and major restorative services when you use Participating Dentists
- » Payments based upon non-Participating Schedule of Allowances if you use a non-Participating Dentist

Call the Benefit Fund's Dental Department at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

See Section II.K for a summary of what is covered and a listing of additional limitations and what is not covered.

- **Vision Care**

You are covered for the following services once every two years when performed by an optometrist or optician:

- » An eye exam; and
- » A pair of glasses or an order of contact lenses.

The Vision Benefit does not include services rendered by an ophthalmologist.

Benefits are paid according to the Benefit Fund's Schedule of Allowances. There are no out-of-pocket costs when you use Participating Optometrists and Opticians, unless you order glasses or other services that are not included in the Benefit Fund's program.

- **Hospital Indemnity Payments**

- » The Fund will pay you up to \$200 (less applicable taxes) for each day you are an inpatient in a hospital as defined in Section IX of this SPD
- » Up to a maximum of 10 days per hospital stay
- » You must be billed for a room and board charge on your hospital bill

This benefit is payable to you upon receipt by the Fund of a completed claim form with a copy of a hospital bill showing the number of days that you were hospitalized.

Hospital indemnity payments are considered taxable earnings. They will be included in a W-2 tax form that you will receive at the end of the year.

Early Retiree Prescription Plan

If you select to be covered for the Early Retirement Prescription Plan, your coverage will include:

- **Vision Care**

You are covered for the following services once every two years when performed by an optometrist or optician:

- » An eye exam; and
- » A pair of glasses or an order of contact lenses.

The Vision Benefit does not include services rendered by an ophthalmologist.

Benefits are paid according to the Benefit Fund's Schedule of Allowances. There are no out-of-pocket costs when you use Participating Optometrists and Opticians, unless you order glasses or other services that are not included in the Benefit Fund's program.

- **Prescription Drugs**

To get your prescription:

- » Ask your doctor to prescribe only covered medications and generics whenever possible;
- » Use Participating Pharmacies for short-term medications; and
- » Show your Health Benefits ID card to the pharmacist when you give him or her your prescription.

There is no out-of-pocket cost for your prescriptions if you comply with the Benefit Fund's prescription programs as described in Section II.L of this SPD:

- » Mandatory Generic Drug Program;

- » Preferred Drug List;
- » Mandatory Maintenance Drug Access Program;
- » Prior Authorization for specified medications;
- » Quantity and day supply limitations;
- » Step therapy; and
- » Use the Specialty Care Pharmacy for injectables and other drugs that require special handling.

Please refer to the Prescription Drug provision (Section II.L) for other procedures you need to follow to help ensure reimbursement for covered prescription drugs.

If you live in New York City, Nassau, Suffolk or Westchester Counties, you must enroll in the Benefit Fund's Medicare Program in order to receive these benefits through the Benefit Fund when you become Medicare-eligible. If you live anywhere other than New York City, Nassau, Suffolk or Westchester Counties, you must enroll in the Benefit Fund's Medicare Part D Prescription Drug Program in order to receive these benefits through the Benefit Fund when you become Medicare-eligible. Please see Section VI.C or VI.D for details.

If you retired and started to receive a pension from the 1199SEIU Greater New York Pension Fund before January 1, 1992:

The Benefit Fund provides a Medicare Supplement Hospital Benefit (Part A only). These benefits are subject to the following conditions:

- Medicare Part A is the primary provider of your Hospitalization Benefits (if you have reached the age at which you would first become eligible for such benefits under Part A of Medicare);
- The Benefit Fund provides supplemental coverage for Medicare hospital coverage, such as your Medicare Part A first-day deductible and your Medicare Part A co-insurance and reserve days;
- Coverage for your spouse is effective for the spouse to whom you are married at retirement, and does not apply to a spouse you subsequently marry;
- Spouses under age 65 receive Hospital Benefits as discussed in Section II.C, and must call the 1199SEIU CareReview Program before going to the hospital for non-Emergency care or within two business days of an Emergency admission;
- Benefits provided to you and your spouse are subject to the Benefit Fund's Coordination of Benefits rules; and
- The coverage provided to your spouse ceases when you die.

NOTE FOR 1115 GOLD CARD

MEMBERS: If you were a member of a bargaining unit formerly represented by Local 1115 SEIU, and you retired before May 31, 2002, and were hired prior to 1985, if you would otherwise not be eligible for Benefit Fund retiree benefits, you may be eligible for certain other Retiree Health Benefits. Please contact the Benefit Fund for additional information.

SECTION VI. G

RETIRED MEMBERS PROGRAMS

A sum determined by the budget approved by the Board of Trustees is allocated each year for retiree programs, including:

- Social programs;
- Recreational programs;
- Educational programs; and
- Cultural programs.

For more information, call (646) 473-8666.

You are eligible to participate in these programs if you are receiving a pension from the 1199SEIU Greater New York Pension Fund, even if you are not eligible to receive the Benefit Fund's retiree health coverage.



SECTION VII – GETTING YOUR BENEFITS

- A. Getting Your Healthcare Benefits
 - Filing a Claim
 - Initial Claim Decision
- B. Your Rights Are Protected — Appeals Procedure
 - Appealing Disability Claims
- C. When Benefits May Be Suspended, Withheld or Denied
- D. What Is Not Covered
- E. Additional Provisions

WHERE TO CALL

Member Services Department (646) 473-9200

Call Member Services if:

- You need a claim form;
- You have questions about completing your claim form;
- You have any questions about what is not covered by the Benefit Fund;
- You have any questions about the processing of your claim; or
- You need information on appealing your claim.

You can also visit our website at www.1199SEIUBenefits.org.

SECTION VII. A

GETTING YOUR HEALTHCARE BENEFITS

PAYMENT INFORMATION FOR PARTICIPATING PROVIDERS

If you are a Participating Provider, any disputes regarding payment for services from the Benefit Fund are not “claims” subject to the U.S. Department of Labor Claims Regulations (codified at 29 C.F.R. 2560.503-1) and shall be handled under the terms set forth in your participation agreement and provider manual.

POST-SERVICE CLAIMS

Filing a Claim

A request for payment or reimbursement for benefits is called a “post-service care claim” or a “claim,” which may be submitted to the Fund in either electronic or paper form.

The Benefit Fund needs to receive a claim so that:

- Your doctor or healthcare provider can be paid; or
- You can be reimbursed if you paid your doctor or healthcare provider.

If You Use a Participating Provider

Your doctor, hospital or healthcare provider will submit the claim to the Benefit Fund.

If You Use a Non-Participating Provider

You may need to submit a claim form to the Benefit Fund. If your provider does not have a claim form, you may obtain one by calling our Member Services Department at (646) 473-9200. You can also obtain a claim form from the “Forms and Other Resources” section of our website at www.1199SEIUBenefits.org. To expedite processing, your claim form should be submitted to the PO Box indicated on your claim form.

For the Benefit Fund to pay your claim to a non-Participating Provider, you must sign the “Assignment of Benefits” authorization on your claim form. This way, you are giving the Benefit Fund your consent to have the payment sent to your doctor, hospital or healthcare provider. However, the Benefit Fund will only pay a claim according to the Schedule of Allowances. You may be responsible for any charges over the Benefit Fund’s allowance.

NOTE: The assignment feature of the Benefit Fund is only for payment of your benefits to providers. No other rights may be assigned or transferred. There is no further liability for any claim by any provider or third party and no such claims may be brought against the Benefit Fund.

