This booklet serves as both a Summary Plan Description (SPD) and Plan Document for participants in the 1199SEIU National Benefit Fund employed in the metropolitan New York City area and other areas covered by this Benefit Fund.

The Plan is administered by the Board of Trustees (the “Trustees”) of the 1199SEIU Benefit Fund for Health and Human Service Employees. 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 active and retired employees may not receive benefits as described in this Plan Document. 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 booklet and the Benefit 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 Benefit 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 Fondo Nacional de Beneficios de la 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.

The Fund believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act, which means that this plan can preserve certain basic health coverage that was already in effect when that law was enacted, and may not include certain new consumer protections that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits. Questions regarding the Fund’s status as a grandfathered health plan and which protections apply can be directed to the Fund at (646) 473-9200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
Dear 1199SEIU Member:

The Benefit Fund cares about you and your family.

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

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 Plan.

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; 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 is covered in full when you use the 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 Member Services Department at (646) 473-9200. The Benefit Fund staff can answer your question, refer you to another department or take the information and get back to you later with an answer.

With your help, your Benefit Fund can continue to provide a comprehensive package of health and welfare benefits in the years ahead for you and your family and other 1199SEIU members and their families.

The Board of Trustees
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NEED TO KNOW WHAT “FAMILY” MEANS IN THIS BOOKLET?

Refer to the Definitions Section

The Definitions section (Section IX) lists the terms used in this booklet 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 booklet refers only to your spouse/same-sex partner 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 National Benefit Fund is a grandfathered, self-administered, 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 (1199SEIU).

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.

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. It exists only to provide you, other 1199SEIU members and your families with quality healthcare and welfare benefits.

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 Benefit 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.

Grandfathered under the Patient Protection and Affordable Care Act means that this plan can preserve certain basic health coverage that was already in effect when that law was enacted, and may not include certain new consumer protections that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits. Questions regarding the Fund’s status as a grandfathered health plan and which protections apply can be directed to the Fund at (646) 473-9200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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 benefits.
OVERVIEW OF YOUR BENEFITS

IMPORTANT PHONE NUMBERS

Member Services Department
(646) 473-9200

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

Call the Following Phone Numbers to Protect Your Benefits:
- 1199SEIU Care Review for prior approval of hospital stays:
  (800) 227-9360
- Ambulatory/Outpatient Surgery Pre-Certification Program:
  (646) 473-9200
- Program for Behavioral Health:
  (646) 473-6900

You can also visit our website at www.1199SEIUBenefits.org for forms, directories and other information. From our website, click on “My Account” and create your own personal information 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 conditions exclusions.

The Benefit Fund believes that it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. Please see page 9 for more details.
### 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, depending on eligibility, as described in Section II.H of this SPD.

- **Up to 365 days per year**

- **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 for inpatient physical rehabilitation in an acute facility. Benefits are not provided for care in a nursing home or skilled nursing facility.**

### HOSPICE CARE

- **Up to 210 days of inpatient hospice care per lifetime in a hospice, hospital or for outpatient home services**
Benefit Coverage

<table>
<thead>
<tr>
<th></th>
<th>Wage Class I</th>
<th>Wage Class II</th>
<th>Wage Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMERGENCY ROOM VISITS</td>
<td>Family</td>
<td>Family</td>
<td>Member Only</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(facility charge only)</td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
<td></td>
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<tr>
<td>• Use of the Emergency Room must be <strong>for an Emergency within 72 hours</strong> of an accident or sudden and serious illness</td>
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<tr>
<td>• Observation Care and Services - See Hospital Section</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Benefit Fund pays negotiated or reasonable rate</td>
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<tr>
<td>PROGRAM FOR BEHAVIORAL HEALTH</td>
<td>Family</td>
<td>Family</td>
<td>Member Only</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient treatment</td>
<td></td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Inpatient Care</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Alcohol/Substance Abuse</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Medically Necessary services for inpatient detoxification</td>
<td><em>Call 1199SEIU CareReview, (800) 227-9360, for prior approval of inpatient treatment.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Up to 30 days within a 12-month period for inpatient rehabilitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient treatment</td>
<td></td>
<td></td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
Benefit Coverage

<table>
<thead>
<tr>
<th>Wage Class I</th>
<th>Wage Class II</th>
<th>Wage Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>Family</td>
<td>Member Only</td>
</tr>
</tbody>
</table>

**SURGERY**
- 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

*Call 1199SEIU CareReview; (800) 227-9360, before having non-emergency surgery.*

**ANESTHESIA**
- Benefits based on the Benefit Fund’s Schedule of Allowances

**MATERNITY CARE**
- An allowance that includes all prenatal and postnatal visits and delivery charges
- Hospital benefit for the mother and newborn, if the mother is you or your spouse
- Disability benefits for you if you are the mother

*Call the Prenatal Program, (646) 473-9200, to register for the Prenatal Care Program during the first three months of your pregnancy.*
## Benefit Coverage

<table>
<thead>
<tr>
<th>MEDICAL SERVICES</th>
<th>Wage Class I</th>
<th>Wage Class II</th>
<th>Wage Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment in a doctor’s office</td>
<td>Family</td>
<td>Family</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Well child care for dependent children</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Immunizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-rays and laboratory tests</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Dermatology: up to 20 treatments per year</td>
<td></td>
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<tr>
<td>Chiropractic: up to 12 treatments per year</td>
<td></td>
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<tr>
<td>Podiatry: up to 15 treatments per year for routine care</td>
<td></td>
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<tr>
<td>Physical/rehabilitation therapy: up to 25 visits per discipline per year</td>
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<tr>
<td>Allergy: up to 20 treatments per year, including diagnostic testing</td>
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<tr>
<td>Outpatient chemotherapy, radiation therapy and hemodialysis</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ambulance Services</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Participating providers bill the Benefit Fund directly and accept the Benefit Fund’s payment as payment in full</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Benefit Coverage

<table>
<thead>
<tr>
<th>MEDICAL SERVICES REQUIRING PRE-AUTHORIZATION</th>
<th>Wage Class I</th>
<th>Wage Class II</th>
<th>Wage Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Home Health Care</td>
<td>Family</td>
<td>Family</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Non-Emergency Ambulance Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Durable Medical Equipment and Appliances</td>
<td>Call the Prior Authorization Department (646) 473-9200 for prior approval for services, except Emergency ambulance and radiology tests.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical Supplies</td>
<td></td>
<td></td>
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<tr>
<td>• Specific Medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Home Infusion Services and Supplies</td>
<td>Call for Prior Authorization for radiology tests at (888) 910-1199.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MRI, MRA, PET and CAT Scans and certain Nuclear Cardiology procedures</td>
<td>Call 1199SEIU CareReview at (800) 227-9360.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ambulatory/Outpatient Surgery</td>
<td></td>
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</tr>
</tbody>
</table>

### VISION CARE

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

### HEARING AIDS

- Once every three years
- Call for referrals to a participating Provider.
- Co-payments may apply

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16
<table>
<thead>
<tr>
<th>Benefit Coverage</th>
<th>Wage Class I</th>
<th>Wage Class II</th>
<th>Wage Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEMBER CHOICE PARTICIPANTS:</td>
<td></td>
<td></td>
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<tr>
<td>COMPREHENSIVE DENTAL BENEFIT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Member or Eligible Dependent</td>
<td>Family</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• 100% of the Benefit Fund’s</td>
<td></td>
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<tr>
<td>Comprehensive Schedule of</td>
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<tr>
<td>Allowances for basic and preventive</td>
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<tr>
<td>services</td>
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<tr>
<td>• Effective 1/1/03, $3,000 maximum</td>
<td></td>
<td></td>
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<tr>
<td>per person (excluding essential oral</td>
<td></td>
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<tr>
<td>pediatric services)</td>
<td></td>
<td></td>
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<tr>
<td>Call (646) 473-9200 for prior approval of treatment over $200.</td>
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<tr>
<td>DENTAL CARE (NON-MEMBER CHOICE)</td>
<td></td>
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<tr>
<td>• 100% of the Benefit Fund’s</td>
<td>Family</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>allowance for basic and preventive</td>
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<td></td>
<td></td>
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<tr>
<td>services</td>
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<tr>
<td>• Participating Providers bill the</td>
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<tr>
<td>Benefit Fund directly and accept the</td>
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<tr>
<td>Benefit Fund’s allowance as payment</td>
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<tr>
<td>in full. For major restorative work,</td>
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<tr>
<td>co-payment may apply.</td>
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<tr>
<td>• Maximum benefit $1,200 per person</td>
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<tr>
<td>per year (excluding essential oral</td>
<td></td>
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<td></td>
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<tr>
<td>pediatric services)</td>
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### Benefit Coverage

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<thead>
<tr>
<th></th>
<th>Wage Class I</th>
<th>Wage Class II</th>
<th>Wage Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRESCRIPTION DRUGS</strong></td>
<td>Family</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>- FDA-approved prescription medication</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- No co-payments, no deductible when you use generic and preferred drugs if available</td>
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<tr>
<td>- Use Participating Pharmacies</td>
<td></td>
<td></td>
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<tr>
<td>- Maintenance drug access program for chronic conditions – <em>The 90-Day Rx Solution</em></td>
<td></td>
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<tr>
<td>- Prior authorization needed for certain medications</td>
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<tr>
<td>- Please refer to “What Is Not Covered” in Section II.L.</td>
<td></td>
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</tr>
<tr>
<td><strong>LIFE INSURANCE</strong></td>
<td>Member Only</td>
<td>Member Only</td>
<td>Member Only</td>
</tr>
<tr>
<td>- First year maximum $1,250</td>
<td></td>
<td></td>
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<tr>
<td>- After first year, based on your Wage Class and annual rate of pay up to a maximum of $50,000</td>
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<tr>
<td><strong>DISABILITY</strong></td>
<td>Member Only</td>
<td>Member Only</td>
<td>Member Only</td>
</tr>
<tr>
<td>- For accidents or illness that are not work-related</td>
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<td></td>
<td></td>
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<tr>
<td>- Amount is based on your Average Weekly Earnings</td>
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<tr>
<td>- Maximum weekly benefit $385</td>
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<td></td>
</tr>
<tr>
<td>- How long you can receive benefits is based on your medical condition</td>
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<tr>
<td>- Maximum coverage 26 weeks within a 52-week period</td>
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### Benefit Coverage

<table>
<thead>
<tr>
<th>ACCIDENTAL DEATH AND DISMEMBERMENT</th>
<th>Wage Class I</th>
<th>Wage Class II</th>
<th>Wage Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Only</td>
<td>Member Only</td>
<td>Member Only</td>
<td>Member Only</td>
</tr>
</tbody>
</table>

- For accidental death or injury
- Equal to, or one-half of, your Life Insurance

<table>
<thead>
<tr>
<th>BURIAL</th>
<th>Wage Class I</th>
<th>Wage Class II</th>
<th>Wage Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member and Spouse</td>
<td>Member and Spouse</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

- Free burial plot with permanent care OR
- $75 payment to your beneficiary

<table>
<thead>
<tr>
<th>ANNE SHORE CAMP PROGRAM</th>
<th>Wage Class I</th>
<th>Wage Class II</th>
<th>Wage Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children Only</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

- For children 9 to 15 years old
- Summer Sleep-Away Camp Program provided at no cost to you, except application fee

<table>
<thead>
<tr>
<th>SCHOLARSHIP</th>
<th>Wage Class I</th>
<th>Wage Class II</th>
<th>Wage Class III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children Only</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

- Provided to eligible children of members
- Scholarships provided to attend accredited schools after high school

### LEGEND

- **Member** – You, the member
- **Spouse** – Your spouse or same-sex partner, if eligible
- **Children** – Your children, if eligible
- **Family** – You, your spouse/same-sex partner and your children, if eligible

See Section I.A to determine if you, your spouse/same-sex partner or your children are eligible for benefits.

*If you work for the City of New York or an agent or authority of New York City, see Section I.F for a summary of the benefits you are eligible for.*
SECTION I – ELIGIBILITY

A. Who’s 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 Unemployment Insurance
   • While Participating in Training Programs
   • While Covered by the Job Security Fund (JSF)
   • While Taking Family and Medical Leave (FMLA)
   • While Taking a Uniformed Services Leave

K. Your COBRA Rights
## ELIGIBILITY RESOURCE GUIDE

### 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 leave; and/or
- Get the answers to any of your questions.

**COBRA Department**  
(646) 473-6815

Call the COBRA Department to:
- Apply for COBRA continuation coverage; and/or
- Get more information on COBRA.

### IMPORTANT REMINDERS

- Enroll in the Benefit Fund to be eligible for benefits.
- 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 **Young Adult Enrollment Form** every year if your child is eligible to receive benefits after age 19 (see Section I.A).
- File a **Certification Form** every year if your child is disabled and eligible to receive benefits after age 26 (see Section I.A).
- Contact the Benefit Fund immediately if you are not working due to a Workers’ Compensation leave, 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.

### PLEASE NOTE:
Generally, wherever the term “your spouse” is used in this booklet, it is intended to refer to your same-sex partner as well, except where noted otherwise or the context would indicate that such usage was not intended.
SECTION I. A
WHO’S ELIGIBLE

YOU
You are eligible to participate in the 1199SEIU National 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 Summary Plan Description (SPD); and
• You have completed the waiting period specified in your employer’s Collective Bargaining Agreement (in most cases 90 days).

If you are an employee of the City of New York or an agent or authority of New York City, you are eligible for a specified package of benefits (see Section I.F).

If you are an employee of 1199SEIU United Healthcare Workers East and participate in the Benefit Fund, you are eligible for a specified package of benefits (see Section I.F).

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 Retiree Health Benefits, Section VI.A).

YOUR SPOUSE OR SAME-SEX PARTNER
Your spouse may be eligible if:
• You and your spouse are legally married; and
• You are eligible for Family coverage, based on your Wage Class (see Section I.D).

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

Your same-sex partner may be eligible if all the following conditions are met:
• You are eligible for family coverage based on your Wage Class (see Section I.D);
• You and your same-sex partner reside in a city, county or state which:
  » Provides for the legal recognition of same-sex marriage, and you have entered into such a relationship and submitted the required documents, which have been accepted by the Fund; or
  » Provides for the legal recognition of same-sex civil unions (but not same-sex marriage), and you
have entered into such a relationship and submitted the required documents, which have been accepted by the Fund; or

» Provides for the legal recognition of same-sex domestic partnerships (but neither same-sex marriage nor same-sex civil unions), and you have entered into such a relationship and submitted the required documents, which have been accepted by the Fund; or

» Does not provide for any legal recognition of same-sex relationships, but you have received legal recognition of your same-sex relationship in another city, county, state or country and submitted the required documents, which have been accepted by the Fund; or

» Does not provide for any legal recognition of same-sex relationships and the following conditions are met:
  - You and your same-sex partner are in a committed, same-sex relationship, which is similar to marriage;
  - This relationship has been in existence for at least twelve (12) months;
  - You and your same-sex partner are both age 18 or older;
  - You and your same-sex partner are financially and emotionally dependent upon each other;
  - You and your same-sex partner live together at the same address and intend to do so indefinitely;
  - You and your same-sex partner intend for your relationship to be permanent;
  - Neither you nor your same-sex partner are married or are related by blood in a manner that would bar marriage in the State of New York; and
  - You have submitted an Affidavit of Domestic Partnership and other required documents, which have been accepted 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 same-sex partners.
PLEASE NOTE: Changes within your family that relate to eligibility must be reported to the Benefit Fund immediately and in no case more than 30 days from the date of the event. Such changes include:

• Separation or divorce of a spouse;

• Legal termination of a civil union or legally recognized domestic partnership;

• Failure to continue to meet the eligibility conditions set forth by the Fund in Section I.A for recognition of your same-sex relationship; or

• Change in status of your dependent children.

Except as provided by court order, Benefit Fund coverage of a spouse or same-sex partner ends upon separation or divorce, legal termination of a civil union or legally recognized domestic partnership, or change in status of same-sex relationship such that it no longer meets the eligibility conditions set forth by the Fund.

YOUR CHILDREN

Your children are eligible up to their 19th 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

• They’re not eligible to enroll in another employer-sponsored health plan (excluding parent coverage); and

• You are eligible for family coverage, based on your Wage Class (see Section I.D).

