Our Benefits

Summary Plan Description of Your Health and Welfare Benefits
The Plan is administered by the Board of Trustees (the “Trustees”) of the 1199SEIU Licensed Practical Nurses Welfare Fund. No individual or entity, other than the Trustees (including any duly authorized designee thereof) has any authority to interpret the provisions of this Plan Document 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 this Plan for any reason and at any time when, in their judgment, 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 employees may not receive benefits as described in this Plan Document. This may happen at any time 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 booklet and the Fund staff are your sources of information on the Plan. You cannot rely on information from co-workers, Union or Employer representatives. If you have any questions about the Plan and how its coverage works, the Fund staff will be glad to help you. Since 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 Plan Document.

¿NECESITA AYUDA CON EL SUMARIO DE DESCRIPCION DEL PLAN?

Este Folleto es un sumario en Ingles de sus derechos y beneficios bajo El 1199SEIU Licensed Practical Nurses Fund.

Si usted no Entiende este Sumario y Necesita ayuda escriba al Fondo:

330 W. 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.
January 2010

Dear Member:

Your Fund cares about you and your family.

The Fund provides you and your dependents with insurance benefits for both full-time and part-time 1199SEIU LPNs employed with the New York City Health and Hospitals Corporation (NYCHHC).

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

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

• What benefits you are eligible to receive;

• What policies and procedures need to be followed to get your benefits;

• How to use your benefits wisely.

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

Your Fund looks forward to continuing to provide you with this supplemental package of benefits in the years ahead for you and your family.

The Board of Trustees
# TABLE OF CONTENTS

Preface ................................................................. 1  
Letter from the Board of Trustees ............................... 2  
Foreword ............................................................. 5  

**OVERVIEW OF YOUR BENEFITS** ........................................ 8

**SECTION I – ELIGIBILITY** .................................................. 11
   I.A Who Is Eligible ................................................. 12  
   I.B When Your Coverage Begins .................................. 14  
   I.C Enrolling in the Fund .......................................... 15  
   I.D Coordinating Your Benefits ................................... 16  
   I.E When Your Benefits Stop ...................................... 18  
   I.F Your COBRA Rights ........................................... 19

**SECTION II – YOUR HEALTH BENEFITS** ............................... 25
   II.A Vision Care .................................................... 26  
   II.B Hearing Aid .................................................. 27  
   II.C Dental Benefits .............................................. 27  
   II.D Prescription Drugs .......................................... 29

**SECTION III – DISABILITY** ................................................ 33
   III.A Short-Term Disability – 6 Months ......................... 34  
   III.B Long-Term Disability – 18 Months ....................... 35

**SECTION IV – LIFE INSURANCE** ....................................... 39
   IV.A Life Insurance Benefits for Full-Time Employees .......... 40  
   IV.B Life Insurance Benefits for Part-Time Employees .......... 43
NEED TO KNOW WHAT “DEPENDENT” MEANS IN THIS BOOKLET?

REFER TO THE DEFINITIONS SECTION

The Definitions section (pages 54-56) lists the terms used in this booklet and explains how they are defined by the Fund.

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

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

YOUR BENEFIT FUND

As a member of the Fund employed through the New York City Health and Hospitals Corporation, you receive your supplemental insurance benefits through the Fund.

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 Fund on your behalf for health and other benefits.

The cost of your benefits is paid through “contributions” to the Fund by your employer.

Your union dues are paid to 1199SEIU to cover the cost of running the union – not to the Fund to cover the cost of providing health benefits.
OVERVIEW OF YOUR BENEFITS
IMPORTANT PHONE NUMBERS

Member Services Department
(646) 473-9200
www.1199SEIUBenefits.org
For answers to your questions about your eligibility and benefits.

Dental
The Dental Shop: (888) 683-3682

Vision Care
General Vision Services (GVS)
(800) VISION-1

Hearing Aid
General Hearing Services (GHS)
(800) 432-1449

Prescription Drugs
Express Scripts: (800) 233-8065

Short-Term Disability and Life Insurance
(646) 473-9200

Long-Term Disability
(646) 473-6710

OVERVIEW OF YOUR BENEFITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Coverage</th>
<th>Full-Time LPN</th>
<th>Part-Time LPN</th>
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</table>
| Vision Care      | • One eye exam every two years through General Vision Service (GVS) stores
                | • One pair of glasses every two years through GVS stores                | Family
                |                                                                          | General Vision Services (GVS) (800) VISION-1 | Member Only       |
| Prescription Drugs | • No co-pay or deductibles for FDA-approved prescription medications prescribed by doctor
                | • Use participating Express Scripts pharmacies                          | Family up to $3,500 per year
<pre><code>            |                                                                          | Express Scripts: (800) 233-8065         | Family up to $1,500 per year |
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<thead>
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<th>Benefit</th>
<th>Coverage</th>
<th>Full-Time LPN</th>
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<tr>
<td><strong>Maintenance Prescription Drug Benefit</strong></td>
<td>• No co-pay or deductibles for FDA-approved prescription drugs for chronic conditions</td>
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<td>Express Scripts: (800) 233-8065</td>
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<td><strong>Dental Benefits</strong></td>
<td><strong>Full-Time LPN</strong></td>
<td>Family</td>
<td>Member Only</td>
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<td></td>
<td>• Full-time employees and their eligible dependents will each be eligible for a maximum benefit of $2,000 per person, per year</td>
<td>The Dental Shop: (888) 683-3682</td>
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<td><strong>Part-Time LPN:</strong></td>
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<td>• Up to $2,000 per calendar year for basic and preventive services and major restorative services</td>
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<td>• No out-of-pocket costs using Dental Shop Preferred Panel dentists</td>
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<td><strong>Disability Benefits</strong></td>
<td>• For accidents or illnesses that are not work-related</td>
<td>Member Only</td>
<td>Not Eligible</td>
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<td>• $300 weekly up to a maximum of 26 weeks</td>
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<td>• For long-term disability, see page 35</td>
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<td>Benefit</td>
<td>Coverage</td>
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<td><strong>Life Insurance</strong></td>
<td><strong>Full-Time LPN:</strong></td>
<td>Family</td>
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<td></td>
<td>• $25,000 for Member</td>
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<td>• $8,000 for Spouse</td>
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<td>• $2,000 for Dependent Children</td>
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<td><strong>Part-Time LPN:</strong></td>
<td>• $12,500 for Member</td>
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<td>• $4,000 for Spouse</td>
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<td>• $2,000 for Dependent Children</td>
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<td><strong>Social Services</strong></td>
<td><strong>Member Assistance Program</strong> helps resolve personal and family problems with referrals to community resources.</td>
<td>Member</td>
<td>Member</td>
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<td><strong>Citizenship Program:</strong></td>
<td>Free application preparation and preparatory classes</td>
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<td></td>
<td><strong>1199SEIU Legal Clinic:</strong></td>
<td>One free consultation per year</td>
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<td><strong>Workers’ Compensation Clinic</strong></td>
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<td><strong>Scholarship Program</strong></td>
<td><strong>$750 scholarship per year for each dependent child who is an eligible student</strong></td>
<td>Dependent Child</td>
<td>Dependent Child</td>
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<td><strong>Additional $750 scholarship per year for a student pursuing a healthcare degree</strong></td>
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SECTION I – ELIGIBILITY