If You Paid Your Provider and Want to Be Reimbursed

You will need to submit a claim form to the Benefit Fund. If your provider does not have a claim form, you may obtain one by calling our Member Services Department at (646) 473-9200. You can also obtain a claim form from the “Forms and Other Resources” section of our website at www.1199SEIUBenefits.org. Submit the claim form with the bill from your provider to the PO Box indicated on your claim form, and make sure the bill lists the amount you have paid. The Benefit Fund will only pay a claim according to the Schedule of Allowances. You may be responsible for any charges over the Benefit Fund’s allowance.

If You Receive an Overpayment

If you (or your provider by assignment) receive an overpayment from the Benefit Fund as a result of an improperly billed claim for benefits, the overpaid funds belong to the Benefit Fund, and you agree to hold that money in trust for the Benefit Fund and to reimburse the Benefit Fund within 30 days of receiving the overpayment.

It Is Very Important to File Your Claim with the Benefit Fund Promptly

- Disability claims must be filed with your Employer’s disability carrier within 30 days of the start of your disability.

- Claims for reimbursement for 50% of the standard Medicare Part B premium must be filed within two years of the premium payment.
- All other claims will be denied if they are filed more than one year after the services were provided.
- Life insurance and AD&D claims must be filed no longer than one year after the date of death or loss.

Claims that are late may be processed if you establish, in the sole discretion of the Plan Administrator, that extenuating circumstances prevented timely filing of the claim.

You may file any claim yourself, or you may designate another person as your “authorized representative” by notifying the Plan Administrator in writing of that person’s designation. In that case, all subsequent notices will be provided to you through your authorized representative.

INITIAL CLAIM DECISION FOR POST-SERVICE CLAIMS

The Plan Administrator’s initial decision on your claim will be provided in writing no later than 30 days after the Plan Administrator receives the claim. If your claim is totally or partially denied, you will be notified of the reasons, and the specific provisions of the Plan on which the decision was based. This 30-day period may be extended by the Plan Administrator for an additional 15 days due to matters beyond the Plan’s control; you will receive prior written

notice of the extension. If your claim form is incomplete, you will be notified; you will then have 45 days to provide any additional information requested of you by the Plan Administrator. In this case, the period for resolving the claim will be tolled (on hold) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information. If you fail to provide the additional information within 45 days, the initial decision on your claim will be made based on the information available to the Plan Administrator.

If your claim is totally or partially denied, you can appeal by requesting an Administrative Review. See “Administrative Review of Adverse Decision” in Section VII.B.

REQUESTS FOR BENEFITS OTHER THAN POST-SERVICE PAYMENT CLAIMS

Initial Benefit Decision

In order to receive certain Benefit Fund benefits, you must get Prior Approval from the Plan Administrator. You may file any Request for Benefits yourself, or you may designate another person as your “authorized representative” by notifying the Plan Administrator in writing of that person’s designation. In that case, all subsequent notices will be provided to you through your authorized representative.

The Plan Administrator will make an initial decision on your Request for Benefits, depending on which category it falls into:

Pre-service Care Requests

Pre-service Care Requests are requests for those benefits that require Benefit Fund approval — “pre-certification” or “Prior Authorization” — before treatment. These include, for example, requests to pre-certify a hospital stay or an ambulatory/outpatient surgery (see Sections II.C and II.F), or to authorize home nursing care or durable medical equipment (see Section II.I). In the case of requests for hospital stays or ambulatory/ outpatient surgery, the Benefit Fund will have 1199SEIU CareReview, a contracted Benefit Fund Agent, review your request.

Concurrent Care Requests

Concurrent Care Requests are requests to extend previously approved benefits for an ongoing course of treatment, or a specific number of treatments. These include, for example, requests to receive physical/rehabilitation therapy, or visits to an allergist, podiatrist or chiropractor beyond the standard number of visits allowed by the Benefit Fund. Where possible, these requests should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought. These claims may be filed by phone or fax (see Section VII.B).

Urgent Care Requests

Certain Pre-service Care or Concurrent Care Requests involve situations that have to be decided quickly because using the usual timeframes for decision-making could: (i) seriously jeopardize the life or health of the patient; or (ii) in the opinion of the treating physician with knowledge of the medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment being requested. These Requests for Benefits are treated as Urgent Care Requests and include those situations commonly treated as Emergencies. These claims may be filed by phone or fax (see Section VII.B).

TIMEFRAMES FOR INITIAL BENEFIT DECISIONS

The Plan Administrator will provide a written decision on your initial Request for Benefits. If your request is denied, you will receive the reasons why your benefits have been denied (or reduced), and the specific provisions of the Plan on which the decision was based. If an Urgent Care Request is denied, this information may be provided orally. A written notification will be given to you no later than three days after this oral notification.

Pre-service Care Requests

You or your authorized representative will be notified of the Plan Administrator's (or 1199SEIU CareReview's) approval

or denial of your Request for Benefits no later than 15 days from the date the Benefit Fund receives the request. This 15-day period may be extended by the Plan Administrator (or 1199SEIU CareReview) for an additional 15 days due to matters beyond the Plan Administrator's (or 1199SEIU CareReview's) control; you will receive prior written notice of the extension. If your request is incomplete, you will be notified within five days after it is filed. You will then have 45 days to provide any additional information requested of you by the Plan Administrator (or 1199SEIU CareReview). The period for making the benefit decision will be tolled (on hold) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information. Within 45 days, the initial decision on your Request for Benefits will be made based on the information available to the Plan Administrator (or 1199SEIU CareReview).

Concurrent Care Requests

You or your authorized representative generally will be notified of the Plan Administrator's denial of your Request for Benefits sufficiently in advance of the reduction or termination of benefits to allow you to appeal and obtain a decision before the benefit is reduced or terminated (assuming that your request was filed before the end of the course of treatment for which the extension is being sought). If the request to extend the course of treatment or the number of

treatments involves urgent care, the Plan Administrator will notify you of its decision, whether adverse or not, within 24 hours after receiving the request, provided that the request is made to the Benefit Fund at least 24 hours before the expiration of benefits. You will be given time to provide any additional information required to reach a decision. If you fail to provide the additional information in a timely fashion, the initial decision on your Request for Benefits will be made based on the information available to the Plan Administrator.

Urgent Care Requests

You or your authorized representative will be notified of the Plan Administrator's approval or denial of your request, as soon as possible, but in no event, later than 72 hours after the Plan Administrator has received the request. If your request is incomplete, you will be notified within 24 hours. You or your authorized representative will then have 48 hours to provide the necessary information, and the Plan Administrator will notify you of its decision within 48 hours of receiving the additional information (or from the time the information was due). If you fail to provide the additional information in a timely fashion, the initial decision on your Request for Benefits will be made based on the information available to the Plan Administrator.

SECTION VII. B

YOUR RIGHTS ARE PROTECTED – APPEALS PROCEDURE

If your claim or your Request for Benefits is denied, the Plan provides for two levels of appeals and an external review appeal as described in Section VII.B.

1ST STEP – ADMINISTRATIVE REVIEW OF ADVERSE DECISION

If your claim or Request for Benefits is totally or partially denied, you may request an Administrative Review of such denial within 180 days after the receipt of the denial notice. Your request for a review must be in writing unless your request involves urgent care, in which case the request may be made orally.