Your stepchildren, foster children and grandchildren are not covered by the Benefit Fund. Children of your same-sex partner 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.
AFTER YOUR CHILD REACHES AGE 19

Your child’s coverage may be continued from your child’s 19th birthday up to his or her 26th birthday if:

• You file a properly completed Young Adult Enrollment Form with the Benefit Fund when your child turns age 19 and each year after that until your child’s 26th birthday; and

• Your child is not eligible to enroll in another employer-sponsored health plan (excluding parent coverage).

CHILDREN WITH DISABILITIES

If your child is disabled, as described in the list immediately 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 handicapped 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 is expected to last for a continuous period of not 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 (ERISA) of 1974, as amended.

A QMCSO may require the Benefit Fund to make coverage available to your child even though the child is not, for income tax purposes or Fund purposes, your legal dependent, because of separation or divorce.

In order to be a qualified order, the medical child support order must:

• Be issued by a court or authorized state agency;

• Clearly specify the alternate recipient;

• Reasonably describe the type of coverage to be provided to such alternate recipient;

• Clearly state the period to which such order applies; and

• Indicate the name and last known address of the member who is required to provide the coverage and the name and mailing address of each child covered by the order.

The Plan Administrator will determine the qualified status of a medical child support order in accordance with the Benefit Fund’s written procedures.
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 specified in your employer’s collective bargaining agreement (in most cases 90 days) and your employer has made 30 consecutive days of contributions to the Benefit Fund based on your employment; or

• On the first day of the month following 30 consecutive days of employer contributions made to the Benefit Fund based upon your employment.

IF YOU ARE A NEWLY ORGANIZED EMPLOYEE
Your coverage begins after:

• You have enrolled in the Benefit Fund; and

• Your employer starts making contributions on your behalf as specified in your employer’s collective bargaining agreement.

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 after an unpaid leave of absence:

• 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.

PLEASE 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:

• They are eligible to receive benefits; and
• Your benefit level is Wage Class I or Wage Class II (see Section I.D).

PLEASE NOTE: You are eligible for Disability benefits after 4 consecutive weeks of employment with a Contributing Employer, as required by the New York State Disability Law.

However, eligibility for all other benefits will begin as described in this section.
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 Benefit Fund before you will be eligible for benefits.

To enroll in the Benefit Fund:

• Get an Enrollment Form from the Benefit Fund office, by calling the Member Services Department at (646) 473-9200, or by visiting our website at www.1199SEIUBenefits.org; and

• 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 Life Insurance beneficiary;
• Your spouse’s employer; and
• Information on other insurance coverage.

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. In the case of a same-sex partner, include all information requested by the Benefit Fund.

Send the form and any related documents to the Benefit Fund’s 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 when:

• You move;
• You get married;
• You are divorced or legally separated, or end your domestic partnership;
• You have a child;
• Your child reaches age 26;
• A family member covered by the Benefit Fund dies;
• You want to change your beneficiary; and/or
• You change employers.

Fill out an **Enrollment Change Form** and send it to the Benefit Fund’s Eligibility Department so that your records can be updated.

Remember to send copies of all the documents needed by the Benefit 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 same-sex partner; and
• Any other documents required by the Benefit Fund.

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

**PLEASE NOTE:** All information appearing on your Enrollment Form is for Benefit Fund use only and will not be released to any third party, except where necessary for the administration and operation of the Benefit Fund, or where otherwise required by law.
SECTION I. D
HOW TO DETERMINE YOUR LEVEL OF BENEFITS

THE BENEFITS YOU RECEIVE ARE BASED ON YOUR WAGES

The Benefit Fund has three levels of benefits called Wage Classes. Your Wage Class is based on:

- The wages you earn; and
- The minimum full-time wage specified in the collective bargaining agreement with your employer ("minimum full-time wage").

Your employer reports your weekly earnings to the Benefit Fund. To determine your Wage Class, the Benefit Fund averages your weekly earnings over the 16-week period immediately preceding the date your claim was incurred by you or a covered member of your family.

Your Average Weekly Earnings are then compared to wage levels stated in the collective bargaining agreement with your employer.

If you work full-time, your benefit level is generally Wage Class I.

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

- Wage Class I if you earn 100% of the minimum full-time wage; or
- Wage Class II if you earn at least 60%, but less than 100%, of the minimum full-time wage; or
- Wage Class III if you earn less than 60% of the minimum full-time wage.

If you work for the City of New York or an agent or authority of New York, this section discussing Wage Classes is not applicable to you.
IF YOU WORK FOR MORE THAN ONE CONTRIBUTING EMPLOYER

Your earnings from all Contributing Employers are combined to determine your Wage Class and eligibility for benefits.

However, you can receive no more than the maximum benefit allowed by the Benefit Fund’s Schedule of Allowances.

WHEN YOU ARE PARTICIPATING IN TRAINING PROGRAMS OR THE JOB SECURITY FUND

You may be eligible to continue receiving your benefits while you are participating in the programs provided through your employer’s collective bargaining agreement, such as the Training and Upgrading Fund or Job Security Fund.

YOUR WAGE CLASS DETERMINES WHO IS ELIGIBLE...

If you are in Wage Class I or II, you are eligible for family coverage. This means that you, your spouse (or same-sex partner) and your children, if eligible, can receive benefits from the Benefit Fund.

If you are in Wage Class III, only you (the member) can receive benefits. Your spouse (or same-sex partner) and your children are not eligible for coverage from the Benefit Fund.

...AND WHAT BENEFITS ARE COVERED

Your Wage Class determines which benefits you and/or your spouse and children can receive from the Benefit Fund.

See page 12 for an Overview of Your 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; and/or
- A Member Choice ID card if you are participating in the 1199SEIU Member Choice program.

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

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

PLEASE NOTE: If you are no longer eligible for benefits, you may not use any ID card from the Benefit Fund, regardless of any expiration date that may appear on the card. If you do, you will be personally responsible for all charges.

Your ID cards 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 rather than your Social Security number when communicating with the Fund. You should not allow anyone else to use your ID cards 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 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 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 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 insurer. However, if you are enrolled in a Health Maintenance Organization (HMO) or any other paid-in-full plan, you must use the benefits provided by that plan. If the Benefit Fund is the secondary coverage, we will provide only for those benefits that are not provided by the primary plan.

WHEN YOU ARE COVERED BY MORE THAN ONE EMPLOYER PARTICIPATING IN THE BENEFIT FUND

The total amount paid 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.
WHEN YOU AND YOUR SPOUSE ARE BOTH COVERED BY THE BENEFIT FUND

If you and your spouse are both covered by the Benefit 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 cost for the Medically Necessary care provided or 100% of the actual expenses, whichever is less.

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 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.

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.

IF BENEFIT COVERAGE IS AVAILABLE THROUGH YOUR SPOUSE’S EMPLOYER, OR IF YOUR SPOUSE IS SELF-EMPLOYED

Your spouse must:

• Enroll in that employer’s benefit plan; or

• Purchase insurance if self-employed, as defined by the Plan Administrator;

• Choose coverage at least for himself or herself; and

• Pay any premiums required by the plan to maintain this insurance.

The Benefit Fund will only pay benefits up to the amount the Benefit Fund would have paid if your spouse had been covered by his or her employer’s plan. You and your spouse will have to pay any charges not paid by the 1199SEIU National Benefit Fund and your spouse’s employer’s plan.
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 earliest in the year; and
- 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.

WHEN COVERED BY AN HMO, PAID-IN-FULL OR PRE-PAID PLAN

If your spouse and/or your children are enrolled in a Health Maintenance Organization (HMO) or any other paid-in-full plan, they must use the benefits provided by that plan.

The Benefit Fund will provide coverage only for those benefits which are not provided by that plan.

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.

If you prefer, you may elect to end your coverage under the Benefit Fund and elect to have Medicare as your only insurance. However, if you elect this option, the Benefit Fund may not provide any benefits that supplement those provided under Medicare.
**MEDICARE AND END STAGE RENAL DISEASE (ESRD)**

In the case of an individual entitled to Medicare benefits on the basis of end stage renal disease (ESRD), the Benefit Fund will be the primary payer of benefits only for the period required by law. Thereafter, the Benefit Fund will be secondary to Medicare.

To protect your benefits, you must enroll in Medicare Part A and Part B immediately upon becoming entitled to Medicare benefits and maintain this coverage prior to and after your transplant as required by law until you have verified that the Fund will become your primary insurer. The Fund will provide reimbursement for 50% of your basic Medicare Part B Premium. You may file a claim, along with the required documentation, once each quarter to get this benefit.

**NEW YORK CITY EMPLOYEES**

If you are employed by the City of New York or an agent or authority of New York City, certain benefits are provided to you by the City. You (and your eligible dependents) are covered by the Benefit Fund only for the following benefits:

- Vision Care
- Dental Care
- Prescription Drugs
- Disability
- Life Insurance
- Accidental Death and Dismemberment
- Burial
- Camp and Scholarship.

See the applicable sections of this SPD for details about these benefits.

You may be eligible for other benefits not provided by the Benefit Fund through your employment with the City. Contact your employer for an explanation of your full benefit coverage.

**1199SEIU UNITED HEALTHCARE WORKERS EAST**

If you are an employee of 1199SEIU United Healthcare Workers East and participate in the Benefit Fund, medical and dental benefits are provided to you (and your eligible dependents) through an arrangement with the Aetna Life Insurance Company. You (and your eligible dependents, where applicable) are eligible for the following benefits through the Benefit Fund:

- Prescription Drugs
- Disability
- Life Insurance
- Accidental Death and Dismemberment
- Burial
- Camp and Scholarship.

See the applicable sections of this SPD for details about these benefits.
SECTION I. G  
WHEN OTHERS ARE RESPONSIBLE FOR YOUR ILLNESS OR INJURY

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

The Plan Administrator recognizes that often the responsibility for illness, injuries or treatment 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.

When another party is responsible for an illness, injury or treatment, the Plan Administrator has rights to recover the full amount it has paid or will pay related to any claims that you may have against any person or entity. This means that by accepting health benefits, you are assigning your rights to the Benefit Fund in any recovery to the extent of the Benefit Fund’s payments that have been made, or will be made on your behalf. The Benefit Fund’s right to recover the payments comes before you can recover any payments you may have made. Therefore, the Benefit Fund has an independent right to bring an action in connection with such an illness, injury or treatment in your name and also has a right to intervene in any such action brought by you. It also means that the Benefit Fund has an equitable lien on the proceeds of any verdict or settlement reached in a lawsuit that you bring against someone for causing an illness, injury or treatment when the Benefit Fund has paid for costs arising from that person’s actions. The Benefit Fund has a right to be repaid from those proceeds. You must notify the Benefit Fund of any accident, injury or treatment 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 or treatment.

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.
Once the Benefit Fund learns that another party may be responsible, you must sign an agreement (or a “lien”) affirming the Benefit Fund’s rights with respect to benefit payments and claims. Benefit payments are not payable until this agreement is signed and received by the Benefit Fund.

If you receive payments from or on behalf of the party responsible for an illness or injury, the Benefit Fund must be repaid from those payments. 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.”

If you fail or refuse to sign a lien or to comply with these terms, the Plan Administrator may suspend your eligibility for benefits and/or recovery from provider’s money paid to them, until the Benefit Fund is fully repaid. In addition, the Plan Administrator may bring a court action against you to enforce the terms of the Plan.

By accepting the Benefit Fund’s payments, you are consenting to a constructive trust being placed on the amount owed to the Benefit Fund out of any proceeds.

WHEN MOTOR VEHICLE OR NO-FAULT INSURANCE PROVIDES COVERAGE

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

This Plan is secondary to:

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

However, the Benefit Fund will be the primary payer for disability benefits, which will be paid at the statutory disability rate.

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 Fees and 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 and loss of wages.

PLEASE 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 family. If you need help or advice concerning your Workers’ Compensation claim, call the Benefit Fund at (646) 473-9200.

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

However, the Benefit Fund will:

- Pay you the difference in disability benefits if the amount paid by Workers’ Compensation is less than the disability benefit you would have received from the Benefit Fund if your disability had not been work-related.

If you can’t go back to work after 26 weeks, your coverage through the Benefit Fund will end. However, you can extend your health benefits under COBRA continuation coverage (see Section I.K).

NOTIFY THE BENEFIT FUND

You need to contact the Benefit Fund within 30 days when you’re not working due to a work-related illness or injury. Call the 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 wage reports it receives from your employer. If you haven’t received any wages, then your coverage may be suspended because the Benefit Fund does not know that you are out on Workers’ Compensation leave.

For more information,
see Section III – Disability Benefits.
SECTION I. I
WHEN YOUR BENEFITS STOP

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

• All benefits end 30 days after the last day for 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.H or Section VI – Retiree Health Benefits.

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

If your employer continuously fails to make contributions and is excessively 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 obligated to continue your coverage through other sources.

If the Collective Bargaining Agreement between your employer and 1199SEIU expires, and

• If the contribution rate paid on your behalf by your Contributing Employer is less than the rate required by the Trustees; and

• If your employer does not agree to make contributions at the rate required by the Trustees; then your benefits will be reduced on the 181st day after the expiration of the Collective Bargaining Agreement to a Plan B Level of Benefits. This plan will be distributed to all affected members at the time benefits are reduced.

IF YOU ARE ON DISABILITY OR WORKERS’ COMPENSATION LEAVE

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

• On the last day of your Disability benefits; 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) 473-9200. See Section I.K for more information on COBRA continuation coverage.

UPON YOUR DEATH

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

• While they 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 death.

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 after a leave:

• **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.

YOUR HIPAA RIGHTS
When your Benefit 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 Benefit 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 Benefit 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 Benefit 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 Benefit 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 Benefit Fund ended or the date your COBRA coverage ended.

Accordingly, the Benefit Fund will provide you with Certificates of Creditable Coverage showing when you were covered by the Benefit Fund:

• On your request, within 24 months after your Benefit Fund coverage ceases;
• When you are entitled to elect COBRA (see Section I.K);
• When your coverage terminates, even if you are not entitled to COBRA (see Section I.K); 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 Benefit Fund at (646) 473-9200.

PRIVACY OF PROTECTED HEALTH INFORMATION

HIPAA also 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. A complete description of how the Benefit 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. Anyone may request an additional copy of this Notice by contacting the Benefit Fund office.
SECTION I. J
CONTINUING YOUR COVERAGE

WHILE RECEIVING UNEMPLOYMENT INSURANCE

Beyond the dates described in Section I.I, the Benefit Fund may extend your benefits for one additional month for each full year you were covered by the Benefit Fund up to a maximum of six consecutive months, if:

• You were covered by the Benefit Fund immediately before you were laid off or terminated; and
• You receive state-provided unemployment benefits and remain unemployed.

Notwithstanding the information in the paragraph directly above, effective May 1, 2009, and for the duration of the COBRA Continuation Coverage Subsidy Program (the “Program”) provided for in the American Recovery and Reinvestment Act of 2009, if you would otherwise be eligible for the Fund’s month-to-month extension described in this section, but you are eligible for benefits from the Job Security Fund and are entitled to a COBRA subsidy (as defined in the Program), you shall not be eligible for the additional months of extended benefits from the Fund as described in this section.

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 League Training and Upgrading Fund.

For more information on the various programs offered by the 1199SEIU League Training and Upgrading Fund, call (212) 643-9340, or visit the website at www.1199SEIUBenefits.org.

WHILE COVERED BY THE JOB SECURITY FUND (JSF)

You may continue to be covered by the Benefit Fund when you participate in the Job Security Fund, which makes contributions on your behalf.

For more information, call the Job Security Fund at (212) 629-5505.
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:

- When your child is born and you need to care for the baby;
- When you adopt a child or become a foster parent;
- 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/father-in-law);
- When you have a serious health condition that keeps you from doing your job;
- 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 this section, you may receive up to 12 work weeks of unpaid leave during a 12-month period.

If you need to care for your spouse, son, daughter, parent or “next of kin” who has a serious injury or illness incurred in the line of active duty, you are eligible for up to 26 work weeks of unpaid FMLA leave in a 12-month period. For Armed Forces members, FMLA defines a serious injury or illness as an illness or injury that may render the service member medically unfit to perform his or her military duties.