A. Who Is Eligible
B. When Your Coverage Begins
C. Enrolling in the Fund
D. Coordinating Your Benefits
E. When Your Benefits Stop
F. Your COBRA Rights
**SECTION I. A**

**WHO IS ELIGIBLE**

**YOU**
You are eligible to participate in the Fund if you are a full-time or part-time Licensed Practical Nurse of the City of New York Health and Hospitals Corporation.

**YOUR SPOUSE OR DOMESTIC PARTNER**
Your spouse may be eligible if:

- You and your spouse are legally married. If you and your spouse are legally divorced or legally separated, your spouse is not covered by the Fund.

If you have a domestic partner, you must register with New York City. Call (212) 306-7343 for information on eligibility and tax consequences.

**PLEASE NOTE:**
Changes within your family, including separation or divorce of a spouse or regarding the status of your dependent children, must be reported to the Fund immediately, and in no case more than 30 days from the date of the event.

Failure to do so may jeopardize your benefits and result in your being responsible for any benefits provided by the Fund for the period in which your spouse or dependent children were not eligible.
YOUR CHILDREN

Your children are eligible up to his/her 19th birthday if all the following conditions are met:
• He/she is your biological child;
• He/she is your legally adopted child; and
• He/she is not married.

The term children also includes any child who is related to you by blood for whom you have legal guardianship through the court and any child covered by a court-appointed child support order although that child may never be legally adopted.

To be eligible for Life Insurance benefits, each child must be at least 14 days of age and under age 19, or a full-time student under age 23.

For other benefits, each child must be under age 19 or a full-time student under age 23.

AFTER YOUR CHILD REACHES AGE 19

Your child’s coverage may be continued from your child’s 19th birthday up to his/her 23rd birthday if:
• He/she is a full-time matriculated student attending high school or college, not married, not working full-time, living at home or school, and totally dependent on you for support.

Your child is not a dependent if he/she:
• Lives outside of the United States, or
• Is in the military or similar forces of any country or subdivision thereof.

CHILDREN WITH DISABILITIES

If your child is disabled, as described below, coverage for your child may continue after age 19 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 Fund each year after your child reaches age 19.

Your child is 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 is expected to last for a continuous period of not less than 12 months or to result in death.
SECTION I. B
WHEN YOUR COVERAGE BEGINS

IF YOU ARE A FULL-TIME
1199SEIU LPN

Your coverage begins:
• On the date of your appointment as a full-time Licensed Practical Nurse of the City of New York Health and Hospitals Corporation.

If you are absent from work on the day on which your insurance would normally begin you will become insured on the day you return to active service.
Should there be any increase in benefits while you are absent from work, your increased benefit will become effective when you return to active service and are on the payroll.

IF YOU ARE A PART-TIME
1199SEIU LPN

Your coverage begins:
• On the day you start work.

If you and your spouse are legally divorced or legally separated, your spouse is not covered by the Fund, unless required by court order.

FOR YOUR DEPENDENTS

Coverage for your spouse, domestic partner and/or your children starts at the same time your coverage begins. Any additional dependents become eligible on the day he/she becomes your dependent.

Except for a child at birth, a dependent confined to a hospital or other covered institution when that person would normally be eligible on resumption of normal activities. This does not apply to Life Insurance benefits.

If any of your dependents is eligible under this plan for coverage as an employee, that person is not eligible for this coverage as a dependent. If both you and your spouse or domestic partner are insured under this plan as employees, your children may only be enrolled as dependents of either you or your spouse or your domestic partner, not both.
SECTION I. C
ENROLLING IN THE FUND

TO GET YOUR BENEFITS, YOU MUST FIRST ENROLL

You must fill out an Enrollment Form and send it to the Fund before you will be eligible for benefits.

To enroll in the Fund:

• Get an 1199SEIU LPN Enrollment Form from the Fund office, by calling the Member Services Department at (646) 473-9200 and identifying yourself as a HHC 1199SEIU LPN.

• Completely fill out the form (including the beneficiary section).

The 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 beneficiary
• Your spouse’s employer
• Information on other insurance coverage.

After you fill out the form, you should:

• Sign and date the form.

• 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.

• Send the form and any related documents to:

1199SEIU LPN Welfare Fund
c/o 1199SEIU Benefit Funds
Times Square Station
PO Box 2426
New York, NY 10108-2426

The Fund will not be able to process your enrollment form, and therefore you will not be able to receive benefits, if you do not include all the documents and information required.

LET THE FUND KNOW OF ANY CHANGES

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

You must notify the Fund immediately, and in no case 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 19
• A family member covered by the Fund dies
• You want to change your beneficiary, or
• You change employers.

Fill out an Enrollment Change Card and send it to the Fund’s Member Services Department so that your records can be updated.

Remember to send copies of all the documents needed by the Fund, including:
• Birth certificate(s)
• Adoption papers
• A marriage certificate if you are adding your spouse
• Your separation or divorce papers if you are separated or divorced
• An Affidavit of Domestic Partnership if you are adding your domestic partner
• Any other documents required by the Fund.

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

All information appearing on your Enrollment Form is for Fund use only and will not be released to any third party, except where necessary for the administration and operation of the Fund, or where otherwise required by law.

SECTION I. D
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.
• The other plan is secondary. It may pay an additional amount, according to the terms of that plan.