For hospital stays or ambulatory/outpatient procedures, the Plan Administrator will have 1199SEIU CareReview conduct the Administrative Review and appeals procedure.

NOTE: All claims by you, your spouse, your children or your beneficiaries against the Benefit Fund are subject to the Claims and Appeals Procedure. No lawsuits may be filed until all steps of these procedures have been completed, by you or a representative authorized by you, and the benefits requested have been denied in whole or in part. No lawsuits may be filed by

providers as an assignee of you, your spouse or your children after five years from the date of service. All lawsuits for benefits must be filed in a federal court in New York City.

2ND STEP – HOSPITAL STAYS OR AMBULATORY/OUTPATIENT PROCEDURES

Non-urgent Care Situations

If the Administrative Review by 1199SEIU CareReview results in a denial of your Request for Benefits, you have the right to make an appeal directly to 1199SEIU CareReview. Such a request must be filed within 60 days after the receipt of the denial notice, unless:

- Your claim involves urgent care, in which case the request may be made orally; or
- Your claim involves a retroactive denial as a result of a Lien Determination, in which case the request must be made in accordance with Section I.G.

If your appeal is denied by 1199SEIU CareReview, you have the right to file a suit, under the Employee Retirement Income Security Act of 1974 (“ERISA”) only in a federal court in New York City.

You may also choose to bring a third, final appeal to the Appeals Committee of the Board of Trustees. Such requests must be filed within 60 days after the receipt of the denial notice. Your request for a review must be in writing unless your claim involves urgent care, in which case the request may be made orally. If your appeal is denied by the Appeals Committee, and you disagree with that decision, you still have the right to file a suit under ERISA only in a federal court in New York City.

Urgent Care Situations

In urgent care situations regarding the Prior Authorization of hospital stays or ambulatory/outpatient procedures, the Administrative Review by 1199SEIU CareReview shall be final and binding on all parties. If the Administrative Review by 1199SEIU CareReview results in a denial of your Request for Benefits, you have the right to file a suit under ERISA only in a federal court in New York City.

Lien Determinations

If the Fund has determined that your claim for benefits is an expense resulting from an illness or accident/injury caused by the conduct of a third party, it is not covered. Please see Section I.G. for a description of your appeals procedures.

All Other Claims or Requests for Benefits

If after the Administrative Review your claim or Request for Benefits is totally or partially denied, you have the right

to make a final appeal directly to the Appeals Committee of the Board of Trustees. Such request must be filed within 60 days after the receipt of the denial notice. Your request for a review must be in writing unless your claim involves urgent care, in which case the request may be made orally.

3RD STEP – INDEPENDENT EXTERNAL REVIEW

If you request an external review, an independent organization will review our decision and provide you with a written determination. If this organization decides to overturn our decision, we will provide coverage or payment for your healthcare item or service.

WHAT YOU ARE ENTITLED TO

In connection with your right to appeal, you:

- Are entitled to submit written comments, documents, records or any other matter relevant to your claim;
- Are entitled to receive, at your request and free of charge, reasonable access to, and copies of, all relevant documents, records and other information that was relied on in deciding your claim for benefits;
- Will be given a review that takes into account all comments, documents, records and other information submitted by you relating to the claim, regardless of whether such information was

submitted or considered in the initial benefit decision;

- Will be provided with the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision;
- Are entitled to have your claim reviewed by a healthcare professional retained by the Plan, if the denial was based on a medical judgment; this individual may not have participated in the initial denial;
- Are entitled to a review that is conducted by a named fiduciary of the Plan who is not the person who made the benefit decision, and who does not work for that person; and
- Are entitled to authorize a representative to appeal on your behalf. Except in the case of an Urgent Care Request, in order to authorize anyone, including a provider, to represent you in an appeal of a benefit denial, you must complete and sign a Benefit Fund Appeal Representation Authorization Form following the benefit denial. No other form will be accepted by the Fund to show that you are allowing someone else to exercise your right to appeal. A representative authorized by you to appeal on your behalf cannot authorize anyone else to appeal; only you can authorize a representative.

- In the case of an Urgent Care Request, you are entitled to a fast review process in which all necessary information, including the Benefit Fund's benefit decision on review, shall be sent to you by telephone, facsimile or other available expeditious methods.

WHAT YOUR PROVIDER IS ENTITLED TO

Providers do not have an independent right to appeal an adverse benefit decision, and you cannot assign your right to appeal. A Participating Provider has a contract with the Fund agreeing that any payment disputes may only be addressed with the Fund, through its contract, and therefore it cannot appeal an adverse determination on your behalf, or sue on an assignment of your benefits.

If you authorize a non-Participating Provider to appeal a benefit determination on your behalf by signing a Benefit Fund Appeal Representation Authorization Form, the provider can challenge the Fund's determination of your benefits under the terms of this plan. This means that if an authorized provider completes the administrative appeals process on your behalf, you will no longer have the right to appeal the same claim.

A provider's challenge to the terms of the Plan or to the Schedule of Allowances will be considered an inquiry, not an appeal, because those Settlor functions are not the proper subjects of appeal or a lawsuit.

For assignments of rights and benefits, see Section VIII.A.

HOW TO REQUEST AN ADMINISTRATIVE REVIEW OR AN APPEAL TO THE APPEALS COMMITTEE OF THE BOARD OF TRUSTEES

<p>Requests for Administrative Review of urgent care for hospitalization or ambulatory/outpatient procedures can be directed to 1199SEIU CareReview by:</p> <ul style="list-style-type: none"> • Phone: (800) 227-9360 • Fax (Medical): (877) 830-8833 • Fax (Behavioral Health): (855) 816-3497 	<p>Requests for Administrative Review of non-urgent hospitalization or ambulatory/outpatient procedures should be sent to:</p> <p>1199SEIU CareReview Program CareAllies 1777 Sentry Park West Dublin Hall, 4th Floor Blue Bell, PA 19422</p>
<p>Requests for other Administrative Reviews and appeals should be sent to:</p> <p>1199SEIU Greater New York Benefit Fund Claim Appeals PO Box 646 New York, NY 10108-0646</p>	<p>Requests involving urgent care can be made by:</p> <ul style="list-style-type: none"> • Phone: (646) 473-7446 • Fax: (646) 473-7447

TIMEFRAMES FOR ADMINISTRATIVE REVIEW AND APPEAL

After each step of the process (i.e., the Administrative Review, and the appeal to the Appeals Committee of the Board of Trustees) the Plan Administrator will provide you with a written decision. If your claim or your Request for Benefits is totally or partially denied, you will be given the specific reason(s) for the decision and the process, and you will be notified of the decision, according to the following timeframes:

- **Pre-service Care Requests**
Not later than 15 days after your request for a review is received.
- **Post-service Care Claims**
Not later than 30 days after your request for a review is received.
- **Urgent Care Requests**
Each level of review of an Urgent Care Request shall be completed in sufficient time to help ensure that the total period for completing both the Administrative Review and the appeal to the Appeals Committee of the Board of Trustees does not exceed 72 hours after your request for a review is received.
- **Concurrent Care Requests**
An appeal of a Concurrent Care Request will be treated as either an Urgent Care Request, a Pre-service

Care Request or a Post-service
Care Claim, depending on the facts.