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.
PLEASE 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.

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 ninety days from the date of discharge if the period of military service was more than one hundred eighty-one (181) days, or within fourteen (14) days from the date of discharge if service was more than thirty (30) days but less than one hundred eighty (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 thirty-one (31) days. If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended for up to two (2) years.

Contact the Benefit Fund office 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.
SECTION I. K
YOUR COBRA RIGHTS

Under the federal law commonly known as COBRA, you, your spouse and your children have the option of extending your group healthcare 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 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 coverage. However, note that life insurance is not covered by COBRA continuation coverage. In addition, 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 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 are reduced, resulting in a change in your wage class; or
- Your employment is terminated for reasons other than gross misconduct on your part.
PLEASE NOTE: that 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 (unless you were a retired member who retired on or after October 1, 1998 – see Section VI.F); or
- You and your spouse become divorced or legally separated; or
- You become entitled to Medicare.

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 a loss of coverage because:

- You die;
- You and your spouse become divorced or legally separated;
- Your child ceases to be an eligible dependent; 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 Benefit 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
• 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, 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, 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 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.

PLEASE 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 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, through the furnishing of this SPD, of both the responsibility to provide and the procedures for providing notice of the Social Security 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 if coverage is lost because:
• 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) 473-9200 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 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 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 in writing 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 Benefit 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 Benefit Fund office on or before the 60-day period noted in Section I.K; or
• Mailed to the Benefit Fund office at PO Box 1036, New York, NY 10108-1036 and postmarked on or before the end of the 60-day period noted in Section I.K. If you or your spouse or dependent children do not elect COBRA continuation coverage, your group health coverage under the Benefit 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. Your same-sex partner does not have the right to elect COBRA continuation 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 must pay the required 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 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 that 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;
- 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.

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 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 Benefit 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 cannot 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 Benefit Fund coverage ends.
SECTION II – HEALTH BENEFITS

A. Participating Providers
   • Member Choice
   • Panel Providers

B. Using Your Benefits Wisely
   • 1199SEIU Care Review
   • Ambulatory/Outpatient Surgery Pre-Certification
   • Program for Behavioral Health
   • Emergency Rooms Are for Emergencies
   • Care Management
   • Prenatal Care Program
   • Wellness and Disease Management Programs

C. Inpatient Hospital Care and Hospice Care

D. Emergency Room Care

E. Program for Behavioral Health (Mental Health and Alcohol/Substance Abuse)

F. Surgery and Anesthesia
   • Ambulatory Surgery

G. Maternity Care
   • Prenatal Care Program

H. Medical Services
   • Doctor Visits
   • Lab and X-Ray
   • What Is Not Covered

I. Services Requiring Prior Authorization

J. Vision Care

K. Dental Care

L. Prescription Drugs
HEALTH BENEFIT 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, click on “My Account” to access information about your eligibility and claims history or to make simple updates to your information.

WHERE TO CALL

Member Services (646) 473-9200
Call Member Services 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 copy of the Dental Program booklet;
• A list of participating dentists in your area;
• A list of participating pharmacies; and/or
• A list of preferred drugs, also known as a Preferred Drug List (PDL).

For Ambulatory/Outpatient Surgery Pre-Certification Program
Call 1199SEIU CareReview 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
Call for prior authorization if:
• You have questions about the treatment your doctor is recommending;
• You require home care or home intravenous (IV) services;
• You require certain diagnostic tests; and/or
• You need prior approval for certain medications.

For the Prenatal Program
Call to register with the Benefit Fund’s Prenatal Care Program.
HEALTH BENEFIT RESOURCE GUIDE

For the Program for Behavioral Health (Mental Health and Alcohol/Substance Abuse)  
(646) 473-6900  
Call to get help with a mental health or alcohol/substance abuse problem.

For the 24-Hour Nurse Helpline and Health Coaching Service  
(866) 935-1199

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

REMINDERS

- Go to any doctor you choose, but if you use a Non-Participating Provider, you can be billed and be responsible for whatever the doctor normally charges above the Benefit Fund’s Schedule of Allowances.

- Call 1199SEIU CareReview before your hospital stay for non-emergency care, or within two business days of an emergency admission.

- Use the emergency room only in the case of a legitimate medical Emergency. If it is an Emergency, your emergency room visit must be within 72 hours of an injury or the onset of a sudden and serious illness.

- Show your Health Benefits ID card when you go to the emergency room or when you are admitted to the hospital. The Benefit Fund will pay the hospital directly.

- Register with the Benefit Fund’s Prenatal Care Program during the first three months of your pregnancy.

- Call the Benefit Fund for services and supplies requiring pre-authorization.

- Get approval from the Benefit Fund before dental work is done, if your dental treatment will cost more than $200.

- Show your Health Benefits ID card to the pharmacist when you have a prescription filled.
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.
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) and certain radiology facilities as “preferred.” You must use these providers to avoid out-of-pocket expenses and to help control costs.

“Participating Providers” are independent practitioners who accept the Benefit Fund’s payment as payment in full for most services (see shaded box).

You can choose any doctor, hospital or other healthcare provider that you want for your family’s care through either the Benefit Fund’s Member Choice program or from the panel of providers.

Some services, such as psychiatric care, require that you pay a share of the cost.

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

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

The Benefit Fund’s Participating Providers are independent practitioners that 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 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 health 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 psychiatric care. And, there are no claim forms to file.
With Member Choice, all your doctors and healthcare providers work together in the same hospital. Your primary care doctor coordinates your healthcare needs with specialists, diagnostic facilities and other healthcare services provided in the same hospital network.

All the services provided in that hospital by Participating Providers, except psychiatric care, are covered in full by the Benefit Fund – including referrals, tests, anesthesia, outpatient treatment or inpatient hospital care.

You must be in Wage Class I or Wage 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](http://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 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 you 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, 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.

**How It Works**

You should go to see your primary care doctor for regular check-ups, 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 receive a referral to a specialist, make sure the provider is also participating in your Member Choice.
Select network or a Panel Provider. This way, you can be sure that the specialist you are seeing is participating in your Member Choice network.

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

Be sure to show your Member Choice ID card whenever you require services through this program.

**PANEL PROVIDERS**

Participating Providers are on the Benefit Fund’s “panel” of healthcare professionals, rather than participating in one of the Member Choice networks.

There are thousands of doctors, hospitals and other healthcare providers participating in the Benefit Fund’s Panel program. Like the Member Choice networks, these providers:

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

If your panel doctor needs to refer you to a specialist or another healthcare provider, make sure that provider is also on the Benefit Fund’s panel of Participating Providers.

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.

For the names of panel doctors and other healthcare providers in your area, call the Benefit Fund at (646) 473-9200 or visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).

**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 whatever the provider normally charges. You may have to pay any cost over the Benefit Fund’s allowance.

**PREFERRED LABORATORY, 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. If your doctor wants you to have lab or radiology tests, please contact the Benefit Fund or visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org) for the listing and locations of these laboratory and radiology facilities.
SECTION II. B  
USING YOUR BENEFITS WISELY

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 pre-certify your hospital stay **within two business days** of an emergency admission;
- For prior approval of inpatient mental health or alcohol/substance abuse treatment;
- To pre-certify your acute inpatient physical rehabilitation; or
- To pre-certify outpatient or ambulatory surgical procedures.

**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.

**PROTECT YOUR BENEFITS**

**If You Use an Emergency Room for Non-Emergency Care**

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

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 room, resulting in a high out-of-pocket cost to you.

**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.**

Remember to call **1199SEIU CareReview** before going to the hospital for inpatient care.
EMERGENCY ROOMS ARE FOR EMERGENCIES

A hospital emergency room should be used only in case of a legitimate medical Emergency. To be considered an Emergency, your emergency room visit must occur within 72 hours of an 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.

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/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 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 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.

THE PREGNATAL CARE 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 the 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 healthy 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) 473-9200 to register for the Fund’s Prenatal Care Program.
WELLNESS AND DISEASE MANAGEMENT PROGRAMS

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

You also have access to a 24-Hour Nurse Helpline that you can call with any health questions, and a Health Coaching Service by phone to help you manage chronic conditions. You can reach the Nurse Helpline and Health Coaching Service at (866) 935-1199.

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 www.1199SEIUBenefits.org.

PREFERRED LABORATORY FACILITIES

The Benefit Fund has contracted with certain free-standing 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 an exclusive lab.
- If you need to have your lab work outside of your doctor’s office, take your referral slip from your doctor to a Patient Care (Drawing) Center at one of the exclusive 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 radiological tests, such as MRI, MRA, PET scans, CAT scans and certain Nuclear Cardiology procedures. 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.

PREFERRED DURABLE MEDICAL EQUIPMENT (DME) VENDORS

The plan covers rental of standard durable medical and surgical equipment such as braces, hospital beds and wheelchairs. By using these vendors, you will avoid out-of-pocket costs. Call for prior authorization at (646) 473-9200.

See Section II.I for 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, depending on eligibility, as described in Section II.H of this SPD.
- Up to 365 days per year.
- Acute care that is Medically Necessary.
- Semi-private room and board.
- Up to 30 days per year for in-patient 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**
Call the 1199SEIU CareReview Program before going to the hospital or within 2 days of an Emergency admission to avoid out-of-pocket costs.
- Wage Class I: Family
- Wage Class II: Family
- Wage Class III: Member

**Inpatient and Outpatient Hospice Care**
- Coverage for a combined total of up to 210 days per lifetime in a Medicare-approved hospice program in a hospice center, hospital, Skilled nursing facility or at home.
- Life expectancy is estimated to be six months or less.

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered if you need to go to the hospital. If you are in Wage Class III, only you are covered for this benefit.

**PLEASE 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:

- 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 he or she 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.

CARE COVERED

Inpatient hospital benefits cover reasonable payments billed by the hospital for the Medically Necessary acute 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;
- Basal metabolic examinations;
- 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; and
- 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 non-governmental 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. This plan must be reviewed and approved by the Benefit Fund’s Medical Advisor before the Benefit Fund will agree to provide benefits for any rehabilitation care.

**ELECTIVE/SCHEDULED ADMISSIONS**

Before you go to the hospital, remember to 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 they are 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 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 your passport or airline tickets, and a certified translation, if requested by the Fund.

**WHAT IS NOT COVERED**

The Benefit Fund does not cover:

- Custodial care or sub-acute care in a hospital or any other institution;
- Care or service in a nursing home, skilled nursing facility, rest home or convalescent home;
- Hospitalization covered under federal, state or other laws except where otherwise required by law;
- Rest cures;
- Blood for transfusions;
- Admissions for cosmetic services;
- Personal or comfort items;
- Private rooms;
- Services related to a claim filed under Workers’ Compensation;
- Services that in the judgment of the Plan Administrator 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.
If you are in Member Choice and 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.

HOSPICE CARE
Hospice care is a type of care and a philosophy of care that focuses on bringing 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 are not limited to:
- Room and board and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management;
- Services and supplies furnished on an outpatient basis;
- Part-time or intermittent nursing care by a RN or LPN for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day;
- Physical and occupational therapy;
- Consultation or case management services by a physician; and
- Psychological counseling.

LIMITATIONS
Unless specified above, the following charges are not covered under this benefit:
- 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.
- 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.
- Respite care. This is care furnished during a period of time when your family or usual caretaker cannot attend to your needs.
SECTION II. D
EMERGENCY ROOM VISITS

BENEFIT BRIEF
Emergency Room 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 Room must be within 72 hours of an accident or sudden and serious illness.
- The Benefit Fund pays a negotiated rate at a Participating Hospital or a reasonable charge at Non-Participating Hospital.

Wage Class I: Family
Wage Class II: Family
Wage Class III: Member

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered for Emergency Room care. If you are in Wage Class III, only you are covered for this benefit.

The Benefit Fund has negotiated emergency room rates with many hospitals in the New York area ("Participating ER Providers"). If you go to the emergency room of a Participating ER Provider, you will have no out-of-pocket costs for the hospital’s charge for the use of the facility.

EMERGENCY ROOMS ARE FOR EMERGENCIES
A hospital emergency room should be used only in the case of a legitimate medical Emergency. To be considered an Emergency, your emergency room visit must meet the definition of Emergency (see Section IX) and must occur within 72 hours of an injury or the onset of a sudden and serious illness.

When you go to the emergency room:
- Show your Health Benefits ID card. The Benefit Fund will pay the hospital directly.
- Call the 1199SEIU CareReview Program at (800) 227-9360 within two business days if you are admitted.

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

NON-EMERGENCY TREATMENT CAN BE COSTLY TO YOU
The cost of non-Emergency treatment in an emergency room is much higher than non-Emergency treatment in your doctor’s office, a clinic or through the use of an urgent care center that may
be conveniently located near where you live. These centers are generally open seven days a 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 Room, 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 Room:

• Call your doctor first;

• Your doctor may be able to recommend treatment over the phone, have you go to the office, or go to the hospital;

• 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

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered for inpatient and outpatient mental health, alcohol or substance abuse treatment. Wage Class III coverage is for inpatient mental health, alcohol or substance abuse treatment benefits. Benefits are paid according to the Benefit Fund’s Schedule of Allowances.

GET THE HELP YOU NEED
The Benefit 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 and concerns with you.

Many professionals, rehabilitation programs and institutions participate in the Benefit Fund’s program to provide you with ongoing treatment. Co-pays may apply.
MENTAL HEALTH BENEFITS

Outpatient Care
• Outpatient visits

Inpatient Care
• Medically Necessary mental health admissions in a non-governmental hospital

ALCOHOL/SUBSTANCE ABUSE BENEFITS

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

Outpatient Care
• Outpatient visits

Inpatient Care
• Medically Necessary services for inpatient detoxification
• Up to 30 days within a 12-month period for inpatient rehabilitation services

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.

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

Wage Class I: Family
Wage Class II: Family
Wage Class III: Member

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered if you have surgery and need anesthesia. If you are in Wage Class III, only you are covered for this benefit.

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 surgery center, or office-based surgery suite.

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

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, as determined by the Plan Administrator.

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 on the Benefit Fund’s allowance and its claims-processing rules for multiple or related operations.

You can find out how much the Benefit Fund can pay for your surgery by:
• Writing to the Benefit Fund’s Prior Authorization Department; and
• Visiting the Plan Administrator’s offices during normal working hours to examine a listing of the Schedule of Allowances.
If you use a Non-Participating Provider, you could face high out-of-pocket costs. You or your doctor must file a claim with the Benefit Fund within 90 days from the date of your treatment.

For the names of participating surgeons in your area, call the Benefit Fund’s Member Services Department at (646) 473-9200.

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

• 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 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 asymmetry;

• Prostheses; and

• 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);

- Performed primarily for cosmetic purposes, except when needed to correct gross disfigurement resulting from surgery, an illness or an accident that occurred while you were covered by the Benefit Fund;

- Related to infertility treatment, including, but not limited to, in vitro fertilization, artificial insemination and reversal of sterilization;

- Not Medically Necessary in the judgment of the Plan Administrator;

- Services of a type usually performed by a Dentist, except certain oral surgical procedures;

- Services by an assistant to the Surgeon performing the operation unless Medically Necessary in the opinion of the Plan Administrator;

- 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 that includes all prenatal and postnatal visits and delivery charges
- Hospital benefit for the mother and newborn if the mother is you or your spouse
- Disability benefits for you, if you are the mother

Wage Class I: Family
Wage Class II: Family
Wage Class III: Member

If you are in Wage Class I or Wage Class II, surgical and hospital benefits are available for you or your spouse for maternity care. Your child is not covered if she becomes pregnant to the extent that there are payments for such coverage available from other sources.

If you are in Wage Class III, only you are covered for these benefits.

You are covered for Disability benefits if you are the mother.

Benefits are paid according to the 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; and
- A hospital benefit for the mother and newborn.

You are covered for Disability benefits up to the maximum disability amount.

If complications arise from the pregnancy, Disability will be paid for the period of disability as certified by your doctor.

**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 still may decide that the mother and newborn should be discharged before 48 (or 96) hours.
THE PRENATAL CARE 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.