If the Fund is:
• Primary, it will pay your claim in accordance with its Schedule of Allowances and the rules set forth in this Summary Plan Document.
• Secondary, the total amount paid by both plans shall not be more than the Trustees determine as the maximum allowable cost for the medically necessary care provided or 100% of the actual expenses, whichever is less. In no event will the Fund pay more than its Schedule of Allowances.
WHEN YOU AND YOUR SPOUSE ARE BOTH COVERED BY THE FUND
If you and your spouse are both covered by the Fund:

• Each of you may claim the other and your children as dependents; and
• The total amount paid shall not be more than the Trustees determine as the maximum allowable benefit.

WHEN YOU AND YOUR SPOUSE ARE COVERED BY DIFFERENT PLANS
When your spouse is covered by another plan, or benefit coverage is available through your spouse’s employer, the Fund will coordinate payment of your benefits with that Plan.

For your care:
• The Fund is the primary payer. It makes the first payment on your 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 Fund is your spouse’s secondary payer.

When submitting a claim for your spouse’s care, you must include a statement from your spouse’s plan showing what action they have taken.

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 the plan of the parent whose birthday is earlier in the year.
• The other parent’s plan is the secondary payer.

EXAMPLE:
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.
SECTION I. E
WHEN YOUR BENEFITS STOP

Your coverage ends when any of the following events occurs:
• You leave employment
• You are no longer eligible
• Group Policy ceases

Your dependent’s insurance ends when any of the following events occurs:
• Insurance ends
• The dependent is no longer an eligible dependent

YOUR HIPAA RIGHTS

When your Fund coverage ends, a federal law – the Health Insurance Portability and Accountability Act (HIPAA) – protects you if your new health plan excludes pre-existing conditions.

When your Fund coverage ends, under HIPAA you and/or your dependents are entitled by law to, and will be provided with, a Certificate of Creditable Coverage. Certificates of Creditable Coverage indicate the period of time you and/or your dependents were covered under the Fund (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you and/or your dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under this Fund ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you and/or your dependents under the new group health plan or health insurance policy.

The Certificate of Creditable Coverage will be provided to you shortly after this Fund knows, or has reason to know, that coverage (including COBRA coverage) has ended. The Certificate of Creditable Coverage will also be provided once the Fund Office receives a written request, provided that the request is received within two (2) years after the later of the date your coverage under the Fund ended or the date your COBRA coverage ended.

Accordingly, the Fund will provide you with Certificates of Creditable Coverage showing when you were covered by the Fund:
• on your request, within 24 months after your Fund coverage ceases;
• when you are entitled to elect COBRA (see page 19);
• when your coverage terminates, even if you are not entitled to COBRA (see page 23), and
• when your COBRA coverage ceases.
You should retain these Certificates of Creditable Coverage as proof of prior coverage for your new health plan. For further information, call the Member Services Department of the Fund at (646) 473-9200.

PRIVACY OF PROTECTED HEALTH INFORMATION

HIPAA also imposes certain confidentiality and security obligations on the Fund with respect to medical records and other individually identifiable health information used or disclosed by the Fund. HIPAA also gives you rights with respect to your health information, including certain rights to receive copies of the health information that the Fund maintains about you, and knowing how your health information may be used. A complete description health information, and your other rights under HIPAA’s privacy rules is available in the Fund’s “Notice of Privacy Practices,” which is distributed to all named participants. Anyone may request an additional copy of this Notice by contacting the Fund office.

SECTION I. F
YOUR COBRA RIGHTS

Under the federal law commonly known as COBRA, you, your spouse and your children have the option of extending your group health care coverage for the benefits described in this SPD for a limited period of time in certain instances where group health coverage under the Fund would otherwise end (called a qualifying event). A qualified beneficiary is someone who will lose group health coverage under the 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 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 Fund’s COBRA department at (646) 473-6815.

If you elect to continue your coverage, you, your spouse and/or your children will receive the same coverage that you were receiving right before you lost your coverage. This may include dental, vision and prescription coverage.

However, note that Life Insurance, Accidental Death and Dismemberment, and Legal benefits are not covered by COBRA continuation coverage.
In addition, a child born to or placed for adoption with you while you are receiving COBRA continuation coverage will also be covered for benefits by the Fund. The maximum coverage period for such 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 FOR HOW LONG YOU ARE 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 are reduced, resulting in a change in your Eligibility Class or
- Your employment is terminated for reasons other than gross misconduct on your part.

Note that when the qualifying event is the end of your employment or reduction of your hours of employment, and when 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 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 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 or
- You and your spouse become divorced or legally separated or
- You become entitled to Medicare.

EXTENDED COVERAGE
Second Qualifying Event Extension

Additional qualifying events can occur while 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, the 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 Fund.

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

• You die;
• You become entitled to Medicare;
• You get divorced or legally separated; or
• If the 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 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, through the furnishing of this SPD, of both the responsibility to provide and the procedures for providing notice of the second qualifying event.

DISABILITY EXTENSION

If you are disabled as determined by the New York City Employees’ Retirement System, or your spouse or a child covered under the Fund is determined by the Social Security Administration to be disabled and you notify the Fund in a timely fashion, you, your spouse and 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 continuation period 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 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 Fund of the disability determination within 60 days after the later of:

• The date of the 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, through the furnishing of this SPD, of both the responsibility to provide and the procedures for providing notice of the disability determination but before the end of the first 18 months of COBRA continuation coverage.

YOU MUST NOTIFY THE FUND TO OBTAIN COBRA CONTINUATION COVERAGE

Under the law, you, your spouse, or your children are responsible for notifying the Fund if:
• You and your spouse are divorced or legally separated
• Your child is no longer an eligible dependent.

You must notify the Fund at (646) 473-9200 or at P.O. Box 1036, New York, NY 10108 within 60 days after the later of (i) the date of the qualifying event; (ii) the date on which the qualified beneficiary loses (or would lose coverage) as a result of the qualifying event; and (iii) the date on which the qualified beneficiary is informed through the furnishing of this SPD, of both the responsibility to provide and the procedures for providing notice of a qualifying event.

Your employer is responsible for notifying the 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 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 Fund of your decision within 60 days of the date (whichever is latest) that:
• You would have lost your Fund coverage, including extensions
• You are notified by the Fund of your right to elect COBRA coverage.

In order for your election to be timely and valid, your election form must be:
• Actually received by the Fund office on or before the 60-day period noted above at PO Box 1036, New York, NY 10108 or
• Mailed to the Fund office and postmarked on or before the 60-day period noted above.

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 and you will lose your right to elect continuation coverage.

Even if you decide not to receive COBRA coverage when you qualify, your spouse and each of your children, if eligible, have a right to choose this coverage.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you may lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you.