The decision of the Appeals
Committee of the Board of Trustees
shall be final and binding on all parties,
subject to your right to file a suit under
ERISA and the terms of this Plan only
in a federal court in New York City.

APPEALING DISABILITY CLAIMS

To appeal a denial of your Request for
Disability Benefits, you must:

1. Follow the directions that are
on the back of the denial notice
(**Form DB-451**). Please provide a
copy of the denial notice for our
review. If you do not have this
form, contact the Benefit Fund at
(646) 473-9200 or contact your
Employer; and
2. **Within 30 days** of receiving the
denial notice, send the request
for a review in writing to the
applicable state agency.

Your claim will be reviewed and
you will receive a written notice of
the decision from your Employer's
disability carrier.

SECTION VII. C

WHEN BENEFITS MAY BE SUSPENDED, WITHHELD OR DENIED

It is important that you provide the Benefit Fund with all the information, documents or other material it needs to process your claim for benefits.

The Benefit Fund may be unable to process your claim if you, your spouse or your children:

- Do not repay the Benefit Fund for benefits that you were not entitled to receive;
 - Do not sign an agreement (or comply with such an agreement) to repay the Benefit Fund in the case of legal claim against a third party;
 - Do not sign the “Assignment of Benefits” authorization when you want your benefits paid directly to your provider; or
 - Do not allow the disclosure of medical information, medical records or other documents and information when requested by the Benefit Fund.
- For claims that you, your spouse or dependent children would otherwise be entitled to until full restitution (which may include interest and expenses incurred by the Fund) has been made for any fraudulent claims that were paid by the Fund; or
 - That were the subject of a legal claim against a third party for which a lien form was not signed and received by the Benefit Fund, or was not repaid to the Benefit Fund, as required in Section I.G.

BENEFIT FUND’S RIGHT TO CONFIRM CLAIMS

Before paying any benefits, the Benefit Fund may require that:

- You, your spouse or your children be examined by a doctor or dentist selected by the Benefit Fund as often as required during the period of the claim; or
- An autopsy be performed to determine the cause of death, except where prohibited by law.

Benefits may be suspended, withheld or denied for the purpose of the recovery of any and all benefits paid:

- That you were not entitled to receive;
- That your spouse or dependent children were not entitled to receive;

SECTION VII. D

WHAT IS NOT COVERED

In addition to the various exclusions and limitations set forth elsewhere in this SPD, the Benefit Fund does not cover the following charges:

- Charges associated with any work-related accidental injuries or diseases that are covered under Workers' Compensation or comparable law
- Charges for care resulting from an act of war
- Charges for claims containing misrepresentations or false, incomplete or misleading information
- Charges for claims submitted more than 12 months after the date of service
- Charges for experimental or unproven procedures, services, treatments, supplies, devices, drugs, etc. (see definition of "Experimental" and exceptions for clinical trials in Section IX)
- Charges for infertility treatment including, but not limited to, in vitro fertilization, artificial insemination, embryo storage, cryosterilization and reversal of sterilization
- Charges for in-hospital services that can be performed on an ambulatory or outpatient basis
- Charges for invalid and/or obsolete CPT or HCPCS codes
- Charges for over-the-counter, personal, comfort or convenience items such as bandages or heating pads (even if your physician recommends them)
- Charges for procedures, treatments, services, supplies or drugs for cosmetic purposes, except to remedy a condition that results from an illness or accidental injury
- Charges for services covered under any mandatory automobile or no-fault policy
- Charges for services in excess of or not in compliance with the Benefit Fund's guidelines, policies or procedures
- Charges for services or materials that do not meet the Benefit Fund's standards of professionally recognized quality
- Charges for services provided and supplies or appliances used before you, your spouse or your children became eligible for Benefit Fund coverage
- Charges for services that are custodial in nature
- Charges for services that are not covered by the Benefit Fund,

even if the service is Medically Necessary

- Charges for services that are not FDA-approved for a particular condition
- Charges for services that are not Medically Necessary
- Charges for services, treatments and supplies covered under any other insurance coverage or plan, or under a plan or law of any government agency or program, unless there is a legal obligation to pay
- Charges for services which are not pre-approved in accordance with the terms of the Plan
- Charges in excess of the Benefit Fund's Schedule of Allowances
- Charges made by your provider for broken appointments
- Charges related to an illness or accident/injury resulting from the conduct of another person, where payment for those charges is the legal responsibility of another person, firm, corporation, insurance company, payer, uninsured motorist fund, no-fault insurance carrier or other entity
- Charges related to interest, late charges, finance charges, court or other legal costs
- Charges related to programs for smoking cessation, weight reduction, stress management and other similar programs that

are not provided by a licensed medical physician or not Medically Necessary

- Charges that are not itemized
- Charges that are unreasonable, excessive or beyond the provider's normal billing rate or beyond his or her scope or specialty
- Charges that would not have been made if no coverage existed or charges that neither you nor any of your dependents are required to pay. For example, the Benefit Fund will not pay for services provided by members of your or your dependent's immediate family.
- To the extent permitted by law, charges related to an illness or accident/injury that was deliberately self-inflicted except where such illness or accident/injury is attributable to a mental condition, or that resulted from the person committing an illegal act

SECTION VII. E

ADDITIONAL PROVISIONS

Nothing in this SPD shall be construed as creating any right in any third party to receive payment from this Benefit Fund.

Payments shall not be made to a person who is:

- A minor (under age 18)
- Unable to care for his or her affairs due to illness, accident/injury or incapacity

Instead, the payment shall be made to a duly appointed legal representative or to such person who is maintaining or has custody of the person entitled to payments.

No legal action may be brought against the Benefit Fund or the Trustees until all remedies under the Fund have been exhausted, including requests for Administrative Reviews or appeals.

No legal action may be brought against the Benefit Fund or the Trustees by providers as an assignee of you, your spouse or you children after five years from the date of service.

No legal action for benefits under the Plan or for a breach of ERISA may be brought in a forum other than a federal court in New York City.

Payments made by the Benefit Fund which are not consistent with the Plan — as stated in this SPD or as it may

be amended — must be returned to the Benefit Fund.

No benefit payable under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge.

Any action by way of anticipating, alienating, selling, pledging, encumbering or charging the same shall be void and of no effect. Nor shall any benefit be in any manner subject to the debts, contracts, liabilities, engagements or torts of the person entitled to such benefit.

Notwithstanding the foregoing, the Benefit Fund shall have the power and authority to authorize the distribution of benefits in accordance with the terms of a court order that it determines is a Qualified Medical Child Support Order (QMCSO), as required by applicable federal law.

The Fund does not cover claims containing misrepresentations or false, incomplete or misleading information. If a false or fraudulent claim is filed, the Fund may seek full restitution plus interest and reimbursement of any expenses incurred by the Fund. In addition, the Fund may suspend the benefits to which the participant and his or her dependent(s) would otherwise be entitled until full restitution has been made. The Trustees reserve the right to turn any such matter over to the proper authorities for prosecution.



SECTION VIII – GENERAL INFORMATION

- A. Your ERISA Rights
- B. Plan Amendment, Modification and Termination
- C. Authority of the Plan Administrator
- D. Information on the Plan

SECTION VIII. A

YOUR ERISA RIGHTS

You have certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”).