If you are in Wage Class III, you are covered for only surgical and hospital benefits. You are not covered for medical benefits such as lab and other diagnostic tests.

Participating in the Prenatal Care Program

1. **Register with the Benefit Fund** within the first three months of the pregnancy by calling (646) 473-9200 or register online at www.1199SEIUBenefits.org.

2. **Ask your doctor** to participate in the program. If you do not have a doctor, the Benefit Fund can help you find an obstetrician who participates in this program.

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 room 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
- Outpatient chemotherapy, radiation therapy and hemodialysis
- Ambulance services

Wage Class I: Family
Wage Class II: Family
Wage Class III: Not Covered

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered for medical benefits. If you are in Wage Class III, you are not covered for this benefit.

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

PLEASE NOTE: Behavioral health benefits are only provided as described in Section II.E.

PARTICIPATING PROVIDERS

Doctors, labs and other health providers that are part of the Benefit Fund’s Participating Provider programs accept 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 your doctor’s charges.

DOCTOR VISITS

You and your family are covered for medical services provided in a doctor’s office, clinic, hospital, emergency room or at home.

A licensed medical provider must provide your care. Specialists must be board-certified or board-eligible in their area of specialty.
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 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; and
- **Physical/Occupational/Speech Therapy**: up to 25 visits per discipline per year.

If it is determined by the Plan Administrator 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.

Benefits are provided for preventive care services, including:

- **Periodic checkups**
  
  Through regular exams, your doctor can detect any problems early, when they are more easily treated.

- **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; and
- 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](http://www.1199SEIUBenefits.org) for the listing and locations of participating providers.
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. There are thousands of primary care physicians in the Benefit Fund’s Participating Provider Programs. Your primary care doctor gets to know you and your medical history, sees you when you’re sick and provides regular checkups 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.

PREFERRED LABORATORY FACILITIES

The Benefit Fund has contracted with certain free-standing 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;
- If you need to have your lab work outside of your doctor’s office, take your referral slip from your doctor to a Patient Care (Drawing) Center at 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 radiological tests, such as MRI, MRA, PET scans, CAT scans and certain Nuclear Cardiology procedures. 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.

HOSPICE CARE

Coverage is available for a combined total of up to 210 days in a Medicare-approved Hospice Program in a hospice center, hospital, skilled nursing facility or at home. See Section II.C for details.
AMBULANCE SERVICES

Emergency transportation and services to the closest hospital where you can be treated are provided in the case of an accident 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:

- Experimental, unproven or non-FDA approved treatments, procedures, facilities, equipment, drugs, devices or supplies;
- Treatment that is cosmetic in nature;
- Treatment that is custodial in nature;
- Infertility treatment, including, but not limited to, in vitro fertilization, artificial insemination and reversal of sterilization;
- Laboratory tests that are not FDA approved;
- Venipuncture;
- Treatment for illness or injury covered by Workers’ Compensation or the Veterans Administration;
- Acupuncture when administered by anyone other than a licensed medical physician;
- Private physicians when care is given in a governmental or municipal hospital;
- Charges in excess of the Benefit Fund’s Schedule of Allowances;
- Employment or return-to-work physicals;
- Treatments determined to be medically unnecessary by the Plan Administrator;
- Habilitation therapies to the extent there is other coverage available from either a government agency or program or through a special organization;
- Charges related to refractions when performed by an ophthalmologist; 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
• Home Infusion Services and Supplies
• Certain Diagnostic and Radiologic Tests
• Ambulatory Surgery

Prior approval required from the Prior Authorization Department, except Emergency ambulance.

Wage Class I: Family
Wage Class II: Family
Wage Class III: Not Covered

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered for medical benefits as described in this section. If you are in Wage Class III you are not covered for this benefit.

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 your provider’s charges.

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.
Participating Providers 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
- Private duty skilled nursing 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, which is authorized by the Fund in advance, Medically Necessary and in compliance with the Fund’s protocols.

**AMBULANCE SERVICE**

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

**PLEASE NOTE:** Emergency transportation and services to the closest hospital where you can be treated in the case of an accident or the onset of a sudden and serious illness do not require prior authorization.

**DURABLE MEDICAL EQUIPMENT**

The plan covers rental of standard durable medical and surgical equipment, such as braces, hospital beds and wheelchairs. 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, such as:

- Prosthesis;
- Blood and blood processing;
- Dressings;
- Catheters; and
- Oxygen.
SPECIFIC MEDICATIONS
You must get prior approval before benefits can be provided for certain prescriptions. The Plan Administrator 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. See Section II.L for further details.

PLEASE NOTE: You may have to pay the entire cost of the prescription if you don’t get prior approval from the Benefit Fund.

AMBULATORY/OUTPATIENT SURGERY
You must get prior approval for hospital and surgery. See Section II.B.

HOME INFUSION SERVICES AND SUPPLIES
If your doctor prescribes home infusion therapy, contact the Benefit Fund in advance of the services being delivered. If the intravenous administration of medication is medically appropriate for your condition and the prescription medication is a covered benefit, the Benefit Fund will coordinate the services and supplies with your doctor and the home infusion company. Some commonly prescribed home infusion therapies include antibiotics, steroids, hydration and clotting factors.

CERTAIN DIAGNOSTIC TESTS
Prior authorization is required for certain radiological tests, such as MRI, MRA, PET scans, CAT scans and certain Nuclear Cardiology procedures. 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 of your particular test.

Some benefits may require prior authorization. Please refer to the sections describing those specific benefits for more information.
SECTION II. J
VISION CARE AND HEARING AIDS

BENEFIT BRIEF

Vision Care
- One eye exam every two years
- One pair of glasses or contact lenses every two years

Wage Class I: Family
Wage Class II: Family
Wage Class III: Member

Hearing Aids
- Once every three years
- Call for referrals
- Co-payments when using participating providers may apply

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered for Vision Care. If you are in Wage Class III, only you are covered for this benefit.

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

YOUR COVERAGE

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 contact lenses every two years.

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 may incur out-of-pocket costs.

If you use a participating optometrist or optician and incur a large out-of-pocket cost, call the Benefit Fund before you pay for your exam, glasses or contact lenses.

If you use a Non-Participating Provider, you’ll be reimbursed up to the Benefit Fund’s allowance.

Certain participating vision care providers also provide hearing aids.
WHAT IS NOT COVERED
The Benefit Fund does not cover
• Non-prescription sunglasses;
• Scratch resistant and/or ultraviolet treatment;
• Visual training; and
• All general exclusions listed in Section VII.D.

HEARING AIDS
Hearing aids are covered once every three years. Call Member Services for a referral to a Participating Provider. Co-payments may apply when using Participating Providers.
If you use a Non-Participating Provider, you can be billed whatever the provider normally charges. You may have to pay any cost over the Benefit Fund’s allowance.
SECTION II. K
DENTAL BENEFITS

If you are in Wage Class I, you, your spouse and your children are covered for dental care. If you are in Wage Class II or Wage Class III, you, your spouse and your children are not covered for this benefit.

Effective January 1, 2011, there is no limit on essential oral pediatric services to the extent required by the Patient Protection and Affordability Care Act. Therefore, reference to a $3,000 or $1,200 maximum in this section excludes essential oral pediatric services.

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 person per year unless you are enrolled in Member Choice. The maximum benefit for Member Choice enrollees is $3,000 per person per year.

Effective January 1, 2003, the maximum benefit for Member Choice enrollees is $3,000 per person per year.

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.

PLEASE NOTE: Members who work or live north of Westchester County may be eligible to enroll in an upstate dental provider program.

If You Are Not Enrolled in Member Choice

• 100% of the Benefit Fund’s Schedule of Allowances for basic and preventive services
• Co-payments of up to 25% of the Benefit Fund’s Schedule of Allowances for services requiring prior authorization
• Maximum benefit $1,200 per person per year (excluding essential oral pediatric services)

Wage Class I: Family
Wage Class II: Not Covered
Wage Class III: Not Covered
All dental work must be done 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.

Cleaning may be performed by a licensed dental hygienist supervised by a licensed dentist.

PLEASE NOTE: All dental treatment is subject to the Benefit Fund’s protocols, procedures, restrictions and time limits.

BASIC AND PREVENTIVE SERVICES

You, your spouse and your children are covered for the following without prior authorization to the maximum annual benefit indicated in Section II.K:

* Examinations twice per year;
* Prophylaxis (cleaning) 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; and
* Oral surgery.

SERVICES REQUIRING PRIOR AUTHORIZATION

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

**Major Care**

* Periodontics (treatment of gum disease);
* Endodontics (treatment of the tooth’s nerve system);
* Removable prosthetics (partial and complete dentures); and
* Crowns, fixed bridgework and other methods of replacing individual teeth.

**Orthodontics**

* Orthodontics (treatment and appliances to correct tooth misalignment) once in a lifetime for children. Adult orthodontic coverage will be considered only when repositioning of teeth is in conjunction with orthognathic surgery.

Benefits start when the appliances are inserted and continue for a maximum of **24 months** for active treatment and a maximum of **8 months** of retention visits during the 12-month period following active treatment.
THE PRIOR AUTHORIZATION PROCESS
If your dentist is planning Major Care or Orthodontics, the Benefit Fund has to review and approve your treatment before the work is done. Your dentist must submit:

- The proposed treatment plan; and
- Any supporting X-rays.

You and your dentist will be told:

- 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, based upon your continued eligibility throughout the period of treatment. If the cost of the service exceeds your annual maximum, you will be responsible for the balance.

IN CASE OF EMERGENCY
If you need Emergency treatment in your dentist’s office, prior authorization is not required. If you are not enrolled in Member Choice, co-payments will apply, if applicable.

However, 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 room 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 room visit, resulting in a large out-of-pocket cost to you.

GETTING YOUR BENEFITS
When Using a Participating Dentist
Participating dentists send your claim form to and receive payment directly from the Benefit Fund. They have agreed to accept the Benefit Fund’s allowance as payment in full up to an annual maximum of $3,000 for each individual enrolled in Member Choice. If you are not enrolled in Member Choice, you will pay:

- Co-payments for Major Care and Orthodontics; and
- All charges over the Benefit Fund’s maximum benefit of $1,200.

Do not make any other payments to a participating dentist without verifying them with the Dental Department.
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 up to a maximum of $3,000 per year for Member Choice enrollees and $1,200 per year for individuals who are not enrolled in Member Choice.

The Benefit Fund pays no more than its allowance or the provider’s charge, whichever is less. You are responsible for the balance.

To receive your benefits, you can:

- Sign the “Assignment of Benefits” section on your claim form and the Benefit Fund will pay your dentist directly. You may be asked to verify the information on the claim form before the dentist is paid; or
- Pay the bill yourself and send a completed claim form to the Benefit Fund for reimbursement. You have to pay any charges not covered under the Schedule of Allowances.

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, the Plan Administrator may require you to have an exam 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.

ADDITIONAL LIMITATIONS

The Benefit Fund will pay up to its Schedule of Allowances for:

- Dental treatment of temporo-mandibular joint (TMJ) disease, limited to the following services:
  - Lateral skull/facial bone X-ray;
  - Injections into the joint by an oral surgeon;
  - TMJ X-ray;
  - Approved prosthesis as required; and
  - Reduction of subluxation by an oral surgeon.
- Surgical repair by an oral surgeon.
- Maryland-type bridges, only for replacement of anterior teeth with anterior teeth as abutments.
WHAT IS NOT COVERED

The Benefit Fund does not cover:

• Services, supplies or appliances that are not Medically Necessary in the judgment of the Plan Administrator;
• Periodontal splinting of otherwise healthy teeth with crowns or inlays/onlays;
• Temporary services, including, but not limited to crowns, restorations, dentures or fixed bridgework;
• Services that are cosmetic in nature;
• Lost or stolen appliances;
• Treatment provided by someone other than a dentist (except for cleanings performed by a licensed dental hygienist under the supervision of a dentist);
• Any dental treatment inconsistent with the Benefit Fund’s approved protocols, procedures, restrictions and time limits (including the five-year limitation on periodontal surgery, removable prosthetics (partial and complete dentures) and crowns, fixed bridgework and other methods of replacing individual teeth);
• Services, supplies, appliances or restorations incurred in connection with implants that do not meet the Benefit Fund’s clinical guidelines and approved protocols;
• The start of orthodontic treatment for children who are 19 years of age or over;

• Deep or intravenous conscious sedation and general anesthesia services that are not performed by a board-certified or board-eligible oral surgeon, or a dental anesthesiologist; and
• All general exclusions listed in Section VII.D.

CALL THE DENTAL DEPARTMENT FOR MORE INFORMATION

Call the Benefit Fund’s Dental Department at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.
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 drugs and preferred drugs where available
• Use participating pharmacies
• Mandatory maintenance drug access program
• You must comply with the Benefit Fund’s Prescription 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.

Wage Class I: Family
Wage Class II: Not Covered
Wage Class III: Not Covered

If you are in Wage Class I, you, your spouse and your children are covered for prescription drugs. If you are in Wage Class II or Wage Class III, you are not covered for this benefit.

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.

Benefits for prescriptions for FDA-approved drugs that are not approved for treatment of your condition must be submitted to the Benefit Fund office for consideration.

Your doctor should provide detailed medical information and supporting documentation for prescribing this medication.
USING YOUR BENEFITS

To get your prescription:

• Ask your doctor to prescribe only covered medications, 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 the same as brand-name drugs. The only major difference is the cost.

By law, generic drugs must contain the same active ingredients in the same quantities and be the same strength as the corresponding brand-name drug. Most importantly, they must meet the same FDA standards for safety and effectiveness.

When your 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 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.

Drugs were selected based on how well they work and their safety. All participating providers have been provided with a copy of the Preferred Drug List. 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 Preferred Drug List, please call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

Prior Authorization for Specified Medications

You must get prior approval before benefits can be provided for prescriptions filled with certain medications. The Plan Administrator 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 use.

PLEASE 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.
PRESCRIPTION DRUG PROGRAMS

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 – is a voluntary program for members using drugs like Tamoxifen and Warfarin to help the physician 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 this mail delivery service.

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 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 hotline at (646) 473-6148 or visit our website at www.1199SEIUBenefits.org.

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 Fund’s Mandatory Maintenance Drug Access Program – The 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 90-Day Rx Solution.

This program requires that you order medications that 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. If you live in New York or New Jersey, 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 3 refills) and fill it either by:

- Mailing the prescription to the Benefit Fund’s mail order pharmacy, where it normally will be delivered within eight days; or
- Taking it to one of the designated pharmacies in New York or New Jersey.

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, you will have to:

- Pay for your prescription when it is filled;
- You may visit the Fund’s website at www.1199SEIUBenefits.org or call the Benefit Fund’s Member Services Department for a Prescription Reimbursement Claim Form; and
- 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.
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 3 refills) that can be filled through the 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 maintenance drug access program, for a mail order form or to determine if the drug that you are taking is a maintenance medication.

WHAT IS NOT COVERED

The Benefit Fund does not cover:

- Over-the-counter drugs (except for diabetic supplies);
- Over-the-counter vitamins;
- Non-prescription items such as bandages or heating pads – even if your physician recommends them;
- Prescriptions for drugs not approved by the FDA for the treatment of your condition;
- Cost differentials for drugs that are not approved through the Benefit Fund’s Prescription Drug Program;
- Experimental drugs;
- Non-sedating antihistamines;
- Migraine medication in excess of FDA guidelines for strength, quantity and duration;
- Medications for cosmetic purposes;
- Proton pump inhibitors in excess of a 90-day supply for FDA-approved indications by diagnosis;
- Cold and cough prescription products;
- Oral erectile dysfunction agents (except for penile functional rehabilitative therapy for up to six months immediately following prostatic surgery); and
- All general exclusions listed in Section VII.D.

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, he or she must use their primary prescription insurer first. Participating Pharmacies will not fill prescriptions for your spouse through the use of this Health Benefits ID card.
Some benefits may require prior authorization. Please refer to the sections describing those specific benefits for more information.