With respect to other health plans, you should also take into account that you have special enrollment rights under federal law.

You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying event.

You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

**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 Fund, except under circumstances giving rise to a qualifying event for active employees
• The 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 which does not include a pre-existing condition clause that applies to you, your spouse or your children (as applicable)
• 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 Fund would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

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

If there is a determination 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 determination that the individual is no longer disabled. The disabled individual or a family member is required to notify the Fund office within 30 days of any such determination.

You do not have to show that you are insurable to elect this continuation coverage. However, you must be eligible for coverage under the Fund to be eligible for COBRA continuation coverage. The Plan Administrator reserves the right to end your COBRA continuation coverage retroactively if you are found to be ineligible for coverage.

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 Fund at (646) 473-6815.

REMEMBER TO NOTIFY THE 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.
SECTION II – YOUR HEALTH BENEFITS

A. Vision Care
B. Hearing Aid
C. Dental
D. Prescription Drugs
   • Maintenance Prescription Drugs
Call Member Services if you have any questions about your benefits, the programs or services offered by the 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.

**Vision Care**
General Vision Services (GVS)
(800) VISION-1

**Hearing Aid**
General Hearing Services (GHS)
(800) 432-1449

**Dental**
The Dental Shop
(888) 683-3682

**Prescription Drugs**
Express Scripts
(800) 233-8065

### SECTION II. A VISION CARE – WHO IS COVERED

**Full-time employees:**
- Full-time employees and eligible dependents are entitled to one pair of eyeglasses every two years when you use a participating General Vision Service (GVS) store.

**Part-time employees:**
- Part-time employees are entitled to one pair of eyeglasses every two years when you use a participating General Vision Service (GVS) store.

**WHAT IS COVERED**
- An eye examination (refraction test).
- Selection of lenses, including single vision, photo chromic single vision, toric kryptok, flat top 25/28, executive or invisible bifocals, glass or plastic lenses, plus tinting, coating and oversize. Some frames and lenses may require a co-payment.

For more information on what’s covered, call GVS at (800) VISION-1.

When you use a non-participating store, you will be reimbursed when you present a paid bill. The maximum reimbursement is $150, which includes eye exam, lenses and frame.
For reimbursement, send your itemized receipt to:
1199SEIU LPN Fund
c/o 1199SEIU Benefit Funds
Times Square Station
PO Box 2426
New York, NY 10108-2426

SECTION II. B
HEARING AID

WHO IS COVERED
• Full-time employees and their eligible dependents
• Part-time employees are not eligible.

COVERAGE LIMITS AND WHAT IS COVERED
You and your eligible dependents are covered for hearing benefits up to $500 for each ear in a 48-month period. This amount includes reimbursement for the purchase of the hearing aid, repair and cost of batteries.

REIMBURSEMENT FOR HEARING AIDS
• Send a copy of a paid bill to the 1199SEIU Licensed Practical Nurses Fund.
• The paid bill must accompany a report from your doctor.
• You will be reimbursed for an amount not to exceed $500 per ear.

SECTION II. C
DENTAL

WHO IS COVERED
• Full-time employees and their dependents
• Part-time employees

Full-Time Employees:
The Maximum Dental Benefit that will be paid for an insured person in a calendar year is $2,000 per covered life.

Part-Time Employees:
The total Maximum Dental Benefit that will be paid for an insured person in a calendar year is $2,000.

WHAT IS COVERED
The Dental Shop
• 100% of the Fund’s Schedule of Allowances for basic and preventive services and for major restorative services when using participating dentists.

WHAT ARE COVERED DENTAL CHARGES?
Covered Dental Charges are charges incurred for any service or supply included in the Schedule of Allowances. Covered Dental Charges do not include charges that exceed the maximum amount shown in the Schedule of Allowances.
PERIODONTAL TREATMENT
The Maximum Periodontal Benefit that will be paid in the lifetime of an insured person for the treatment of periodontal disease or any diagnosis, surgery or adjunctive services in connection with the disease is shown in the Schedule of Allowances.

WHEN IS A CHARGE INCURRED?
A charge is incurred:
• For dentures or fixed bridges, on the date the impression is taken;
• For crown work, on the date the preparation of the tooth begins;
• For root canal therapy, on the date the work on the tooth begins; or
• For any other work, on the date the work is done.

Claims should be mailed to:
The Dental Shop
100 Corporate Parkway, Suite 342
Amherst, NY 14226

WHAT IS NOT COVERED
Covered Dental Charges do not include charges for services and supplies:
• Not ordered by a doctor
• Which do not meet the standards set by the American Dental Association
• In a Veterans’ Administration Hospital
• Due to loss or theft of an appliance
• Which an insured person would not legally have to pay if there were no insurance

• Due to war, if declared or not
• From a health department maintained by an employer, a union, a trustee or a similar type of entity.
• Which are payable by a local or other agency of a government
• For cosmetic reasons, including altering or extracting and replacing sound teeth to change appearance
• For installing or for adding to, a denture or fixed bridge, unless:
  • The work is needed due to extraction of injured or diseased natural teeth; and
  • The tooth is extracted while the person is insured for these benefits; and
  • The work includes replacing the extracted tooth.
• A denture or bridge is considered to be installed for the first time if it does not replace any existing denture or bridge.
• For replacing or altering a denture or fixed bridge, unless:
  • The change is needed due to one of these events:
  • An accidental injury requiring oral surgery; or
  • Oral surgery which involves changing the position of muscle, attachments, or removing a tumor, cyst, torus or excess tissue; and
  • The bridge is unusable and/or is six or more years old;
• The event occurs while the person is insured for these benefits; and
• The work is finished within 12 months after the event.
• For replacing a full denture unless needed due to a change in the structure of the mouth, if replaced after the later of:
  • Five years after the date the denture is installed; and
  • Two years after the date the person became insured for these benefits.
• For an injury or sickness due to employment with any employer or self-employment.
• For orthodontic appliances and treatment.

**EXTENDED DENTAL BENEFITS**

If a person’s coverage ends, and he or she has not completed dental work that began while insured, benefits will be paid for Covered Dental Charges incurred for the unfinished dental work as if the coverage had not ended.

No benefits will be paid for any charges incurred for that dental work performed:

• More than one month after the date the person’s coverage ends, if it ends because the Group Policy ceases or coverage ends for the class of which the person is a member.
• After the date the person’s coverage ends, if it ends for any other reason.