GETTING INFORMATION

You have the right to:

- Examine, without charge, at the Benefit Fund, all required Benefit Fund documents, including Schedule of Allowances, Collective Bargaining Agreements, insurance contracts, provider lists, detailed annual reports (Form 5500 series) and descriptions;
- Obtain copies of all required Benefit Fund documents, such as copies of the trust, the latest annual report, Summary Plan Description or Summary of Benefits and Coverage by writing to the Plan Administrator at PO Box 2661, New York, NY 10108-2661. The Plan Administrator can make a reasonable charge for copies; and
- Receive a summary of the Benefit Fund’s annual financial report. The Plan Administrator is required by law to provide each member with a copy of this summary annual report. Union and Benefit Fund periodicals may be used for this purpose.

NOTE: The above rights may NOT be transferred or assigned to a third party. Only you, as the participant or beneficiary, are entitled to request the documents described above.

CONTINUE GROUP HEALTH COVERAGE

If you lose health coverage for yourself, your spouse or dependents under the Plan as a result of a qualifying event, you, your spouse or your dependents may have to pay for continued coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

PRIVACY OF PROTECTED HEALTH INFORMATION

A federal law — the Health Insurance Portability and Accountability Act (“HIPAA”) — imposes certain confidentiality and security obligations on the Benefit Fund with respect to medical records and other individually identifiable health information used or disclosed by the Benefit Fund. HIPAA also gives you rights with respect to your health information, including certain rights to receive copies of the health information that the Benefit Fund maintains about you, and knowing how your health information

may be used. The 1199SEIU Family of Funds' Eligibility Department may share eligibility and enrollment information with the Benefit Fund, your Employer, the Job Security Fund (JSF) or the Union for enrollment and outreach purposes. The Benefit Fund may share enrollment information with the 1199SEIU Family of Funds' Eligibility Department for enrollment purposes. A complete description of how the Fund uses your health information, and your other rights under HIPAA's privacy rules, is available in the Benefit Fund's "Notice of Privacy Practices," which is distributed to all named participants and posted on the Fund's website. Anyone may request an additional copy of this Notice by contacting the Benefit Fund at (646) 473-9200.

FIDUCIARY RESPONSIBILITY

In addition to creating rights for Benefit Fund participants, ERISA imposes duties on the people responsible for operating the Benefit Fund, called "fiduciaries."

The fiduciaries have a responsibility to operate the Benefit Fund prudently and in the interest of all Benefit Fund members and eligible dependents.

No one, including your Employer or any other person, may fire you or discriminate against you in any way to prevent you from obtaining a benefit from the Benefit Fund or from otherwise exercising your rights under ERISA.

If your claim for benefits is entirely or partially denied:

- You must receive a written explanation of the reason for the denial, and obtain copies of documents relating to the decision without charge; and
- You have the right to have the Benefit Fund review and reconsider your claim, using the appeals procedure in Section VII.B.

ENFORCING YOUR RIGHTS

Under ERISA, there are steps you can take to enforce your rights:

- If you request a copy of the required Benefit Fund documents described in this section from the Plan by writing to the Plan Administrator at PO Box 2661, New York, NY 10108-2661, and you do not receive them within 30 days, you may file a suit under ERISA only in a federal court in New York City.

In this case, the court may require the Plan Administrator to provide the documents and possibly pay you up to \$110 a day until you receive the materials, unless the documents were not sent because of reasons beyond the control of the Plan Administrator.

- If you have a claim for benefits which is entirely or partially denied or ignored, you have the right to file a suit under ERISA only in a federal court in New York City, after you have completed the appeals procedure

(see Section VII.B), if you believe that the decision against you is arbitrary and capricious or violates ERISA.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you have the right to file a suit under ERISA only in a federal court in New York City.
- If the Benefit Fund's fiduciaries misuse the Benefit Fund's money, or if you are discriminated against for asserting your rights, you may get help from the U.S. Department of Labor, or you have the right to file a suit under ERISA only in a federal court in New York City.
- The court will decide who should pay court costs and legal fees. If you are successful, the court may order that you be paid these costs and fees. If you lose, the court may require you to pay these costs and fees (for example, if it finds your claim is frivolous).

For information regarding your federal civil rights, see Section VIII.D.

ASSIGNING YOUR RIGHTS

You may not transfer or assign your Plan rights or benefits to anyone, with one exception: You may assign to non-Participating Providers your right to a Plan benefit and to sue to get a Plan benefit. If you assign to a non-Participating Provider your right to a Plan benefit, the provider will have no greater rights than you have, and may not in turn

assign the right to anyone else. If the provider exercises the right to the benefit, you will no longer have the right to receive that benefit. A non-Participating Provider can only file a lawsuit disputing an adverse benefit determination:

- As an assignee of your right to plan benefits and to bring an ERISA claim;
- In a federal court in New York City;
- Within three years from the date of service; and
- After the administrative appeal has been completed, in accordance with Section VII.B.

NOTE: No other rights conferred under the terms of this Plan or ERISA may be transferred or assigned. You cannot assign your right to appeal an adverse benefit determination but you can authorize a representative to appeal on your behalf. See Section VII.B.

QUESTIONS?

If you have any questions about:

- Your Benefit Fund, contact the Benefit Fund at (646) 473-9200; or
- Your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest area office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue,

NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Publications Hotline of the Employee Benefits Security Administration at (866) 444-3272.

SECTION VIII. B

PLAN AMENDMENT, MODIFICATION AND TERMINATION

The Plan Administrator reserves the right, within its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason, by action of the Board of Trustees, or any duly authorized designee of the Board of Trustees, in such manner as may be duly authorized by the Board of Trustees.

Neither you, your beneficiaries or any other person has or will have a vested or non-forfeitable right to receive benefits under the Benefit Fund.

SECTION VIII. C

AUTHORITY OF THE PLAN ADMINISTRATOR

Notwithstanding any other provision in the Plan, and to the full extent permitted by ERISA and the Internal Revenue Code, the Plan Administrator shall have the exclusive right, power and authority, in its sole and absolute discretion:

- To administer, apply, construe and interpret the Plan and any related Plan documents;
- To decide all matters arising in connection with entitlement to benefits, the nature, type, form, amount and duration of benefits, and the operation or administration of the Plan; and
- To make all factual determinations required to administer, apply, construe and interpret the Plan (and all related Plan documents).

Without limiting the generality of the statements in Section VIII.C, the Plan Administrator shall have the ultimate discretionary authority to:

- (i) Determine whether any individual is eligible for any benefits under the Plan;
- (ii) Determine the amount of benefits, if any, an individual is entitled to under the Plan;
- (iii) Interpret all of the provisions of the Plan (and all related Plan documents);

- (iv) Interpret all of the terms used in the Plan;
- (v) Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;
- (vi) Decide questions, including legal or factual questions, relating to the eligibility for, or calculation and payment of, benefits under the Plan;
- (vii) Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other related Plan documents; and
- (viii) Process and approve or deny benefit claims and rule on any benefit exclusions.

All determinations made by the Plan Administrator (or any duly authorized designee thereof) and/or the Appeals Committee of the Board of Trustees with respect to any matter arising under the Plan and any other Plan documents shall be final and binding on all parties. In addition, the Plan Administrator may bring a court action to enforce the terms of the Plan or to recover benefit overpayments.