NEW YORK CITY EMPLOYEES
For New York City employees, certain classes of drugs will be covered through the health program provided to you through the City and not covered through the NBF prescription benefit. For a list of these drugs, please contact the Benefit Fund’s Prescription Department.
SECTION III – DISABILITY BENEFITS

A. When You Are Eligible for Disability Benefits

B. Your Disability Benefits
   • The Disability Intervention Program

C. Filing Your Disability Claim

D. When You Are on Workers’ Compensation Leave
## DISABILITY BENEFITS RESOURCE GUIDE

### WHERE TO CALL

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

Call Member Services to:
- Request a Disability Form or Accident Report Form;
- Notify the Benefit Fund when you return to work;
- Receive advice on benefits available from other sources if your disability lasts longer than 26 weeks; and
- Receive help with filing Workers’ Compensation claims with your employer’s insurer.

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

### REMINDERS

**For accidents and injuries that are not work-related:**
- Disability benefits are available only when your accident/injury or illness is not work-related.
- File your claim **within 31 days** of your injury or the start of your illness. Be evaluated or have your doctor submit medical updates when requested by the Benefit Fund; otherwise your benefits could be reduced or denied.
- Call the Benefit Fund when you return to work.

**If you are injured on the job:**
- Report an accident or work-related incident to your employer immediately.
- File a Disability claim when you are out on Workers’ Compensation leave to protect your benefits from the Benefit Fund.
- Call the Benefit Fund if you need help in filing a claim for Workers’ Compensation from your employer’s insurer.
- Call the Benefit Fund if your Workers’ Compensation claim is disputed or denied.
SECTION III. A
WHEN YOU ARE ELIGIBLE FOR DISABILITY BENEFITS

WHO IS COVERED
You may receive Disability benefits when you are unable to work because of an accident or illness that is not related to your job.
Your spouse and children are not eligible for this benefit.

WHEN YOUR BENEFITS BEGIN
When your benefits begin is determined by:
• Whether you have an accident/injury or an illness; and
• When you were first examined by a doctor for that injury or illness.
If someone else is responsible for your accident or injury, see Section I.G. Read this important information on special Benefit Fund requirements for you to receive benefits.

PLEASE NOTE: You cannot receive Disability benefits for any period in which you receive any other compensation, such as pension, sick leave or wages from any other employer.

If You Have An Accident
Your Disability benefits start:
• From the day of your accident/injury, if you are examined by a doctor within eight days of the date of your accident; or
• From the day you were first examined by a doctor, if it was not within the first eight days of the date of your accident.

If You Have An Illness
Your Disability benefits start:
• On the eighth day after your illness started, if you are examined by a doctor within eight days of the date you became ill; or
• From the day you are examined by a doctor, if you see your doctor after eight days.
If You Are Pregnant

You are eligible for the same benefits provided for other temporary physical disabilities if you can’t work because you’re pregnant, having your baby or have a related condition.

To receive Disability benefits, your doctor must state that you are medically unable to work.

**Before you stop working**, call the Benefit Fund’s Disability Department to make sure you’re eligible for benefits.

**WORK-RELATED INJURY OR ILLNESS**

If your illness or injury is work-related, you are covered by your employer’s Workers’ Compensation insurance. However, you must still contact the Benefit Fund to protect your benefits. See Section III.D for more information.
SECTION III. B
YOUR DISABILITY BENEFITS

BENEFIT BRIEF
Benefit Fund Disability Benefits (partial salary replacement)

• Amount is based on your Average Weekly Earnings
• Maximum weekly benefit is $385
• How long you can receive benefits is based on your medical condition, up to 26 weeks within a 52-week period
• Your Benefit Fund coverage for all other benefits may continue for up to a maximum of 26 weeks within a 52-week period while you are receiving Benefit Fund disability benefits

Covered only for accidents or illnesses that are not work-related.
Wage Class I: Member
Wage Class II: Member
Wage Class III: Member

After you are eligible for benefits from the Fund (usually after 90 days), your Benefit Fund Disability benefit is based on your Average Weekly Earnings during the eight weeks immediately before your injury or illness.

To calculate your weekly Benefit Fund Disability benefit:
• Add together the wages you earned for the last eight weeks you worked before your disability; and
• Divide by 8 to determine your Average Weekly Earnings for that eight-week period.

Look at the chart on this page to determine your weekly benefit.

PLEASE NOTE: Members of New Jersey employers will receive weekly disability benefits based upon the chart below or the New Jersey rate schedule, whichever is greater.

<table>
<thead>
<tr>
<th>Average Weekly Earnings</th>
<th>Weekly Disability Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $338</td>
<td>2/3 of Average Weekly Earnings</td>
</tr>
<tr>
<td>$338.00 – $449.99</td>
<td>$225</td>
</tr>
<tr>
<td>$450.00 – $599.99</td>
<td>$245</td>
</tr>
<tr>
<td>$600.00 – $749.99</td>
<td>$280</td>
</tr>
<tr>
<td>$750.00 – $899.99</td>
<td>$310</td>
</tr>
<tr>
<td>$900.00 – $1049.99</td>
<td>$340</td>
</tr>
<tr>
<td>$1050.00 – $1199.99</td>
<td>$375</td>
</tr>
<tr>
<td>More than $1200</td>
<td>$385</td>
</tr>
</tbody>
</table>
**DISABILITY INTERVENTION PROGRAM**

For long-term illnesses, the Benefit Fund may ask that you be evaluated periodically by an independent doctor selected by the Benefit Fund at no cost to you.

You will be notified by the Benefit Fund if an evaluation is required. Your benefits may be denied or reduced if you do not have these evaluations when requested by the Benefit Fund.

**IMPORTANT TAX NOTE**

The Benefit Fund is required by law to deduct your share of FICA (Social Security and Medicare) taxes from your disability payments.

Disability payments are considered taxable earnings. They will be included in the W-2 form that you’ll receive from your employer after the end of the year.

Contact the Benefit Fund if you want federal and/or state tax withheld.
SECTION III. C
FILING YOUR DISABILITY CLAIM

You must fill out a Disability Form and send it to the Benefit Fund within 31 days of your injury or the start of your illness.

1. Call the Benefit Fund’s Member Services Department at (646) 473-9200 to get a Disability Form.

2. Complete Part A as soon as you receive the form.

3. Have your doctor fill out Part B.

4. Send Parts A and B to the Benefit Fund so it can update your records and begin processing your claim.

5. Send Part C to your employer so it can provide the Benefit Fund with information on your earnings.

STATUTORY DISABILITY BENEFITS THROUGH YOUR STATE

Disability benefits for members who have been employed for more than 4 consecutive weeks but less than 90 days, or for claims incurred during the 30 days after you stop working, are provided by the Benefit Fund based upon the state maximum and other provisions of your state plan.

Health benefits are not provided or extended while a member is receiving statutory Disability benefits from the Benefit Fund.

If you are employed for fewer than 4 consecutive weeks, no Disability benefits are provided.

WORK-RELATED INJURY OR ILLNESS

If your illness or injury is work-related, you are covered by your employer’s Workers’ Compensation insurance. However, you must still contact the Benefit Fund to protect your benefits. See Section III.D for more information.
PROTECT YOUR DISABILITY AND HEALTH BENEFITS

While you are receiving Benefit Fund Disability benefits, 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 the Benefit Fund receive your Disability Form within 31 days of your illness or injury. Otherwise, you may jeopardize your Disability benefit as well as your health benefits.

Here’s why: The Benefit Fund determines your eligibility for benefits based on wage reports it receives from your employer.

If you haven’t received any wages, then your coverage may be suspended because the Benefit Fund does not know that you are out on Disability leave.

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 for more information and advice on how to file a claim for this aid.
SECTION III. D
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.

In some cases, payments may be higher and for longer periods of time than are provided by the Benefit Fund.

PLEASE 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 family.

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;
• Causes a permanent defect, whether or not you lose time from work; and
• Requires you to seek medical attention or treatment.

Workers’ Compensation Benefits include:

• Payment for lost wages (if you are unable to work for more than 7 days);
• Lump-sum payments or other awards for permanent injuries;
• Medical expenses;
• Coverage for drugs and appliances; and
• Carfare to and from the doctor’s office or hospital.

PLEASE NOTE: Lost wages may be paid from the first day if you are unable to work for 14 or more days.

A Workers’ Compensation claim must be filed within two years of the date of the accident or incident to protect your rights to Workers’ Compensation benefits.
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 within a 52-week period;

• Advance Disability benefits while your claim is disputed and pending before the Workers’ Compensation Board;

• If you receive Workers’ Compensation benefits for any period in which the Benefit Fund has advanced you Disability benefits, you must repay the Benefit Fund from those benefits;

• Pay you the difference in Disability benefits if the amount paid by Workers’ Compensation is less than the Disability benefit you would have received from the Benefit Fund if your disability had not been work-related.

If you cannot 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).

PROTECTING YOUR BENEFITS

File Claims with BOTH Workers’ Compensation and the Benefit Fund

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. Ask your Union Delegate or call the Benefit Fund’s Member Services Department at (646) 473-9200 to get a Benefit Fund Disability Form.

4. Complete the Benefit Fund’s Disability Form and send it to the Benefit Fund Disability Department within 30 days of the date of the accident/injury or onset of the illness to continue receiving benefits for care not related to your job injury or illness. Include copies of all correspondence you have received including a Workers’ Compensation Form C6, which indicates that your benefits have begun.

   » Here’s why: The Benefit Fund determines your eligibility for benefits based on wage reports it receives from your employer. If you haven’t received any wages, then your coverage may be suspended because the Benefit Fund does not know that you are on Workers’ Compensation.
5. Continue to send copies of any correspondence you receive in connection with your Workers’ Compensation claim to the Benefit Fund’s Disability Department, including a C8 Workers’ Compensation 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.

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

File Claims with BOTH Workers’ Compensation and the Benefit Fund

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 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 in filing your claim; or
- You need a referral to a qualified attorney.
SECTION IV – LIFE INSURANCE

A. Life Insurance Eligibility
B. Life Insurance Benefit
C. Accidental Death and Dismemberment
D. Burial
**LIFE INSURANCE RESOURCE GUIDE**

<table>
<thead>
<tr>
<th>WHERE TO CALL</th>
<th>REMINDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Services Department</strong></td>
<td>• Complete your Enrollment Form and select a beneficiary.</td>
</tr>
<tr>
<td><em>(646) 473-9200</em></td>
<td>• You may change your beneficiary at any time.</td>
</tr>
<tr>
<td>Call Member Services:</td>
<td>• You or your beneficiary need to file a claim for Accidental Death and</td>
</tr>
<tr>
<td>• To request a Change of Beneficiary Form</td>
<td>dismemberment benefits within 31 days of your death or dismemberment.</td>
</tr>
<tr>
<td>• To request a claim form for Life Insurance</td>
<td></td>
</tr>
<tr>
<td>You can also visit our website at <a href="http://www.1199SEIUBenefits.org">www.1199SEIUBenefits.org</a></td>
<td></td>
</tr>
</tbody>
</table>
SECTION IV. A
LIFE INSURANCE ELIGIBILITY

WHO’S COVERED
Once you’re enrolled in the Benefit Fund and eligible for benefits, you are covered for:
• Life Insurance; and
• Accidental Death and Dismemberment Benefit.
If you are in Wage Class I or II, you and your spouse are eligible for the Burial benefit.
If you are in Wage Class III, you and your spouse are not eligible for the Burial benefit.
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:
• Call the Benefit Fund’s Member Services Department and ask for an Enrollment Change Form, or visit our website at www.1199SEiUBenefits.org;
• Fill out the form; and
• Return it to the Benefit Fund. The change of beneficiary will not be effective until it’s received by the Benefit Fund office.

HOW YOUR BENEFICIARY APPLIES FOR BENEFITS
After your death, your beneficiary must, as soon as reasonably possible:
• Notify the Benefit Fund’s Member Services Department; and
• Submit a certified original copy of your Death Certificate and a 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 brother 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 whom 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 9 months after the time you stop working; and
• Your condition is recertified by your doctor 3 months before each anniversary of the start of the disability.

**When you reach age 65**, your Life Insurance amount is immediately reduced by 20%. Then every year thereafter, the original amount is further reduced by 20% until you reach the minimum Life Insurance amount of $1,250.

**After age 60**, you’ll 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 9 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 and/or burial. If your beneficiary chooses to assign their benefit after your death, that assignment shall be considered irrevocable.
SECTION IV. B  
LIFE INSURANCE BENEFIT

BENEFIT BRIEF

Life Insurance
• First year maximum $1,250
• Death from any case

Wage Class I: Member
Wage Class II: Member
Wage Class III: Member

See the section on continuing your Life Insurance in Section I.K.

Life Insurance is paid for your death for any cause without restriction.

Your Life Insurance is $1,250 during the first year you are covered by the Benefit Fund.

If you’re in Wage Class I, your Life Insurance is based upon your annual rate of pay, up to a maximum benefit of $50,000:

<table>
<thead>
<tr>
<th>Annual Rate of Pay</th>
<th>Weekly Wages</th>
<th>Life Insurance Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $20,800</td>
<td>Less than $400</td>
<td>Maximum of $15,000</td>
</tr>
<tr>
<td>$20,801 – $26,000</td>
<td>$401-$500</td>
<td>$16,000</td>
</tr>
<tr>
<td>$26,001 – $31,200</td>
<td>$501-$600</td>
<td>$18,000</td>
</tr>
<tr>
<td>$31,201 – $36,400</td>
<td>$601-$700</td>
<td>$20,000</td>
</tr>
<tr>
<td>$36,401 – $41,600</td>
<td>$701-$800</td>
<td>$22,000</td>
</tr>
<tr>
<td>$41,601 – $46,800</td>
<td>$801-$900</td>
<td>$24,000</td>
</tr>
<tr>
<td>$46,801 – $52,000</td>
<td>$901-$1,000</td>
<td>$32,000</td>
</tr>
<tr>
<td>$52,001 – $57,200</td>
<td>$1,001-$1,100</td>
<td>$40,000</td>
</tr>
<tr>
<td>Over $57,200</td>
<td>More than $1,100</td>
<td>$50,000</td>
</tr>
</tbody>
</table>

If you’re in Wage Class II, your maximum Life Insurance amount is $2,500.

If you’re in Wage Class III, your maximum Life Insurance amount is $1,250.
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
Wage Class I: Member
Wage Class II: Member
Wage Class III: Member
Retirees are not eligible for this benefit.

Accidental Death and Dismemberment (AD&D) benefits are paid only if your death or 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; and
- Occurs while you are employed and covered by the Benefit Fund.
Retirees are not eligible for AD&D benefits.

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 AD&D 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;
- Bodily or mental infirmity;
- Disease or illness of any kind;
- Medical or surgical treatment (except where necessary solely by injury);
- Bacterial infection (except pyogenic infections resulting solely from injury);
- Intentionally self-inflicted injury;
- Suicide or any attempt thereof;
- The use of alcohol or substance abuse;
- 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 a fare-paying passenger in any aircraft then licensed to carry passengers; or
- Your commission of or participation in a crime or act that can be prosecuted as a crime.
Free non-sectarian burial plots with permanent care are available for you and your spouse if you are in Wage Class I or Wage Class II. Free plots are located in New York and New Jersey. A $75 payment can be made to your beneficiary in place of the Benefit Fund’s plot.

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

A. Anne Shore Camp Program

B. Scholarship

C. Social Services and Member Assistance Program
WHERE TO CALL
Anne Shore Camp Program and Scholarship Program
(212) 564-2220
Call Camp and Scholarship:
• To request an application for the Summer Camp Program
• To request an application for the Scholarship Program
• For more information on either the Camp or Scholarship programs.

Member Assistance Program
(646) 473-6900
Call Member Assistance:
• To make an appointment to confidentially discuss a personal or family problem
• To reach the Program for Behavioral Health.

Citizenship Program
(646) 473-9200
Call Citizenship:
• 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.