**EXTENDING DENTAL COVERAGE WITH COBRA**

Under the federal law commonly known as COBRA, you, our spouse and your children have the option of extending your group health care coverage for a limited period of time in certain instances where group health coverage under the Fund would otherwise end.

See “Your COBRA Rights,” page 19.

**SECTION II. D PRESCRIPTION DRUGS**

**WHO IS COVERED**

• Full-time employees and their eligible dependents
• Part-time employees and their eligible dependents

**WHAT IS COVERED**

Covered Drug Charges will be reimbursed as follows:

• To purchase a drug from a participating Express Scripts pharmacy that has agreed to participate in the prescription drug plan, payment will be made to the pharmacy for that part of the covered drug charge.
• To purchase a drug from a nonparticipating pharmacy, you will be reimbursed for the following:
  • The dispensing fee for the covered prescription drug
which the individual provider most frequently charges his customers for dispensing similar drugs, plus

- The actual cost of the covered prescription drug to the provider, plus
- Any applicable state sales tax for the covered prescription drug.

WHAT IS COVERED

Covered Drug Charges are charges that are incurred while you are insured and on account of accidental bodily injury or sickness that is not connected with your employment. These charges only include the regular and customary charges for the drugs furnished.

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

- Have been approved for treating your specific condition
- Have been prescribed by your doctor
- Are filled by a pharmacist.

Prescriptions for FDA-approved drugs that are not approved for treatment of your condition must be submitted to Express Scripts for consideration. Your doctor should provide a detailed explanation for prescribing this medication.

WHAT ARE COVERED DRUG CHARGES?

“Covered Drug Charges” consist of charges for the following items when dispensed by a physician or a licensed pharmacist upon written prescription:

- “Legend” drugs and compound medications of which at least one ingredient is a legend drug. A legend drug means any medical substance that is required to bear the legend: “Caution: Federal Law prohibits dispensing without a prescription” on its label.
- Injectable insulin.

WHAT IS NOT COVERED

Covered Drug Charges shall not include expenses incurred for drugs that are:

- Obtained without a prescription.
- Non-legend drugs (formulary), unless specifically provided for as Covered Drug Charges.
- Drugs for which a hospital makes a charge.
- Provided through or received from the pharmacy of your employer that would normally have been available without cost to you.
- Covered under any governmental program or law, or for which no charge is made or there is no legal obligation to pay, or dispensed in a hospital contracted for or operated by the United States government for the treatment of members or ex-
members of the Armed Forces, or by a rest home, sanitarium or similar institution.

- In excess of a six-month supply, when taken in accordance with the physician’s directions.
- For contraceptives or contraceptive materials or any therapeutic device (e.g., hypodermic needles, syringes, support garments and other non-medical substances) regardless of the intended use.

**USING YOUR BENEFIT**

To get your prescription filled:

- Use participating Express Scripts pharmacies for short-term medications
- Show your ID Card to the pharmacist when you give him or her your prescription.

You can also track your medications online at [www.express-scripts.com](http://www.express-scripts.com).

**HOW TO FILE A PRESCRIPTION CLAIM**

- If you take your prescription to an Express Scripts pharmacy, present your ID Card to the pharmacist.
- If you take your prescription to a pharmacy that is not an Express Scripts pharmacy or if the prescription is for a dependent child over age 18;
  - Obtain an Express Scripts reimbursement form from Member Services and take it to the pharmacy;
  - Fill out the employee portion, have the pharmacist complete the pharmacy portion, and you keep the completed form;
  - Pay the pharmacy for the full cost of the prescription; and
  - Mail the completed Direct Reimbursement claim form to Express Scripts at the address listed on the form.
PRESCRIPTION DRUG BENEFIT FOR MAINTENANCE MEDICATIONS

WHO IS COVERED

- Full-time employees and eligible dependents
- Part-time employees and eligible dependents

WHAT IS COVERED

- Prescription drugs that you are required to take for chronic conditions such as diabetes, hypertension and cardiac problems.
- Drugs for other conditions where a 34-day supply or more is prescribed.

USING YOUR BENEFIT:

WHAT IS NOT COVERED

- Drugs obtained without a prescription.
- Non-legend drugs.
- Drugs for which a hospital makes a charge.
- Drugs provided through or received from the pharmacy of your employer that would normally have been available without cost to you.
- Drugs covered under any governmental program or law, or for which no charge is made or there is no legal obligation to pay, or dispensed in a hospital contracted for or operated by the United States government for the treatment of members or ex-members of the Armed Forces, or by a rest home, sanitarium or other similar institution.
- Any therapeutic device (e.g., hypodermic needles, syringes, support garments and other non-medical substances) regardless of the intended use.

NOTE:
The City of New York provides coverage for certain specialty medications, such as chemotherapy and injectable drugs, through the PICA program. For more information, contact Express Scripts at (800) 233-8065.
SECTION III – DISABILITY

A. Short-Term Disability – 6 Months
B. Long-Term Disability Benefits – 18 Months
SECTION III. A SHORT-TERM DISABILITY

WEEKLY INDEMNITY BENEFITS

WHO IS COVERED

- Full-time employees.
- Part-time employees are not eligible.

WHAT IS COVERED

If you become totally disabled due to an accidental injury or sickness covered by these benefits, a weekly benefit is payable for up to six months. You must be unable to do all duties pertaining to your work.

Payments will be made after a waiting period of 14 days provided that you are still disabled. You must be under the direct care of a doctor; such care starts when the doctor first examines you.

HOW MUCH IS THE BENEFIT?

Your benefit is currently two-thirds of your average weekly compensation up to $300 weekly for a maximum of 26 weeks within a 52-week period.

NOTE:

- The Internal Revenue Service may consider Disability benefits from the Fund taxable income. Contact your accountant or the IRS when preparing your income tax return.
- Social Security (FICA) withholding tax will be withheld from each check in accordance with applicable Federal Law.

PERIODS OF DISABILITY

If you have more than one period of disability, they are treated as follows:

- If they are due to unrelated causes and are separated by your return to active work, they are treated as separate periods.
- If they are due to related causes:
  - they are treated as separate periods if they are separated by your return to active work for at least two weeks in a row; or
  - they are treated as one period when not so separated.

WHAT IS NOT COVERED

No benefits will be paid for a disability that is:

- For an injury or sickness due to employment with any employer or self-employment.
- Due to intentionally self-inflicted injury.
HOW TO FILE A SHORT-TERM DISABILITY CLAIM

To file a claim, call Member Services at (646) 473-9200 and request an Amalgamated Life Insurance Disability form. Make sure you return the form to the Amalgamated Life address provided – not to the Fund. Otherwise, your benefit payment may be delayed.