SECTION VIII. D

INFORMATION ON THE PLAN

NAME OF THE PLAN

The 1199SEIU Greater New York Benefit Fund

TYPE OF PLAN

Taft-Hartley (Union-Employer) Jointly Trusteed Employee Welfare Benefit Fund

ADDRESS

Headquarters and Offices:
330 West 42nd Street
New York, NY 10036

SOURCE OF INCOME

Payments are made to the Benefit Fund by your Employer and other Contributing Employers, according to the Collective Bargaining Agreements with 1199SEIU United Healthcare Workers East.

Employers' contribution rates are set forth in the applicable Collective Bargaining Agreements. They are estimated to adequately meet the anticipated cost of claims and administration. Because the Benefit Fund is a multi-employer fund, costs are calculated on a pooled basis.

You may get a copy of any Collective Bargaining Agreement by writing to the Plan Administrator at PO Box 2661, New York, NY 10108-2661, or by examining a copy at the Benefit Fund.

You can find out if a particular Employer contributes to the Benefit Fund by writing to the Plan Administrator. The address of the Employer will also be given.

ACCUMULATION OF ASSETS

The Benefit Fund's resources are held in checking and savings accounts to pay benefits and expenses. Assets are also invested by Investment Managers appointed by the Trustees to whom the Trustees have delegated this fiduciary duty.

PLAN YEAR

The Benefit Fund's fiscal year is January 1 to December 31.

PLAN ADMINISTRATOR

The Benefit Fund is self-administered and primarily self-funded. The Plan Administrator consists of the Board of Trustees and its duly authorized designees and subordinates, including, but not limited to, the Executive Director, the Appeals Committee and other senior employees.

The Trustees may be contacted at:

c/o Executive Director
1199SEIU
Greater New York Benefit Fund
330 West 42nd Street
New York, NY 10036

FOR SERVICE OF LEGAL PROCESS

Legal process may be served on the Board of Trustees, the Plan Administrator or the Benefit Fund's Counsel.

The Trustees may be contacted at:

c/o Executive Director
1199SEIU
Greater New York Benefit Fund
330 West 42nd Street
New York, NY 10036

The Benefit Fund's Counsel may be contacted at:

1199SEIU
Greater New York Benefit Fund
General Counsel's Office
330 West 42nd Street, 31st Floor
New York, NY 10036

IDENTIFICATION NUMBER

Employer Identification Number:
13-6125570

DISCRIMINATION IS AGAINST THE LAW

The 1199SEIU Benefit Funds comply with applicable federal civil rights laws and do not discriminate against or exclude people on the basis of race, color, national origin, age, disability or sex. The Funds provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats). The Funds provide free language services to people

whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Compliance Coordinator.

If you believe the Funds have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Compliance Coordinator, 330 West 42nd Street, New York, NY 10036; (646) 473-6600 (phone); (646) 473-8959 (fax); PrivacyOfficer@1199Funds.org (email). You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Compliance Coordinator can help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201; (800) 368-1019 or (800) 537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

TRUSTEES

The Board of Trustees is composed of an equal number of Union and Employer Trustees. Employer Trustees are elected by the Employers. Union Trustees are chosen by the Union. The Trustees of the Benefit Fund are:

UNION TRUSTEES	
Yvonne Armstrong Senior Executive Vice President 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036	Milly Silva Executive Vice President 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036
Maria Castaneda Secretary-Treasurer 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036	Julio Vives Vice President 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036
Ronald McCalla Assistant Division Director 1199SEIU United Healthcare Workers East – New Jersey Region 555 Route 1 South, 3rd Floor Iselin, NJ 08830	Noreen Wray Vice President 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036
Allan Sherman Assistant Division Director 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036	

EMPLOYER TRUSTEES

Michael Balboni
Executive Director
Greater New York Health Care
Facilities Association
519 8th Avenue, 16th Floor
New York, NY 10018

Howard A. Sukoff
President
Creative Management
32 Heidi Drive
Fords, NJ 08863

William Pascocello
c/o 1199SEIU Greater New York
Benefit Fund
330 West 42nd Street
New York, NY 10036

Doug Wissmann
Director of Finance
Hillside Manor Rehabilitation and
Extended Care Center
182-15 Hillside Avenue
Jamaica Estates, NY 11432

Robin Rosen
Labor Attorney
Greater New York Health Care
Facilities Association
519 8th Avenue, 16th Floor
New York, NY 10018



SECTION IX – DEFINITIONS

DEFINITIONS

Accident

An unusual, unexpected, fortuitous, unintended event causing injury for which no third party is legally responsible.

Accidental Death and Dismemberment

Plan sponsored by Amalgamated Life Insurance Company under an agreement with the Trustees providing for payments to a beneficiary designated by the employee under the circumstances described in Section IV.C and in the Certificate of Coverage (policy).

Administrative Review

The procedure to appeal a claim that the Benefit Fund has rejected or denied in part. An Administrative Review can be requested by you, your dependents (your spouse or your children) or a provider of services which has received an Assignment of Benefits and your written authorization to appeal on your behalf.

Affordable Care Act

The Patient Protection and Affordable Care Act, as amended from time to time.

Ambulatory Care

Health services that do not require an overnight hospital stay. These services may be performed in the outpatient center of a hospital, surgical center,

ambulatory care center or in the operating room at a doctor's office.

Annual Rate of Pay

Fifty-two times the base weekly wage rate under the Collective Bargaining Agreement with your Employer, which was in effect on January 1 of the last year you actually worked.

Assignment of Benefits

1. The Benefit Fund will pay its allowance to your doctor, dentist, laboratory, etc. directly when you request it to do so by signing the "Assignment of Benefits" authorization on your claim form. The Benefit Fund will only pay those benefits allowed under the Plan. The Benefit Fund pays the hospital directly for the inpatient and Emergency Department care charges allowed by the Plan.
2. See Lien Acknowledgement.

No other rights conferred under the terms of the Plan or ERISA may be assigned.

Average Weekly Hours

The weekly average of your hours reported to the Benefit Fund by your Employer. Sixteen weeks are averaged to determine your Eligibility Class.

Beneficiary(ies)

The person(s) you have named to receive any Life Insurance Benefit.

Benefit(s)

Any of the scheduled payment(s) or service(s) provided by the Plan.

Calendar Year

The 12-month period beginning January 1 and ending December 31.

Children

Your children who are eligible to receive benefits from the Benefit Fund, as described in Section I.A.

Chiropractor

A person licensed by the appropriate department of the state to practice within the chiropractic profession for which he or she has been licensed.

Claim Form

One of the Benefit Fund forms that must be completed to request any of the benefits provided by the Plan.

COBRA Continuation Coverage or COBRA Coverage

Coverage provided to a member or eligible dependents for a temporary period under certain circumstances. The member or eligible dependent must pay for this coverage. (See Section I.K for more detailed information.)

Concurrent Review

A review of a request to extend a course of treatment, as services are being provided to you, to determine whether such services continue to be Medically Necessary Covered Services.

Contributing Employer

1. An Employer who has a Collective Bargaining Agreement with 1199SEIU United Healthcare Workers East, or one of its affiliates, which provides for regular monthly payments in an amount specified by the Trustees to this Benefit Fund on behalf of the employees covered by the agreement for all benefits in this Summary Plan Description.
2. 1199SEIU United Healthcare Workers East, its affiliates, the Benefit Fund or any other Employer accepted as a contributor by the Trustees and its affiliated and related Funds that are obligated to make regular monthly payments in an amount specified by the Trustees to the Benefit Fund on behalf of its employees.