REMINDERS
• Applications for the Summer Sleep-Away Camp Program are available in the fall. They must be returned to the 1199SEIU Child Care Corporation by the last day of February.
• Applications for the Scholarship Program are available in the fall. They must be returned to the 1199SEIU Child Care Funds by the last day of January.
• If your children are receiving a scholarship from the Benefit Fund, they must re-apply every year for the next year.
• Please mail applications for the Anne Shore Summer Camp Program to: 1199SEIU Child Care Corporation P.O. Box 955 New York, NY 10108-0955
• Please return applications for the Scholarship Program to: 1199SEIU Child Care Fund Joseph Tauber Scholarship Program 330 West 42nd Street, 18th Floor New York, NY 10036-6977

You can also visit our website at www.1199SEIUBenefits.org
SECTION V. A
ANNE SHORE CAMP PROGRAM

BENEFIT BRIEF

Camp

- For children 9 to 15 years old
- Summer Camp Program provided at no cost to you, except application fee
- FICA and FUTA taxes paid by the Fund (you may be responsible for income taxes)

Wage Class I: Children
Wage Class II: Not Covered
Wage Class III: Not Covered

Your children may be selected to participate in the Benefit Fund’s Sleep-Away Summer Camp Program if all of the following conditions are met:

- You file an official application form within the time period required by the Benefit Fund;
- They are 9 to 15 years old;
- You have been eligible for Wage Class I benefits for at least one year; and
- They are eligible for benefits as described in Section I.A.

The camp program is provided at no cost to you, except for a small application fee. The value of the camp benefit is considered as wages by the IRS for which you may owe income tax. You will receive a W-2 tax form from the Fund at the end of each year.

However, the other taxes that are normally taken out of your paycheck, like FICA and FUTA, will be paid by the Benefit Fund. Camps are located in Vermont, New Jersey, Connecticut, and upstate New York, including camps for children with special needs.

An effort is made to give each member a chance to send his or her children to camp. Only one child per family may attend each year, except that twins can attend together. If space is available, repeat campers and additional children per family will be considered.

CRITERIA APPROVED BY TRUSTEES

The number of children who can participate in the camp program is based upon actuarial formulas recommended by the Benefit Fund Actuary and adopted by the Camp and Scholarship Committee of the Board of Trustees.

Criteria for selection are approved and announced by the Board of Trustees.

APPLICATIONS

Applications for the Anne Shore Camp Program are available in the fall. They must be returned to the 1199SEIU Child Care Corporation by the last day of February.

Call the Camp Program at (212) 564-2220 if you have questions or for more information.
SECTION V. B
SCHOLARSHIP

BENEFIT BRIEF

Scholarship

- Scholarships provided to attend accredited schools after high school
- Provided to eligible children of members

Wage Class I: Children
Wage Class II: Not Covered
Wage Class III: Not Covered

Your children may be considered for the 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 Benefit Fund;
- You have been eligible for Wage Class I benefits for at least one year;
- They are eligible for benefits as described in Section I.A;
- They are high school graduates;
- They are attending or plan to attend an accredited institution of higher learning no more than three years after graduating from high school; and
- They are applying for state or federal grants.

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 post-graduate studies. However, consideration is given for students pursuing medical careers where five years of undergraduate work may be required.

The scholarship benefit is considered taxable wages by the IRS for which you may owe income tax. You will receive a W-2 tax form from the Benefit Fund at the end of each year. However, the other taxes that are normally taken out of your paycheck, like FICA and FUTA, will be paid by the Benefit Fund.

APPLICATIONS
Applications for the Scholarship Program are available in the fall. They must be returned to the 1199SEIU Child Care Funds by the last day of January.

YOUR CHILDREN MUST RE-APPLY EVERY YEAR
If your children are receiving scholarship benefits, they must re-apply every year for the next year. Leaves of absence from school of more than one year will jeopardize a student’s eligibility for this benefit.

INCENTIVE PROGRAM
To encourage academic excellence, a study incentive program was established for students who perform well in their studies.

Your child’s cumulative grade point average is used to determine whether he or she will be considered for the additional monetary incentive award.

CRITERIA APPROVED BY TRUSTEES
The number of scholarship grants and the amount of these grants is based upon actuarial formulas recommended by the Benefit Fund Actuary and adopted by the Camp and Scholarship Committee of the Board of Trustees. Criteria are approved and announced by the Board of Trustees.
### SECTION V. C
SOCIAL SERVICES

<table>
<thead>
<tr>
<th>BENEFIT BRIEF</th>
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<tr>
<td><strong>Member Assistance Program</strong></td>
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<tr>
<td>• Help and referral for personal and family problems for you, your spouse or your children</td>
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<tr>
<td><strong>Citizenship Program</strong></td>
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<tr>
<td>• Assistance in applying for United States citizenship</td>
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<tr>
<td><strong>Earned Income Tax Credit Assistance Program</strong></td>
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<tr>
<td>• Tax preparation help</td>
</tr>
<tr>
<td>Wage Class I: Covered</td>
</tr>
<tr>
<td>Wage Class II: Covered</td>
</tr>
<tr>
<td>Wage Class III: Covered</td>
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</tbody>
</table>

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 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.

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.
SECTION VI – RETIREE HEALTH BENEFITS

A. Retiree Health Benefits
B. Using Your Benefits Wisely
C. If You Retire at Age 65 or Older and Live in New York City, Nassau County, or Designated Counties in Florida (10 Years of Pension Fund Credited Service)
D. If You Retire at Age 65 or Older and Live Outside New York City, Nassau County, or Designated Counties in Florida (10 Years of Pension Fund Credited Service)
E. If You Retire Between Ages 62 Through 64 (20 Years of Pension Fund Credited Service)
F. If You Retire Between Ages 55 Through 64 (10 Years of Pension Fund Credited Service)
G. If You Retire With a Disability Pension at Any Age (10 Years of Pension Fund Credited Service)
H. Retired Members Programs
WHERE TO CALL

Retiree Services Department
(646) 473-8666

Call Member Services:
• For general questions about your retiree health benefits
• If you need claim forms
• For more information on continuing the coverage you had as a working member through COBRA after you retire
• For a list of participating pharmacies
• For prior approval for private duty nursing
• For prior approval for other medical benefits.

REMINDERS

• Your benefits as a retired member can’t exceed the coverage you had just before you retired. Your benefits must be coordinated with Medicare.
• You and your spouse must register for Medicare at a local Social Security office at least 90 days before you retire if you are age 65 or older.
• If you or your spouse are not covered by Medicare and are covered for full hospital benefits through the Benefit Fund, you must call the 1199SEIU CareReview Program before going to the hospital for non-Emergency care or within two business days of an Emergency admission.

1199SEIU CareReview
(800) 227-9360

If you or your spouse are not covered by Medicare:
• Call to pre-certify your hospital stay before going to the hospital for non-Emergency care; and
• Call within two business days of an Emergency admission.

Retired Members Division
(646) 473-8666

• Call the Retired Members Division for information on retiree programs.

Please refer to Section II of this booklet (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.
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 following pages.

The benefits for which you are eligible depend on your age and Years of Pension Fund Credited Service. 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 age 65 or older with 10 or more Years of Pension Fund Credited Service (Sections VI.C and VI.D)
- If you retire between the ages of 62 and 64, on or after July 1, 1998, with at least 20 Years of Pension Fund Credited Service (25 Years of Pension Fund Credited Service required from June 15, 1995, through June 30, 1998) (Section VI.E)
- If you retire between the ages of 55 and 64 with 10 or more Years of Pension Fund Credited Service (Section VI.F)
- If you retire with a Disability pension with 10 or more Years of Pension Fund Credited Service (Section VI.G)

SPECIAL RULE

Members who have at least 15 years of consecutive coverage by the Benefit Fund immediately prior to retirement and are age 65 or older, who are not participants in the Pension Fund, may be eligible for a Life Insurance Benefit.

In most cases, retiree benefits start 30 days after you retire and stop for you and your spouse if you go back to work. If you retired before October 1, 1998, your spouse’s benefits will stop 30 days after your death. If you retired on or after October 1, 1998, your spouse will continue to be eligible after your death for Retiree Health Benefits for the remainder of his or her life. Your benefits must be coordinated with any other health insurance that you or your spouse may have, including Medicare (Section I.F).

Except as indicated above, in order to be eligible for retiree health benefits, you must be receiving a pension from the 1199SEIU Health Care Employees 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.
Your benefits as a retired member can’t exceed the coverage you had just before you retired.

For example:
If you did not have prescription coverage right before you retired, you are not covered for prescription benefits after you retire.

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 this 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.

You and your beneficiaries do not have or will not have a vested or non-forfeitable right to receive benefits under the Plan.

SPECIAL RULE FOR NEW YORK CITY EMPLOYEE RETIREES:

If you retire from employment by the City of New York or an agent or authority of New York City, certain benefits are provided to you by the city. If the city makes contributions to the Benefit Fund on your behalf, effective July 1, 2001, you are covered by the Fund only for the following supplemental retiree benefits:

- Vision Care
- Prescription Drugs
- Life Insurance.

After the death of a member, benefits for a surviving spouse are extended for a period of one year.

See the description of these benefits for retirees on the following pages.

You may be eligible for other benefits not provided by the Benefit Fund through your employment with the city. Contact your employer for an explanation of your full retiree benefit coverage.
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 and/or your spouse are age 65 or over; or
• You are eligible for Medicare as a result of receiving a Disability pension through Social Security.

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 and your spouse must register for Medicare at a local Social Security office at least 90 days before 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.

If you live in New York City, Nassau County or designated counties in Florida and are eligible for Medicare, you and your spouse 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.

WHEN YOU NEED TO SEE A DOCTOR

Participating Providers Accept the Fund’s and/or Medicare’s Allowances
If you are not eligible for Medicare, the Benefit Fund has doctors, hospitals and other healthcare professionals who accept the Benefit Fund’s allowances as payment in full for non-Medicare eligible members and their dependents.

If you are eligible for Medicare, many Participating Providers will accept Medicare’s allowance as payment in full.

This means you can continue to use many of the same doctors you had as an active member.

IF YOU NEED HOSPITAL CARE OR INPATIENT SURGERY AND ARE NOT COVERED BY MEDICARE
If you are not covered by Medicare and are covered for full hospital benefits through the Benefit Fund, you must call the 1199SEIU CareReview Program at (800) 227-9360:

• Before going to the hospital for non-Emergency care; and
• Within two business days of an Emergency admission.
IF YOU NEED AMBULATORY/OUTPATIENT SURGERY AND ARE NOT COVERED BY MEDICARE

If you are not covered by Medicare, you must call the Benefit Fund’s Ambulatory/Outpatient Surgery Pre-Certification Program at (646) 473-9200 if your surgery is going to be performed in the outpatient department of a hospital or in a doctor’s office.

IF YOU NEED PRESCRIPTION DRUGS

For Participants in the Benefit Fund Medicare Program:

If you are enrolled in the Benefit Fund Medicare Program, you will receive your medication, including mail order prescriptions for chronic or maintenance medications, through that program.

For Participants who enroll in a Medicare Part D Prescription Plan:

If you enroll in a Medicare Part D Prescription Plan, that plan will be your primary coverage and will pay your prescription claims first. When you exhaust your Medicare Part D prescription benefit, the Benefit Fund will provide prescription benefit coverage as your secondary insurer.

FOR ALL OTHER RETIREES:

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 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 90-Day Rx Solution.

This program requires that you order medications that 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. If you live in New York or New Jersey, 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 3 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 pharmacies in New York or New Jersey.

For new maintenance medications, ask your doctor for two prescriptions: one for a 30-day supply (with one refill) and another for 90-day supply (with 3 refills) that can be filled through the 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 maintenance drug access program, for a mail order form or to determine if the drug that you are taking is a maintenance medication.
SECTION VI. C
IF YOU RETIRE AT AGE 65 OR OLDER AND LIVE IN NEW YORK CITY, NASSAU COUNTY OR DESIGNATED COUNTIES IN FLORIDA

You are eligible for the benefits described in this section when you retire at or after age 65 with at least 10 Years of Pension Fund Credited Service. If you live in New York City, Nassau County or designated counties in Florida you must enroll in the Benefit Fund Medicare Program in order to receive retiree health benefits through the Benefit Fund.

If you are eligible for Medicare and live in New York City, Nassau County or designated counties in Florida you will only be able to receive Retiree Health Benefits from the Benefit Fund if you enroll in the Medicare Health Maintenance Organization with which the Benefit Fund has negotiated a special package of benefits for Benefit Fund retirees (“Benefit Fund Medicare Program”). When your spouse becomes eligible for Medicare, he or she must enroll in the Benefit Fund Medicare Program in order to receive benefits through the Benefit Fund.

This Benefit Fund Medicare Program will provide you with a basic prescription benefit as well as hospital, medical, dental care, podiatry, chiropractic, vision and hearing benefits. In addition, eligible members and spouses will receive coverage for a full prescription benefit similar to the benefit presented in this Summary Plan Description for active members. Depending upon the Retiree Health package that you and your spouse are eligible to receive, the Benefit Fund will supplement the Benefit Fund Medicare Program by continuing to provide you with Retiree Health Benefits described in the following pages, such as reimbursement for a part of your Medicare Part B premium, Life Insurance, and burial benefits and prescription benefits beyond those provided by the Benefit Fund Medicare Program.

*If you are required to enroll in the Benefit Fund Medicare Program and choose to “opt out” for any reason, you and your spouse 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 applying to 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 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.

**If your spouse is covered by Medicare**, he or she is covered for the same benefits, except for Life Insurance.

**If your spouse is not covered by Medicare**, he or she is covered only for prescription drugs, vision care and burial benefits. *When your spouse reaches age 65* or is covered by Medicare, he or she will receive the same benefits you receive, except for Life Insurance.

Your retiree health benefits through the Benefit Fund can’t exceed the coverage you had just before you retired. For example, if you did not have prescription benefits just before you retired, you are not covered for prescription benefits after you retire.

**ELIGIBILITY**

To receive the benefits described in this section from the Benefit Fund, you must be covered by the Benefit Fund as an active employee right before you retire, or be receiving Benefit Fund Disability or an award of permanent partial disability or total permanent 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.

In addition, you must meet all of the following conditions:

- Retire at or after age 65;
- Live in New York City, Nassau County or designated counties in Florida;
- Have at least 10 Years of Pension Fund Credited Service under the 1199SEIU Health Care Employees Pension Fund; and
- Be receiving a pension from the 1199SEIU Health Care Employees Pension Fund or have your application in process.
YOUR BENEFITS

Benefit Fund Medicare Program

When you and your eligible spouse enroll in the Benefit Fund Medicare Program, your health benefits, including a basic prescription benefit, will be provided through the Benefit Fund Medicare Program Provider.

Your basic health benefits are provided through the Benefit Fund Medicare Program, including:

- Hospital
- Medical
- Prescription
- Dental
- Podiatry
- Chiropractic
- Vision
- Hearing Aids.

Remember to use physicians that participate in the Benefit Fund Medicare Program to avoid out-of-pocket costs.

For detailed information on these benefits, call the Benefit Fund’s Retiree Health Benefits office at (646) 473-8666.

Eligible members also receive supplemental benefits, including the full prescription benefit beyond that provided by the Benefit Fund’s Medicare Program, reimbursement for 50% of your Medicare Part B Premium, Life Insurance and Burial benefits through the Benefit Fund.

Prescription Drugs

You are covered for a full prescription benefit, similar to what is described in Section II.L, beyond the basic benefit provided by the Benefit Fund Medicare Program.

Medicare Part B Premium

You will be reimbursed for 50% of your basic Medicare Part B premium.

You may file a claim form once each quarter to get this benefit.

Medicare Part D Premium - Income Related Adjustment

As a result of their enrollment in the Fund’s Medicare Prescription Employer Group Waiver Program (EGWP), some members whose incomes are above certain levels established by Medicare may incur a reduction in their monthly Social Security benefit, which is known as an Income Related Medicare Adjustment Amount (IRMAA).

If your monthly Social Security check is reduced by an IRMAA, you may file a quarterly claim to obtain a reimbursement.

Life Insurance

Your Life Insurance amount as a working member is immediately reduced by 20% when you retire.

Then every year thereafter, your Life Insurance benefit is further reduced by 20% of the Life Insurance benefit you
had as a working member until you reach the minimum Life Insurance amount based on your date of retirement:

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1, 1961 – June 30, 1973</td>
<td>$500</td>
</tr>
<tr>
<td>July 1, 1973 – June 30, 1983</td>
<td>$1,000</td>
</tr>
<tr>
<td>After July 1, 1983</td>
<td>$1,250</td>
</tr>
</tbody>
</table>

This benefit does **not** include coverage for accidental death or dismemberment.