If during your period of disability you know that your disability will continue for more than six months, you should file a Long-Term Disability claim. Please call (646) 473-9200 to obtain a Long-Term Disability Claim Form.

SECTION III. B
LONG-TERM DISABILITY

WHO IS COVERED

• Full-time employees.

• Part-time employees are not eligible.

WHAT IS COVERED

If you become totally disabled due to an accidental injury or sickness and your disability lasts longer than six months, you may be eligible for a monthly Disability benefit. To qualify, you must be continuously disabled beyond the six-month Waiting Period.

If you qualify, you will receive a monthly disability benefit for up to 18 months.

WHAT IS TOTAL DISABILITY?

You are “totally disabled” if as a result of sickness or injury you are not able to perform all of the duties of your occupation.

You will not be deemed disabled if you do any work for compensation or gain, or during a period in which you are not under the direct care of a doctor. This direct care starts when the doctor first examines you.

HOW MUCH IS THE BENEFIT?

Your monthly benefit will be 50% of your monthly compensation (wages) just before the start of the period of your disability, up to a maximum of $500.

The payment will be reduced by what you are paid for that month including:

(a) Any type of remuneration from the Fund.

(b) Your annuity or pension plan.

(c) Due to your disability from the sources described below.

In (c), the sources are:

(1) from the Fund’s Life Insurance plan, but only if:

(i) such benefits do not reduce the amount of your life insurance; or

(ii) you may choose to refuse them.

(2) as a periodic benefit from:

(i) an employer, labor-management trustee, union, employee benefit plan;
(ii) a government agency, or program or coverage required or provided by law. You do not have to include payments that began before you were insured, unless after you became insured such payment was increased because of a change in the degree of your disability. In that case, you have to include the amount of the added payment.

Payments from an individual life insurance policy do not reduce your Disability benefits.

(d) From Social Security or Railroad Retirement due to your disability or retirement.

In (d), it will be assumed that you are entitled to the largest amount of benefits, including those for dependents. If you are not so entitled, you must give proof that will satisfy the Fund.

LUMP SUM PAYMENTS UNDER OTHER PLANS

A lump sum might be paid by other sources in place of periodic payments. If it is so paid, the lump sum will be deemed paid in the amount and for the time that would have applied if there had not been a lump sum payment.

WHEN DO DISABILITY BENEFITS BEGIN AND END?

Monthly benefits will start the day after the Waiting Period is complete. They will go on as long as you remain totally disabled, subject to the maximum period stated below. You must give proof of your disability that will satisfy the Fund. Medical documentation supporting your total disability must be sent in on a monthly basis.

Benefits will end as of the first of:

(a) The date that 18 months of benefits have been paid for any one period of disability, or

(b) The date medical information in your claim does not support total disability as defined earlier in this section, or

(c) The date you reach age 65.

PERIODS OF DISABILITY

Periods of Disability are treated as follows:

(a) If they are due to unrelated causes and separated by your return to active work, they are treated as separate periods.

(b) If they are due to related causes:

(i) they are treated as separate periods if they are separated by your return to active work for at least three months in a row; or

(ii) they are treated as one period when not so separated.
Only one Waiting Period of six months will be required for all periods of disability, which are treated as one period of disability. All these periods must begin while you are covered by the Fund.

**DISABILITIES AT THE SAME TIME**

A monthly benefit due to more than one cause will be the same as the rate for one due to a single cause.

**WHAT IS NOT COVERED**

No benefits will be paid for disability:

- Due to intentionally self-inflicted injury;
- Due to war, if declared or not;
- Due to, or as a result of taking part in, commission of a felony.

**FILING A CLAIM FOR LONG-TERM DISABILITY BENEFITS**

After the end of the qualifying period, proof of your total disability must be given within 90 days after the end of the first monthly benefit period. After that, written proof that you have remained so disabled must be given monthly.

- Call the Fund’s Disability Department at (646) 473-9200 to ask for a Disability Claim Form.
- Please complete the form as soon as you receive it and return it to the Fund promptly so that an evaluation of your claim may begin.

**CALL THE FUND WHEN YOU RETURN TO WORK**

You must let the Fund know when you go back to work after being on Disability leave.
SECTION IV – LIFE INSURANCE

A. Life Insurance Benefits – Full-Time Employees

B. Life Insurance Benefits – Part-Time Employees
SECTION IV. A LIFE INSURANCE BENEFITS FOR FULL-TIME EMPLOYEES

LIFE INSURANCE BENEFIT

If you die while insured for these benefits, the amount of your Life Insurance benefit of $25,000 is payable to your beneficiary.

If you became insured after December 1, 1968, and your death occurs at or after age 70, the benefit payable is one-half the amount in effect before you reach age 70.

To change your beneficiary, you must notify the 1199SEIU LPN Fund in writing.

After your death, your beneficiary may name a person to receive any amount, which would be paid to the beneficiary’s estate.

Your spouse’s Life Insurance coverage is $8,000.

Your dependent children’s Life Insurance coverage is $4,000 for each child.

LEAVING EMPLOYMENT

If you leave employment, your Group Life insurance protection continues for 31 days. During this time you may convert your Group Life insurance to Individual Life insurance. You do not have to give evidence of good health.
FOR YOUR DEPENDENTS

LIFE INSURANCE BENEFIT
If your dependent dies while insured for these benefits, a benefit of $8,000 for your spouse or $4,000 for a dependent child is payable to you. If you are not alive when your dependent dies, payment will be made:

- For your spouse’s death, to your spouse’s estate.
- For your child’s death, to the survivors in the first surviving class of those that follow: the child’s (i) parent or (ii) brothers and sisters. If none survives, payment will be made to the child’s estate.

If a minor has no legal guardian, that minor’s share may be paid to the adult or adults who, in the insurance carrier’s opinion, have assumed the custody and support of the minor.

CONTINUANCE OF PROTECTION
If you leave employment, your dependents’ Group Life Insurance protection continues for 31 days. If you die while insured for “Employee Life Insurance Benefits” Your dependents’ protection continues for six months.

During the first 31 days after you leave employment or your death, your spouse may convert this protection to Individual Life insurance. This is a self-pay option. Your spouse does not have to give evidence of good health.