New Jersey Employers with Collective Bargaining Agreements with SEIU 1199 New Jersey are not Contributing Employers under this SPD.

Coordination of Benefits

A method of sharing costs among payers, which sets the order of payment by each. (See Section I.F for more detailed information.)

Co-payment

A dollar amount paid by you directly to the healthcare provider at the time services are received. Some of the benefits to which you are entitled are subject to co-payments. These co-payments are described on a separate list which will be supplied to you. Co-payments may be changed by the 1199SEIU Greater New York Benefit Fund from time to time.

Cosmetic Surgery

Cosmetic surgery includes any procedure whose primary purpose is to improve, alter or enhance appearance. Procedures to correct a cosmetic disfigurement due to disease are not covered unless the disfigurement causes a functional impairment, or unless the surgical correction of the cosmetic disfigurement due to disease is performed in conjunction with a staged reconstructive surgical procedure to improve or restore bodily function.

Cosmetic surgery for psychological or emotional reasons is not covered when no functional impairment is present.

Covered Employment

Employment for which your Employer makes contributions to the Benefit Fund on your behalf pursuant to a Collective Bargaining Agreement or other agreement accepted by the Board of Trustees.

Custodial Care

Care is considered custodial when it is primarily for the purpose of attending to the participant's daily living activities and could be provided by persons without professional skills or training. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected wounds, post-operative or chronic conditions, preparation of special diets and supervision of medication which can be self-administered by the member.

Dentist

A person licensed by the appropriate department of the state to practice within the dental profession for which he or she has been licensed.

Dependent

Your spouse or your children who are eligible to receive benefits from the Benefit Fund as described in Section I.A.

Direct Payment

Payments made on a self-pay basis to continue your life insurance coverage after your benefits have terminated.

Disability Pension

You have retired from all active employment and have received a Pension Disability Award from Social Security, which entitles you to a Disability Retirement Pension from the 1199SEIU Greater New York Pension Fund.

Disabled

You are temporarily unable to work due to an accident/injury or illness.

Doctor

A person licensed by the appropriate department of the state to practice within the medical profession for which he or she has been licensed.

Durable Medical Equipment

Equipment that can withstand repeated use, is primarily and usually used to serve a medical purpose and is generally not useful to a person in the absence of illness or injury.

Earnings

Wages reported by a Contributing Employer as the basis for determining the Employer's payments to the Benefit Fund.

Eligibility Class

One of the three wage-earning levels used by the Benefit Fund to determine the level of benefits to which a member and/or eligible dependents are entitled.

Eligible

You have met the criteria adopted by the Trustees of the Benefit Fund to determine your enrollment, plan of benefits and Eligibility Class.

Eligible Charges

The maximum amount that the Benefit Fund recognizes as a reasonable charge for the service rendered, as set forth in the Benefit Fund's Schedule of Allowances.

Emergency

Services provided in connection with an "Emergency Condition," including screening and examination services provided to a member or his or her eligible dependent who requests medical treatment to determine if an Emergency Condition exists. "Emergency Condition" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person. Emergency care includes healthcare procedures, treatments or services, including psychiatric stabilization and medical detoxification from drugs or alcohol that are provided for an Emergency Condition.

Employer

See Contributing Employer.

Enrollment Form

The form used to provide the Benefit Fund with the personal, employment and beneficiary information needed to determine your benefits and process your claims.

ERISA

The Employee Retirement Income Security Act of 1974, as amended from time to time.

Executive Director

The Executive Director is the person who has been authorized by the Board of Trustees to administer, apply and interpret the Plan on a day-to-day basis.

Experimental

Experimental means any investigational or unproven treatment, procedure, facility, equipment, drug, device or supply which does not meet any one or more of the following criteria:

- If a drug, biological product or device or other item requires governmental approval, that item has completed the required clinical trials and has received final approval from the appropriate governmental regulatory bodies for commercial distribution for use in treating the condition being reviewed;
- The treatment is endorsed by an appropriate medical society;

- There must be scientific evidence, including peer-review literature, demonstrating that the technology improves net health outcomes or offers a significant benefit over conventional treatment, in terms of efficacy, safety and reliability; or
- The improvement in net health outcome must be attainable under the usual conditions of medical practice.

Notwithstanding the above, the Benefit Fund will cover experimental treatment provided in an approved clinical trial (as defined by the Affordable Care Act and its supporting regulations) according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, subject to Plan limitations as described in this SPD.

Family

Your spouse and your children who are eligible to receive benefits from the Benefit Fund, as described in Section I.A.

FDA (Food and Drug Administration)

The U.S. Department of Health and Human Services agency responsible for ensuring the safety and effectiveness of all food, drugs, biologics, vaccines and medical devices.

Fiduciary

Each of the Trustees and others responsible for directing the administration of the Benefit Fund, and their responsibilities under the law.

Full Time

The number of hours worked in a normal regular workweek, as set forth in the applicable Union contract. Overtime is not included.

Fund or Trust Fund

The 1199SEIU Greater New York Benefit Fund whose principal office is at 330 West 42nd Street in New York City, through which benefits are provided.

Habilitation Therapies

Physical, occupational or speech therapy services that help a developmentally delayed or disabled person learn, keep or improve skills and functional abilities that he or she may not be developing normally.

Health Benefits ID Card

The card issued by the Benefit Fund to serve as identification to assist you in getting various benefits.

Hospital

An institution which:

- Primarily provides services to diagnose, treat and care for injured, disabled or sick patients by or under the supervision of a doctor;
- Provides 24-hour nursing service with the care given or supervised by a registered professional nurse;
- Maintains clinical records on all patients;

- Has by-laws in effect with respect to its staff of physicians;
- Has a hospital utilization review plan in effect;
- Is licensed by the federal government and by the state in which the hospital is located; and
- Has accreditation under one of the programs of the Joint Commission.

The term “hospital” does not include an institution or part of an institution that is used mainly as:

- A rest or nursing facility;
- A facility for the aged, chronically ill, convalescents, or alcohol or drug addicts; or
- A facility providing custodial, psychiatric, education or rehabilitative care.

Illness

Sickness, disease or disorder of body or mind of such character as to affect the general soundness and healthfulness of the system.

Legal Separation

A marital status whereby spouses, while remaining legally married, have chosen to live separate lives physically and economically, as determined in the sole discretion of the Trustees, and as evidenced by (but not limited to) such circumstances as the following: living separate and apart from each other, maintaining separate legal residences and/or separate finances,

having custody arrangements for children, or formally dividing joint legal property, assets and responsibilities.

Legally Separated

See Legal Separation.

Level of Benefit

The Eligibility Classification (Eligibility Class I, Eligibility Class II or Eligibility Class III) used to determine the specific package of benefits for which you, your covered spouse and your covered children are entitled.

Lien Acknowledgment

A form that describes and acknowledges the Benefit Fund's right to recover up to the amount it has paid or will pay for expenses relating to any claims which you or your beneficiary may have against any person or entity responsible for an illness or accident/injury, including illness or accident/injury resulting from medical malpractice, as described in Section I.G.

Lien Determination

A determination that one or more of your claims for benefits is not covered because it is an expense resulting from an illness or accident/injury caused by the conduct of a third party, including expenses for treatment related to an illness or accident/injury that resulted from medical malpractice.