Your spouse is not eligible for this benefit.

**Burial**

You are covered for a free burial plot.
SECTION VI. D  
IF YOU RETIRE AT AGE 65 OR OLDER AND LIVE OUTSIDE NEW YORK CITY, NASSAU COUNTY OR DESIGNATED COUNTIES IN FLORIDA

You are eligible for the benefits described in this section when you retire at or after age 65 with at least 10 Years of Pension Fund Credited Service.

If your spouse is covered by Medicare, he or she is covered for the same benefits, except for Life Insurance.

If your spouse is not covered by Medicare, he or she is covered only for prescription drugs, vision care and burial benefits. When your spouse reaches age 65 or is covered by Medicare, he or she will receive the same benefits you receive, except for Life Insurance.

If Your retiree health benefits through the Benefit Fund can’t exceed the coverage you had just before you retired. For example, if you did not have prescription benefits just before you retired, you are not covered for prescription benefits after you retire.

ELIGIBILITY
To receive the benefits described in this section from the Benefit Fund, you must be covered by the Benefit Fund as an active employee right before you retire, or 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.

In addition, you must meet all of the following conditions:

• Retire at or after age 65;
• Live outside New York City, Nassau County, or designated counties in Florida;
• Have at least 10 Years of Pension Fund Credited Service under the 1199SEIU Health Care Employees Pension Fund; and
• Be receiving a pension from the 1199SEIU Health Care Employees Pension Fund or have your application in process.
YOUR BENEFITS

If you or your eligible spouse are not required to enroll in the Benefit Fund 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;
- Your Medicare Part A co-insurance and reserve days; and
- Additional coverage up to a total of 365 days per calendar year after you have exhausted your Medicare Part A coverage.

PLEASE NOTE: the Fund does not provide benefits for services rendered in a nursing home or skilled nursing facility.

Anesthesia

Medicare is your primary insurer and must pay for your care first.

The Benefit Fund pays only if the amount paid by Medicare is less than what the Benefit Fund would have paid for anesthesia if you had not been covered by Medicare.

Vision Care

You are covered once every two years for:

- An eye exam; and
- A pair of glasses or contact lenses.

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.

Hearing Aids

- Hearing aids are covered once every three years. Call Member Services for a referral to a Participating Provider.
- If you use a Non-Participating Provider, you can be billed whatever the provider normally charges. You may have to pay any cost over the Benefit Fund’s allowance.

Prescription Drugs

You are covered for a full prescription benefit, similar to what is described in Section II, L, beyond the basic benefit provided by the Benefit Fund Medicare Program.
Private Duty Nursing at Home
Private Duty Skilled Nursing Care at home will be covered by the Benefit Fund if it is authorized in advance, Medically Necessary and in compliance with the Benefit Fund’s Nursing protocol. Benefits are payable in accordance with the Benefit Fund’s Schedule of Allowances up to the maximum benefits available and will be coordinated with Medicare.

Other Benefits
Medicare is your primary insurer and must make the first payment towards the following outpatient (Medicare Part B) services: durable medical equipment; medical supplies; physical, occupational or speech therapy; ambulatory/outpatient surgery; Emergency ambulance service and hemodialysis/chemotherapy drugs.

The Benefit Fund covers any difference between what Medicare pays and the Benefit Fund’s Schedule of Allowances for the services listed in the paragraph directly above under “Other Benefits.” You pay any remaining charges.

The Benefit Fund is your primary insurer for hearing aids.

Call the Prior Authorization Department at (646) 473-9200 for prior approval on all benefits, except Emergency ambulance.

Medicare Part B Premium
You will be reimbursed for 50% of your basic Medicare Part B premium.

You may file a claim form once each quarter to get this benefit.

Medicare Part D Premium - Income Related Adjustment
As a result of their enrollment in the Fund’s Medicare Prescription Employer Group Waiver Program (EGWP), some members whose incomes are above certain levels established by Medicare may incur a reduction in their monthly Social Security benefit, which is known as an Income Related Medicare Adjustment Amount (IRMAA).

If your monthly Social Security check is reduced by an IRMAA, you may file a quarterly claim to obtain a reimbursement.

Life Insurance
Your Life Insurance amount as a working member is immediately reduced by 20% when you retire.

Every year thereafter, your Life Insurance benefit is further reduced by 20% of the Life Insurance benefit you had as a working member until you reach the minimum Life Insurance amount based on your date of retirement:

<table>
<thead>
<tr>
<th>Date Range</th>
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</tr>
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<tbody>
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<td>$1,000</td>
</tr>
<tr>
<td>After July 1, 1983</td>
<td>$1,250</td>
</tr>
</tbody>
</table>
This benefit does **not** include coverage for accidental death or dismemberment.

Your spouse is **not** eligible for this benefit.

**Burial**

You are covered for a free burial plot.
SECTION VI. E
IF YOU RETIRE BETWEEN AGES 62 THROUGH 64

You and your spouse are eligible for the benefits described in this section when you retire after age 62 and before age 65 with at least 20 Years of Pension Fund Credited Service if you retire on or after July 1, 1998 (or 25 Years of Pension Fund Credited Service if you retired after June 15, 1995, through June 30, 1998).

When you become eligible for Medicare, you will receive the benefit package given to members who retired at or after age 65 with 10 or more Years of Pension Fund Credited Service as described in Sections VI.C or VI.D. At that time, if your spouse is not covered by Medicare, he or she will be covered for prescription drugs, vision care and burial benefits only.

When your spouse is eligible for Medicare, he or she will receive the same benefits that members who retired at age 65 with 10 or more Years of Pension Fund Credited Service receive as described in Section VI.C or VI.D, except for Life Insurance.

If you retired before October 1, 1998, your spouse’s benefits will stop 30 days after your death. If you retired on or after October 1, 1998, your spouse will continue to be eligible after your death for Retiree Health Benefits for the remainder of his or her life.

Your Retiree Health Benefits through the Benefit Fund cannot exceed the coverage you had just before you retired. For example, if you did not have prescription benefits just before you retired, you are not covered for prescription benefits after you retire.

ELIGIBILITY
To receive the benefits described in this section from the Benefit Fund, you must be covered by the Benefit Fund as an active employee right before you retire, or 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.

In addition, you must meet all of the following conditions:

• Retire between the ages of 62 through 64;
• Be receiving a pension from the 1199SEIU Health Care Employees Pension Fund or have your application in process; and
• Retire on or after July 1, 1998, with 20 Years of Pension Fund Credited Service under the 1199SEIU Health Care Employees Pension Fund; or
• Have retired on or after June 15, 1995, but before July 1, 1998, with 25 Years of Pension Fund Credited Service under the 1199SEIU Health Care Employees Pension Fund.

YOUR BENEFITS

Hospital

Your coverage is the same as the coverage you had as a working member:
• Up to 365 days per year;
• Semi-private room and board;
• Medically Necessary services;
• Up to 30 days per year for inpatient mental health; and
• Up to 30 days for physical rehabilitation when provided in an acute care facility. The Fund does not provide benefits for services rendered in a nursing home or skilled nursing facility.

Medical

You have the same coverage you had as a working member for:
• Doctor visits;
• Lab and X-ray;
• Surgery and anesthesia; and
• Other medical benefits requiring prior authorization.

Benefits are based upon the Benefit Fund’s Schedule of Allowances.

Vision Care

You are covered once every two years for:
• An eye exam; and
• A pair of glasses or contact lenses.

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.

Hearing Aids

• Hearing aids are covered once every three years. Call Member Services for a referral to a Participating Provider.
• If you use a Non-Participating Provider, you can be billed whatever the provider normally charges. You may have to pay any cost over the Benefit Fund’s allowance.

Prescription Drugs

To get your prescription:
• Ask your doctor to prescribe only covered medications 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.

Please refer to the Prescription Drug provision of Section II. L for other procedures you need to follow to assure reimbursement for covered prescription drugs.

Life Insurance

Your Life Insurance amount as a working member is immediately reduced by 20% when you retire.

Every year thereafter, your Life Insurance benefit is further reduced by 20% of the Life Insurance benefit you had as a working member until you reach the minimum Life Insurance amount.

This benefit does not include coverage for accidental death or dismemberment.

Your spouse is not eligible for this benefit.

Burial

You are covered for a free burial plot.
SECTION VI. F
IF YOU RETIRE BETWEEN AGES 55 THROUGH 64
WITH AT LEAST 10 YEARS OF PENSION FUND
CREDITED SERVICE

If you retire after age 55 and before age 65 with at least 10 Years of Pension Fund Credited Service, you and your spouse will be eligible only for vision care and prescription drug benefits.

Even after you are eligible for Medicare, you and your spouse will not receive the benefits available to members who retire at or after age 65 with 10 Years of Pension Fund Credited Service.

You must enroll in the Benefit Fund Medicare Program to receive your full prescription benefit.

See Section VI.A to see if you are eligible for other retiree health packages for members who retire after age 60 and meet other criteria.

Your retiree health benefits through the Benefit Fund can’t exceed the coverage you had just before you retired. For example, if you did not have prescription benefits just before you retired, you are not covered for prescription benefits after you retire.

Depending on the year that you retire, you and your spouse may age into full retiree health benefits when you become eligible for Medicare.

If you retired between ages 55 through age 64 before October 1, 1998, or retire between the ages of 55 through 59 on or after October 1, 1998, you and your spouse will not be eligible for the Retiree Health benefits as described in Section VI.C or VI.D, even after you become eligible for Medicare.

If you retire between ages 60 through 64 on or after October 1, 1998, you or your spouse will be eligible for the retiree health benefits as described in Section VI.C or VI.D when you or your spouse become eligible for Medicare.

If you retired before October 1, 1998, your spouse’s benefits will stop 30 days after your death. If you retired on or after October 1, 1998, your spouse will continue to be eligible after your death for Retiree Health benefits for the remainder of his/her life.
ELIGIBILITY

To receive the benefits described in this section from the Benefit Fund, you must be covered by the Benefit Fund as an active employee right before you retire, or 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.

In addition, you must meet all of the following conditions:

• Retire after age 55 and before age 65 before October 1, 1998, or Retire after age 55 and before age 60 on or after October 1, 1998; and

• Not be eligible for the ages 62 through 64 Retiree Health package (see Section VI.E) or the age 60 Retiree Health package described in Section VI.F; and

• Have at least 10 Years of Pension Fund Credited Service under the 1199SEIU Health Care Employees Pension Fund; and

• Be receiving a pension from the 1199SEIU Health Care Employees Pension Fund or have your application in process.

YOUR BENEFITS

Vision Care

You are covered once every two years for:

• An eye exam; and

• A pair of glasses or contact lenses.

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.

Hearing Aids

• Hearing aids are covered once every three years. Call Member Services for a referral to a Participating Provider.

• If you use a Non-Participating Provider, you can be billed whatever the provider normally charges. You may have to pay any cost over the Benefit Fund’s allowance.

Vision Care

You are covered once every two years for:

• An eye exam; and

• A pair of glasses or contact lenses.

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.

Hearing Aids

• Hearing aids are covered once every three years. Call Member Services for a referral to a Participating Provider.

• If you use a Non-Participating Provider, you can be billed whatever the provider normally charges. You may have to pay any cost over the Benefit Fund’s allowance.
**Prescription Drugs**

To get your prescription:

- Ask your doctor to prescribe only covered medications 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
- Use the Specialty Care Pharmacy for injectables and other drugs that require special handling.

Please refer to the Prescription Drug provision of Section II. L for other procedures you need to follow to assure reimbursement for covered prescription drugs.
SECTION VI. G  
IF YOU RETIRE WITH A DISABILITY PENSION

You are covered for the benefits described in this section when you receive a Disability Pension at any age from the 1199SEIU Health Care Employees Pension Fund with at least 10 Years of Pension Fund Credited Service.

When you are eligible for Medicare, you will receive the same benefits given to members who retired at or after age 65 with 10 or more Years of Pension Fund Credited Service as described in Section VI.C or VI.D.

Your Retiree Health Benefits through the Fund can’t exceed the coverage you had just before you retired. For example, if you did not have prescription benefits just before you retired, you are not covered for prescription benefits after you retire.

ELIGIBILITY

To receive the benefits described in this section from the Benefit Fund, you must be covered by the Benefit Fund as an active employee right before you retire, or 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.

In addition, you must meet all of the following conditions:

- **Have at least 10 Years of Pension Fund Credited Service** under the 1199SEIU Health Care Employees Pension Fund; and

- Be receiving a Disability pension from the 1199SEIU Health Care Employees Pension Fund or have your application in process.

If your spouse is not covered by Medicare, he or she is covered for the same benefits you have as a disabled pensioner, except for Life Insurance, until he or she reaches age 65.

When your spouse becomes eligible for Medicare, he or she will receive the same benefits that members who retired at or after age 65 with 10 or more Years of Pension Fund Credited Service receive, except for Life Insurance.
YOUR BENEFITS

Hospital
Your coverage is the same as the coverage you had as a working member:
• Up to 365 days per year
• Semi-private room and board
• Medically Necessary services
• Up to 30 days per year for inpatient mental health
• Up to 30 days for physical rehabilitation when provided in an acute care facility. The Fund does not provide benefits for services rendered in a nursing home or skilled nursing facility.

Surgery and Anesthesia
Your coverage is the same as the coverage you had as a working member.
Benefits are based upon the Benefit Fund’s Schedule of Allowances.

Medical – Effective October 1, 1998
If you receive a Disability pension on or after October 1, 1998, you have the same coverage you had as a working member for:
• Doctor visits;
• Lab and X-ray; and
• Medical benefits.

Vision Care
You are covered once every two years for:
• An eye exam; and
• A pair of glasses or contact lenses.
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.

Hearing Aids
• Hearing aids are covered once every three years. Call Member Services for a referral to a Participating Provider.
• If you use a Non-Participating Provider, you can be billed whatever the provider normally charges. You may have to pay any cost over the Benefit Fund’s allowance.
Prescription Drugs

To get your prescription:

• Ask your doctor to prescribe only covered medications 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
• Use the Specialty Care Pharmacy for injectables and other drugs that require special handling.

Please refer to the Prescription Drug provision of Section II. L for other procedures you need to follow to assure reimbursement for covered prescription drugs.

Life Insurance

Your Life Insurance is the same amount you were eligible for as a working member, until you reach age 65. At age 65, your Life Insurance amount will immediately be reduced by 20%. Then every year thereafter, your Life Insurance benefit is further reduced by 20% of the Life Insurance benefit you had as a working member until you reach the minimum Life Insurance amount based on your date of retirement:

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1, 1961 – June 30, 1973</td>
<td>$500</td>
</tr>
<tr>
<td>July 1, 1973 – June 30, 1983</td>
<td>$1,000</td>
</tr>
<tr>
<td>After July 1, 1983</td>
<td>$1,250</td>
</tr>
</tbody>
</table>

This benefit does not include coverage for accidental death or dismemberment.

Your spouse is not eligible for this benefit.

Burial

You are covered for a free burial plot.
SECTION VI. H
RETIRED MEMBERS PROGRAMS

A sum determined by Resolution of 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 Health Care Employees 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
RESOURCE GUIDE

WHERE TO CALL

Member Services Department
(646) 473-9200

Call Member Services:

• If you need any claim forms;
• If you have questions about completing your claim form;
• If you have any questions about what is not covered by the Benefit Fund;
• If you have any questions about the processing of your claim; or
• If 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 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 Benefit Fund in either electronic or paper form. The Benefit Fund needs to receive a claim form 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 health care 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” 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 an Assignment of Benefits statement. 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.

PLEASE NOTE: The assignment feature of the Benefit Fund is only for payment of your benefits to providers. 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” section of our website at www.1199SEIUBenefits.org. Submit this 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.

It is very important to file your claim with the Benefit Fund promptly.

- Disability claims must be filed within 30 days of the start of your disability.
- 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 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 Benefit 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 into which category it falls.

**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 Section II.B), 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 Fund Agent, review your request.

**Concurrent Care Requests** are requests to extend previously approved benefits for an ongoing course, 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.A.