If your spouse dies after having applied to convert the Group Life Insurance to individual Life Insurance, the beneficiary named under the Individual Policy will be deducted from the amount due under the Group Policy. Any premiums paid under the Individual Policy will be paid to the beneficiary on return of that policy.

CONVERSION TO AN INDIVIDUAL POLICY
If the group Life Insurance stops, you and your covered dependents may each buy an individual Life Insurance policy from the insurance carrier. Proof of good health will not have to be given to the insurance carrier.

HOW TO APPLY
The person must apply within 31 days after the Life Insurance stops.

Obtain an application from the insurance carrier or the Member Services Department.

You will be told the cost. The first premium must be paid before the policy can be put in force.

The amount of the policy will be limited to the amount of the person’s group Life Insurance. The person can ask for a lower amount of Life Insurance.

The policy can be any one of the individual policies offered by the Insurance Carrier except that:

- For the first year, you and your dependents may each choose an individual policy, which provides term insurance.
• After the first year, the individual policy will not provide term insurance. The policy will not have disability benefits or other extra benefits.

If the Life Insurance stops because the Fund has:
• Ended the group plan with the insurance carrier or
• Changed the plan so that you are no longer an eligible employee, the new policy will be reduced by any amount you or your dependents are or become eligible for under any other group plan within the 31 days. The other group plan may be issued or reinstated by the insurance carrier.

If you or your dependent dies within the 31-day conversion period, the insurance carrier will pay the beneficiary the amount of Life Insurance that could have been bought under the individual policy. The individual policy will not go into effect.

IF THERE IS NO BENEFICIARY
If you do not list a beneficiary, your beneficiary dies before your death, or the 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 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
• If none of the above survive, to your estate after it has been established.

If the total amount of your Life Insurance benefit is $20,000 or more, benefits will be paid to the administrator or executor of your estate.
SECTION IV. B
LIFE INSURANCE
BENEFITS FOR PART-TIME EMPLOYEES

LIFE INSURANCE BENEFIT
If you die while insured for these benefits, the amount of $12,500 is payable to your beneficiary. You may choose to have this amount paid in a lump sum or installments. You may change your beneficiary or change the mode of payment to one offered by the Fund at any time. If you do so, you must give written notice to the Fund.

After your death your beneficiary may:

• Choose a mode of payment, if you did not choose one.

• Name a person to receive any amount, which would be paid to the beneficiary’s estate.

FOR YOUR DEPENDENTS
If your spouse dies while insured for these benefits, a benefit of $4,000 is payable to you. If a dependent child dies while insured for these benefits, a benefit of $2,000 is payable to you.

LIFE INSURANCE BENEFIT
If your dependent dies while insured for these benefits, a benefit of $4,000 for your spouse or $2,000 for a dependent child is payable to you. If you are not living at the time your dependent dies, payment will be made:

• For your spouse’s death, to your spouse’s estate.

• For your child’s death, to the survivors in the first surviving class of those that follow: the child’s (i) parent or (ii) brothers and sisters. If none survives, payment will be made to the child’s estate.

If a minor has no legal guardian, that minor’s share may be paid to the adult or adults who, in the insurance carrier’s opinion, have assumed the custody and support of the minor.

LEAVING EMPLOYMENT
If you leave employment, your group Life Insurance protection goes on for 31 days. During this time you may convert your group Life Insurance to individual Life Insurance, on a self-pay basis. You do not have to give evidence of good health.
CONVERSION TO AN INDIVIDUAL POLICY

If the group Life Insurance stops, you and your covered dependents may each buy an individual Life Insurance policy from the insurance carrier.

Proof of good health will not have to be given to the insurance carrier.

HOW TO APPLY

• You must apply within 31 days after the Life Insurance stops.

• Obtain an application from the Insurance Carrier or the Fund’s Member Services Department.

• You will be told the cost. The first premium must be paid before the policy can be put in force.

• The amount of the policy will be limited to the amount of the person’s group Life Insurance. The person can ask for a lower amount of Life Insurance.

• The policy can be any one of the individual policies offered by the insurance carrier except that:

  • For the first year, you may each choose an individual policy, which provides term insurance.

  • After the first year, the individual policy will not provide term insurance. The policy will not have disability benefits or other extra benefits.

If the Life Insurance stops because the Fund has:

• Ended the group plan with the insurance carrier or

• Changed the plan so that you are no longer an eligible employee, the new policy will be reduced by any amount you are or become eligible for under any other group plan within the 31 days. The other group plan may be issued or reinstated by the insurance carrier.

If you die within the 31-day conversion period, the insurance carrier will pay the beneficiary the amount of Life Insurance that could have been bought under the individual policy. The individual policy will not go into effect.
SECTION V – OTHER BENEFITS

A. Social Services
B. Scholarship Program
SECTION V. A.
SOCIAL SERVICES

MEMBER ASSISTANCE PROGRAM

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

If you are having a problem, speak to one of the Fund’s social workers or other staff. They can work with you to try to get you 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
- Legal advice and referral
- and many more.

Call the Member Assistance Program at (646) 473-6900 for an appointment.

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.
SECTION V. B. SCHOLARSHIP PROGRAM

Scholarships are provided to eligible children of members to attend accredited schools after high school. The benefit is $750 per year for all full-time eligible students, with the possibility of an additional $750 per year (for $1,500 per year total) for students pursuing healthcare degrees.

For information on scholarships, please call (212) 564-8999.

Your child may be considered for the LPN Benefit Fund’s Scholarship Program if all of the following conditions are met:

- You file an official application form within the time period required by the LPN Fund;
- You have been eligible for benefits for at least one year;
- They are high school graduates; and
- They are attending an accredited institution of higher learning after graduating from high school.

Any accredited school is acceptable, including:

- 2-year colleges;
- 4-year colleges or universities;
- Business schools;
- Nursing schools;
- Trade schools; and
- Art and design schools.

Scholarships are not available for postgraduate studies.
SECTION VI – GETTING YOUR BENEFITS

A. Filing a Claim Form

B. Proof of Claim
SECTION VI. A
FILING A CLAIM FORM

HOW TO GET A CLAIM FORM

• Contact Member Services at (646) 473-9200
• Write to:
  1199SEIU Licensed Practical Nurses Welfare Fund
  c/o 1199SEIU Benefit Funds
  Times Square Station
  PO Box 2426
  New York, NY 10108-2426

The Fund will validate your Claim Form and process it for payment.

Payments will be made in connection with the outlined benefits.