Life Insurance

Plan sponsored by Amalgamated Life Insurance Company under an agreement with the Trustees for the purpose of providing payments to beneficiaries designated by the employee in the event of the death of the employee as described in Section IV and in the Certificate of Coverage (policy).

Maternity Care

Includes prenatal and postnatal care, as well as care required by childbirth and miscarriages.

Medically Necessary

Services or supplies which are determined by the Plan Administrator as Medically Necessary and rendered at the appropriate level of care to identify or treat the non-occupational illness, non-occupational injury or pregnancy, which a doctor has diagnosed or reasonably suspects. To be Medically Necessary, the Plan Administrator must determine, in its sole exercise of discretion, that the services or supplies:

- Are consistent with the diagnosis and treatment of the patient's condition;
- Are in accordance with the standards of accepted medical practice;
- Are not solely for the convenience of the patient, physician and/or supplier;
- Are performed at a level of care not greater than required for the patient's condition;

- Will result in a measurable and ongoing improvement in the patient's health. For example, if the maximum therapeutic benefit has been met, then Medical Necessity cannot be established;
- Will result in a change in diagnosis or proposed treatment plan. For example, if other procedures have already established a diagnosis, ongoing procedures are not considered Medically Necessary if their only purpose is confirmatory; and
- Are advanced therapies that have only been rendered after more conservative medical treatments have been attempted without therapeutic improvement.

Medicare

The program of health insurance legislated by the federal government and administered by the Social Security Administration of the U.S. Department of Health and Human Services.

Member

An employee who is working for a Contributing Employer on whose behalf payments to the Benefit Fund are required in the contract specified by the Trustees.

An employee who formerly worked for a Contributing Employer and who is covered for certain benefits is a member only with respect to those benefits provided to his or her class of former members.

Mental Health Benefits

Services for illnesses typically treated by psychiatrists, psychologists or other licensed therapists using psychotherapy and/or psychotropic drugs.

Network

See Participating Provider.

Newly Organized

Those employees in a bargaining unit when 1199SEIU United Healthcare Workers East concludes a Union contract, which, for the first time, requires payment to the Greater New York Benefit Fund for employees in that bargaining unit. It does not include employees covered under expired contracts, which are subsequently renewed or extended, or employees joining a bargaining unit after coverage under the Plan for employees in such a unit has been negotiated.

Non-Panel or Non-Participating

A duly licensed healthcare professional or other provider who does not have any fee agreement with the Benefit Fund.

Outpatient Observation Care and Services

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment before a decision can be made regarding whether a patient will require further treatment

as a hospital inpatient or if he or she is able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the Emergency Department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Generally, observation services are for a period of less than 48 hours and usually less than 24 hours.

Over-the-Counter

Any medication that is customarily and legally purchased without a prescription.

Panel Doctor

See Participating Provider.

Part Time

An employee who is regularly scheduled to work a number of hours per week which is less than the number of hours stipulated in the applicable Union contract for full-time employees performing the same work.

Participating Pharmacy

A licensed, registered pharmacy that has signed an agreement with the Benefit Fund's Pharmacy Benefit Manager.

Participating Provider

A duly licensed health practitioner such as a dentist, dental specialist, physician, board-certified or board-eligible specialist, podiatrist, chiropractor, psychologist, psychiatric social worker,

optician, optometrist or medical supplier, who has signed an agreement with the Benefit Fund or with a network with which the Benefit Fund has a contract, to charge no more than the Fund's Schedule of Allowances.

Pension Fund Credit

A period of time for which an employee earns service toward a pension under the rules described in the Plan and Summary Plan Description (including credited service recognized by the 1199SEIU Greater New York Pension Fund for purposes of pension eligibility in accordance with the terms of a reciprocity agreement between the Fund and another pension plan) of the 1199SEIU Greater New York Pension Fund or its successors.

Permanently Disabled

The inability to perform any gainful employment prior to age 65 as certified by the granting of a Social Security Award from the Social Security Administration.

Physician

A person licensed by the appropriate department of the state to practice within the medical profession for which he or she has been licensed.

Plan

The benefits and the rules and regulations pertaining to the 1199SEIU Greater New York Benefit Fund for the various levels of benefits as adopted and interpreted by the Trustees and the

official documents, such as the Trust Agreement and this SPD, including its preface, in which those benefits and rules and regulations are described.

Plan Administrator

As used in this SPD, shall mean the Board of Trustees and any individuals, such as the Executive Director, duly designated by the Trustees to carry out administrative functions.

Podiatrist

A person licensed by the appropriate department of the state to practice within the podiatric profession for which he or she has been licensed.

Pre-certification

See Prior Approval.

Primary Care Doctor

The doctor having primary responsibility for your medical care. You choose your own primary care doctor in accordance with the 1199SEIU Benefit Fund guidelines, subject to the doctor's acceptance. A primary care doctor generally practices in the area of family medicine, internal medicine or pediatrics.

Prior Approval

A requirement to submit a treatment plan or call the Benefit Fund or its agents prior to receiving services or supplies. This review process evaluates the Medical Necessity and appropriateness of a proposed service or care. This includes,

but is not limited to, some dental claims, certain home care services or treatment, admissions and intermediate care for mental health or alcohol/substance abuse, admissions for physical rehabilitation, certain prescription drugs, all non-Emergency hospital admissions and surgical procedures. Prior Approval does not include an eligibility determination or a review of a non-Participating Provider's charges. There may be certain penalties, as described in this SPD, if you fail to obtain Prior Approval.

Prior Authorization

See Prior Approval.

Psychiatric Social Worker

A person licensed by the appropriate department of the state to practice within the psychiatric social work profession for which he or she has been licensed.

Psychologist

A person licensed by the appropriate department of the state to practice within the psychology profession for which he or she has been licensed.

Retired Member or Retiree

A person who is currently receiving a pension from the 1199SEIU Greater New York Pension Fund.

Retrospective Review

A review of a request, after services have been provided to you, to determine whether such services were Medically

Necessary Covered Services and whether and to what extent benefits are payable.

Union and Contributing Employers establishing the Benefit Fund.

Schedule

A list of items covered and/or amounts paid.

Schedule of Allowances

Any one of the various fee schedules, such as medical/surgical, vision or dental, established by the Trustees that is used to determine the amount allowed or paid by the Plan for the appropriate service, which is subject to change.

Skilled Nursing Facility

A facility that provides medical and nursing care and is recognized as such by Medicare.

Spouse

The person to whom a member is legally married and who is eligible for benefits from the Benefit Fund as described in Section I.A.

Surgeon

A person licensed by the appropriate department of the state to practice within the surgical profession for which he or she has been licensed.

Totally Disabled

See Permanently Disabled.

Trust Agreement

The Agreement and Declaration of Trust entered into between the

Trustees

The Benefit Fund Trustees acting pursuant to the Agreement and Declaration of Trust establishing the Benefit Fund, and any successor Trustees, duly designated in the manner set forth in the Agreement and Declaration of Trust.

You or Your

As used in this SPD, the term “You” or “you” (or “Your” and “your”) refers to the member, as an individual, and/or to the member’s Dependents, individually or together, depending on the context in which it is used.



1199SEIU GREATER NEW YORK BENEFIT FUND

330 West 42nd Street, New York, NY 10036-6977

(646) 473-9200

Outside New York City area codes: (800) 575-7771

www.1199SEIUBenefits.org

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