HOW TO FILE A CLAIM FORM

FOR VISION, PRESCRIPTION AND DENTAL CLAIMS

Read the instructions on the claim form carefully and include any required attachments when you return the completed claim form. Since the Fund contracts with outside providers for your care, you will need to return the claim form to that carrier.

If you have questions about submitting your claim form, contact Member Services at (646) 473-9200.

FOR WEEKLY INDEMNITY INSURANCE

The initial Claim Form for Weekly Indemnity Insurance must be submitted within 20 days after the date of the accidental injury or sickness. Failure to give notice within 20 days shall not invalidate or reduce any claim if it is shown that it would not have been reasonably possible to give such notice within the required time and that notice was given as soon as was reasonably possible.

If you do not receive a settlement within 90 days after you return the completed claim form, or 180 days if you were notified of a delay, you should write or call the Fund.

SECTION VI. B
PROOF OF CLAIM

FOR LONG-TERM DISABILITY INSURANCE

After the end of the qualifying period (the 6-month waiting period), proof of your total disability must be given as above within 90 days after the end of the first monthly benefit period. After that, written proof that you have remained so disabled must be given on a monthly basis.

The Fund will require as part of the proof of claim evidence:

• Proof of the amount and source of all other benefits named and payable in the insurance plan; and...
• That you applied for, and gave all the required proof for all other such benefits.

ALL OTHER INSURANCE
Proof of claim must be given as above within 90 days after the date of loss for which claim is made. Itemized bills may be required as part of proof of claim.

Late proof will be accepted if it is furnished as soon as reasonably possible.

EXAMINATIONS
The Fund, at its own expense, has the right to have a doctor examine any person when it deems it reasonably necessary while there is a claim pending under the policy.

LEGAL ACTIONS
No one may sue for payment of a claim less than 60 days after a proof of claim is furnished or more than two years after the date the proof of claim is required to be filed by the policy.

The insurance evidenced by this certificate provides life, weekly indemnity, dental and long-term disability benefits. It does not provide basic hospital insurance as defined by the New York State Insurance Department.

HOW TO APPEAL A CLAIM
If your claim is denied in whole or in part and you do not agree with the reason for the denial, you should write, within 60 days of the date you were notified of the denial, to the person who wrote to advise you of the denial. Be sure to state why you believe the claim should not have been denied, and submit any data, questions or comments you think are appropriate.

Your appeal will be reviewed by the specific insurance carrier or by the Board of Trustees if it is a self-insured benefit.

You will be notified in writing of the final decision within 60 days of the date your appeal is received, unless there are special circumstances, in which case you will be notified in writing of the date by which the final decision will be made within 60 days of the date your appeal is received.
SECTION VII – DEFINITIONS
DEFINITIONS

Accident
An unusual, unexpected, fortuitous, unintended event causing injury for which no third party is legally responsible.

Active Work/Actively at Work
This term means the performance of all the duties that pertain to your work at the place where it is normally done, or where it is required to be done by your employer.

Beneficiary
The beneficiary for your insurance for loss of life will be the person(s) named by you as shown on the records kept on the Group Policy. You may change your beneficiary at any time by giving written notice to the Fund. This change will take effect on entry in those records.

If your insurance for loss of life under this Group Policy replaces another group policy, the beneficiary named under the replaced policy will be in effect until you: (a) name a beneficiary under this Group Policy; or (b) change your beneficiary as set forth above.

If a minor has no legal guardian, that minor’s share may be paid to the adult or adults who, in the insurance carrier’s opinion, have assumed the custody and support of the minor.

If you die after having applied to convert your group Life Insurance to individual Life Insurance, the beneficiary named under the Individual Policy or in the application for it will receive any benefits payable under the Group Policy.

Benefit(s)
Any of the scheduled payment(s) or services provided by the Plan.

Charges, Fees, Expenses
The terms charges, fees, or expenses will not include any amounts:
• More than what is reasonable and customary in the locale where incurred
• For a service or supply not generally accepted in medical practice as needed in the diagnosis or treatment of the patient’s condition
• For repeated tests which are not needed.

These amounts will be determined by the Fund. The Fund may make use of the certification of a professional or peer review group as to the extent to which a service or supply is needed for the diagnosis or treatment of the patient’s condition.

Children
Your children who are eligible to receive benefits from the Fund, as described on pages 12-13.
COBRA Continuation 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 page 19 for more detailed information.)

Coordination of Benefits
A method of sharing costs among payers which sets the order of payment by each. (See pages 16-17 for more detailed information.)

Dentist
A person licensed by the appropriate department of the State to practice within the dental profession for which they have been licensed.

Dependent
Your spouse or domestic partner and your children who are eligible to receive benefits from the Fund as described on pages 12-13.

Disabled
You are temporarily unable to work due to an accident or illness.

Doctor
A person licensed by the appropriate department of the State to practice within the medical profession for which they have been licensed.

Enrollment Form
The form used to provide the Fund with the personal, employment, and beneficiary information needed to determine your benefits and process your claims.

Family
Your spouse and your dependent children who are eligible to receive benefits from the Fund, as described on pages 12-13.

Fund
1199SEIU Licensed Practical Nurses Welfare Fund, whose principal office is at 330 West 42nd Street in New York City.

Illness
Sickness, disease or disorder of body or mind of such character as to affect the general soundness and the healthfulness of the system.

Member
An employee who is working for a Contributing Employer on whose behalf payments to the 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 class of former members.
Participating Pharmacy
A licensed, registered pharmacy that has signed an agreement with the Fund’s Prescription Benefit Manager.

Physician
A person licensed by the appropriate department of the State to practice within the medical profession for which they have been licensed.

Plan
The benefits and the rules and regulations pertaining thereto for the various levels of benefits as adopted and interpreted by the Trustees and the official documents, such as the Trust Agreement and this booklet, including its preface, in which they are described.

Plan Administrator
As used in this booklet, shall mean the Board of Trustees and any individuals, such as the Executive Director, duly designated by the Trustees to carry out administrative functions.

Spouse
The person to whom a member is legally married and who is eligible for benefits from the Fund as described on page 12.

Trust Agreement
The Agreement and Declaration of Trust entered into between the Union and Contributing Employer establishing the Fund.

Trustees
The Fund Trustees acting pursuant to the Agreement and Declaration Trust establishing the 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 booklet, the term “You” or “you” (or Your or your) refers to the member, as an individual, or to the member and her/his family, as an entity, depending on the context in which it is used.