**Urgent Care Requests.** Certain Pre-Service Care or Concurrent Care Requests involve situations that have to be decided quickly because using the usual time frames 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 II.I for requests involving hospitalization or inpatient/ ambulatory surgery; see Section II.B for all other requests.

**Disability Claims** are requests for Disability benefits. See Section III.C, “Filing Your Disability Claim.”
TIME FRAMES 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 furnished to you not later than three days after this oral notification.

Pre-Service Care Request – 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 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 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 Request – 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 on a timely basis, the initial decision on your Request for Benefits will be made based on the information available to the Plan Administrator.
**Urgent Care Request** – 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 on a timely basis, the initial decision on your Request for Benefits will be made based on the information available to the Plan Administrator.

**Disability Claim** – You or your authorized representative generally will be notified of the Plan Administrator’s approval or denial of your request for disability benefits no later than 45 days from the date the Benefit Fund receives the request. This 45-day period may be extended by the Plan Administrator for an additional 30 days due to matters beyond the Plan Administrator’s control; you will receive prior written notice of the extension.
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, as described in Section VII.B.

FIRST 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 outpatient/ambulatory procedures, the Plan Administrator will have 1199SEIU CareReview conduct the Administrative Review and appeals procedure.

PLEASE NOTE: All claims by you, your spouse/same-sex partner, your children, your beneficiaries or third parties against the Benefit Fund are subject to the Claims and Appeals Procedure. No lawsuits may be filed in any court until all steps of these procedures have been completed and the benefits requested have been denied in whole or in part.

SECOND 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 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. If your appeal is denied by 1199SEIU CareReview, you have the right to file suit in federal court under the Employment Retirement Income Security Act (“ERISA”).

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 pursue your case under ERISA in federal court.
Urgent Care Situations

In urgent care situations regarding the prior authorization of Hospital Stays or Ambulatory/Outpatient Procedures the Administrative Review of 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 suit in federal court, under ERISA.

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.

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; and
- 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.
# HOW TO REQUEST AN ADMINISTRATIVE REVIEW OR AN APPEAL TO THE APPEALS COMMITTEE OF THE BOARD OF TRUSTEES

<table>
<thead>
<tr>
<th>Requests for Administrative Review of Urgent Care for hospitalization or ambulatory/inpatient procedures can be directed to CareReview at:</th>
<th>Requests for Administrative Review of non-urgent hospitalization or ambulatory/ inpatient procedures should be sent to:</th>
</tr>
</thead>
</table>
| • Phone: (800) 227-9360  
• Fax (Medical): (866) 623-5793  
• Fax (Behavioral Health): (952) 996-2836 | 1199SEIU CareReview Program  
CareAllies  
1777 Sentry Park West  
Dublin Hall, 4th Floor  
Blue Bell, PA 19422 |

Requests for other Administrative Reviews and Appeals should be sent to:  
1199SEIU National Benefit Fund  
Claim Appeals  
PO Box 646  
New York, NY 10108-0646

Requests involving Urgent Care can be made by:  
• Phone: (646) 473-7446  
• Fax: (646) 473-7447

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.

## TIME FRAMES 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 time frames.

- **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 Request** – Each level of review of an Urgent Care Request shall be completed in sufficient time to 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 Request, or a Post-Service Claim, depending on the facts.

The decision of the Appeals Committee shall be final and binding on all parties, subject to your right to file suit in a federal court, under ERISA.

**APPEALING DISABILITY CLAIMS**

To appeal a denial of your request for Disability benefits, you must:

- Follow the directions that are on the back of the rejection notice (DB-451). If you do not have this form, contact the Benefit Fund at (646) 473-9200; and

- **Within 30 days** of receiving the denial notification, 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 the state.

If the state denies your request for Disability benefits, you may appeal directly to the Appeals Committee of the Board of Trustees by sending a letter to the Benefit Fund within 180 days of the State’s issuance of the denial. You or your authorized representative will be notified of the Appeals Committee’s approval or denial of your claim for disability benefits no later than 45 days from the date the Plan Administrator receives the request. This 45-day period may be extended by the Plan Administrator for an additional 45 days due to matters beyond the Plan Administrator’s control; you will receive prior written notice of the extension.

If additional information is needed to resolve your appeal, you will be notified by the Plan Administrator. 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 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 Appeals Committee will resolve your appeal based on the information available.
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 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.

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;
• 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 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; and/or
• An autopsy be performed to determine the cause of death, except where prohibited by law.
SECTION VII. D
WHAT IS NOT COVERED

In addition to the various exclusions and limitations set forth elsewhere in this booklet, the Benefit Fund does not cover the following charges:

• Charges in excess of the Benefit Fund’s Schedule of Allowances
• 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 covered under any mandatory automobile or no-fault policy
• Charges related to 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
• To the extent permitted by law, charges related to an illness or injury that was deliberately self-inflicted except where such illness or injury is attributable to a mental condition or that resulted from the person committing an illegal act
• Charges for services or materials that do not meet the Benefit Fund’s standards of professionally recognized quality
• 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.
• Charges made by your provider for broken appointments
• Charges for in-hospital services that can be performed on an ambulatory or outpatient basis
• Charges for procedures, treatments, services, supplies or drugs for cosmetic purposes, except to remedy a condition that results from an accidental injury that occurred while covered by the Benefit Fund
• Charges for experimental or unproven procedures, services, treatments, supplies, devices, drugs, etc. (See Definitions, Section IX.)
• 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 that are not FDA-approved for a particular condition
• Charges that are unreasonable, excessive, or that are beyond the provider’s normal billing rate or beyond their scope or specialty
• Charges for services that are not covered by the Benefit Fund, even if the service is Medically Necessary
• Charges for services that are not Medically Necessary in the judgment of the Plan Administrator (see Section VIII.C)
• Charges related to interest, late charges, finance charges, court or other costs
• Charges related to programs for smoke cessation, weight reduction, stress management and other similar programs that are not provided by a licensed medical physician or not Medically Necessary
• Charges for infertility treatment including but not limited to, in vitro fertilization, artificial insemination, and reversal of sterilization
• Charges for claims submitted more than 12 months after the date of service
• Charges related to an illness or 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, insurance carrier or other entity
• Charges for services that are custodial in nature
• Charges for services in excess of or not in compliance with the Benefit Fund’s guidelines, policies, or procedures
• Charges that are not itemized
• Charges for over-the-counter, personal, comfort or convenience items such as bandages or heating pads (even if your physician recommends them)
• Charges for Services that are not pre-approved in accordance with the terms of the Plan
• Charges for claims containing misrepresentations or false, incomplete or misleading information
• Charges for invalid and/or obsolete CPT or HCPCS codes.
SECTION VII. E
ADDITIONAL PROVISIONS

Nothing in this booklet 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, injury, or incapacity.

Instead, the payment shall be made to a duly appointed legal representative or to such person who, in the judgment of the Plan Administrator, 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 Benefit Fund have been exhausted, including requests for administrative reviews or appeals.

Payments made by the Benefit Fund that are not consistent with the Plan – as stated in this booklet 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, 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 dependents(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 Your Plan
SECTION VIII. A  
YOUR ERISA RIGHTS

You have certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

GETTING INFORMATION

You have the right to:

- Examine, without charge, at the Benefit Fund office, all required Benefit Fund documents, including collective bargaining agreements, insurance contracts, detailed annual reports (Form 5500 series) and descriptions;

- Obtain copies of all required Benefit Fund documents, such as insurance contracts, collective bargaining agreements, copies of the latest annual report and Summary Plan Description, by writing to the Benefit Fund Administrator. The Benefit Fund Administrator can make a reasonable charge for copies; and to

- Receive a summary of the Benefit Fund’s Annual Financial Report. The Benefit Fund 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.

CONTINUE GROUP HEALTH COVERAGE

- If you lose health coverage for yourself, your spouse or your dependents under the Plan as a result of a qualifying event, you or your dependents may have to pay for continued coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- You will be provided a Certificate of Creditable Coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of Creditable Coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
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 this 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 appeal 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 plan documents or the latest annual report from the Plan and you do not receive them within 30 days, you may file suit in federal court.

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 may file suit in a state or federal court, after you have completed the appeals procedure (see Section VII.B), if you believe that the decision against you is arbitrary and capricious.

• If you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.

• 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 may file suit in a federal court.

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).
QUESTIONS?

If you have any questions about:

- Your Benefit Fund, contact the Benefit Fund office 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 N.W., Washington, D.C. 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.
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 this 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 nor any other person has or will have a vested or nonforfeitable 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 benefits under this Plan;

(ii) Determine the amount of benefits, if any, an individual is entitled to under this Plan;

(iii) Interpret all of the provisions of this Plan (and all related Plan documents);

(iv) Interpret all of the terms used in this 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 with respect to any matter arising under the Plan and any other Plan documents shall be final and binding on all parties.
SECTION VIII. D
INFORMATION ON YOUR PLAN

NAME OF THE PLAN
The 1199SEIU National Benefit Fund for Health and Human Service Employees

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. Since this 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 Benefit Fund Administrator, or by examining a copy at the Benefit Fund office.

You can find out if a particular employer or employee organization is a sponsor of the Benefit Fund by writing to the Benefit Fund office. The address of the sponsor 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-insured. 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:
c/o Executive Director
1199SEIU National Benefit Fund for Health and Human Service Employees
330 West 42nd Street
New York, NY 10036
FOR SERVICE OF LEGAL PROCESS
Legal papers may be served on the Benefit Fund Trustees or the Benefit Fund’s Counsel.

IDENTIFICATION NUMBER
Employer Identification Number:
13-1628401

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:

<table>
<thead>
<tr>
<th>UNION TRUSTEES</th>
<th>EMPLOYER TRUSTEES</th>
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<tr>
<td><strong>Norma Amsterdam</strong></td>
<td><strong>Angela Doyle</strong></td>
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<td>Dalton Mayfield</td>
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<td>Neva Shillingford</td>
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<td>Joyce Neil</td>
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<td>Laurie Vallone</td>
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<td>Bruce Popper</td>
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<td>Estela Vasquez</td>
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<td>John Reid</td>
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<td>Fernando Wilson</td>
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<td>Bruce Richard</td>
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<td>Gladys Wrenick</td>
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<td>EMPLOYER TRUSTEES</td>
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<td>Christopher Berner</td>
<td>Jeffrey Cohen</td>
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<td>Assistant Vice President</td>
<td>Vice President of Labor Relations</td>
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<td>of Labor and Employee Relations</td>
<td>Mount Sinai Medical Center</td>
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<td>Montefiore Medical Center</td>
<td>19 East 98th Street, Suite 10A</td>
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<td>Elliot Brooks</td>
<td>Glenn Courounis</td>
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<td>Senior Vice President</td>
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<td>St. Luke’s Cornwall Hospital</td>
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<td>Metropolitan Jewish Health System</td>
<td>70 Dubois Street</td>
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<td>6323 Seventh Avenue</td>
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<td>Dennis Buchanan</td>
<td>Thomas Doherty</td>
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<td>New York Methodist Hospital</td>
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<td>Traci Burch</td>
<td>Sheila Garvey</td>
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<td>Senior Director of Labor Relations</td>
<td>Assistant Vice President of Labor Relations</td>
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<td>and Labor Counsel</td>
<td>Columbia University in the City of New York</td>
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<td>Rite Aid Pharmacy</td>
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<td>James Carey</td>
<td>Rebecca Gordon</td>
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<td>c/o Trustee Relations</td>
<td>Vice President of Labor and Employee Relations</td>
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<td>1199SEIU National Benefit Fund</td>
<td>North Shore – LIJ Health System</td>
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<td>330 West 42nd Street</td>
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<td>Lake Success, NY 11042</td>
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<td>Howard Green</td>
<td>c/o Trustee Relations</td>
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<tr>
<td>Frank Scheets</td>
<td>Corporate Senior Vice President of Human Resources</td>
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<td>Bart Minsky</td>
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<td>Roseann Simonelli</td>
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<td>Bruce McIver</td>
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<td>Carmen Suardy</td>
<td>Vice President of Labor and Employee Relations</td>
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<td>Michael Rosenblut</td>
<td>President and CEO</td>
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<td>Audrey Wathen</td>
<td>Senior Vice President of Human Resources</td>
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<td>Nancy Sanchez</td>
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<td>Keith Wolf</td>
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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 and 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 who has received an Assignment of Benefits.

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
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 statement 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 room care charges allowed by the Plan.

2. See Lien/Subrogation Reimbursement Agreement.

Average Weekly Earnings
The weekly average of your earnings wages reported to the Benefit Fund by your employer. Sixteen weeks are averaged to determine your wage class. Eight weeks are used to determine your disability benefit amount.

Beneficiary
The person(s) you have named to receive any Life Insurance benefit.

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

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.)

Contributing Employer

1. An employer who has a Collective Bargaining Agreement with 1199SEIU United Healthcare Workers East or one of their affiliates who 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.

2. 1199SEIU United Healthcare Workers East, their affiliates, the 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.

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.)

Cosmetic Surgery

Cosmetic surgery includes any procedure whose primary purpose is to improve, alter or enhance appearance. Procedures to correct a cosmetic disfigurement resulting from 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.

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, post-operative or chronic conditions, preparation of special diets and supervision of medication that 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 they have been licensed.

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

**Dependent**
Your spouse or same-sex partner and your children who are eligible to receive benefits from the Benefit Fund as described in Section I.A.

**Dependent**
Your spouse or same-sex partner and 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.

**Earnings**
Wages reported by a contributing employer as the basis for determining the employer’s payments to the Benefit Fund.

**Eligible**
You have met the criteria adopted by the Trustees of the Benefit Fund to determine your enrollment, plan of benefits and wage 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.

**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 Health Care Employees Pension Fund.

**Disabled**
You are temporarily unable to work as a result of an accident or illness.

**Emergency**
Services provided in connection with an “Emergency Condition” including screening and examination services provided to a member or his/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.

**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.

**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 that does not meet any one or more of the following criteria:

(i) 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.

(ii) The treatment is endorsed by an appropriate medical society.

(iii) There must be scientific evidence, including peer-review literature demonstrating that the technology improves net health outcomes or offers significant benefit over conventional treatment, in terms of efficacy, safety and reliability.

(iv) The technology/treatment must offer a significant benefit over conventional treatment.

(v) The improvement in net health outcome must be attainable under the usual conditions of medical practice.

**Family**

Your spouse or same-sex partner and your children who are eligible to receive benefits from the Benefit Fund, as described on Section I.A.
**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 work week as set forth in the applicable Union contract. Overtime is not included.

**Fund or Trust Fund**

The 1199SEIU National Benefit Fund for Health and Human Service Employees whose principal office is at 330 West 42nd Street in New York City.

**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 that:

- Primarily provides services to diagnose, treat and care for injured, disabled or sick patients by or under the supervision of a doctor; and
- Provides 24-hour nursing service with the care given or supervised by a registered professional nurse; and
- Maintains clinical records on all patients; and
- Has by-laws in effect with respect to its staff of physicians; and
- Has a hospital utilization review plan in effect; and
- 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 on Accreditation of Hospitals.

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, educational or rehabilitative care.
**Illness**

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

**Level of Benefit**

The Wage Classification (Wage Class I, Wage Class II or Wage Class III) used to determine the specific package of benefits for which you, your covered spouse/same-sex partner and your covered children are entitled.

**Lien/Subrogation Reimbursement Agreement**

An agreement that gives the Benefit Fund the right to recover payment for any amount it has paid or will pay arising out of, or relating to, any and all of the rights, claims, causes of action, and interest that you (or your spouse or covered children) may have against any person, firm, corporation, insurance company, payor, uninsured motorist fund, no-fault insurance carrier or other entity in regard to such injuries, expenses or losses.

**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.B and in the Certificate of Coverage.

**Medically Necessary**

Those services or supplies that 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:

A. Are consistent with the diagnosis and treatment of the patient’s condition;

B. Are in accordance with the standards of accepted medical practice;

C. Are not solely for the convenience of the patient, physician and/or supplier;

D. Are performed at a level of care not greater than required for the patient’s condition;

E. 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);

F. 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
G. 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**

1. 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.

2. 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/her class of former members.

**Mental Health Benefits**

Services for illness listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or subsequent editions, regardless of etiology, and typically treated by psychiatrists, psychologists or other licensed therapists using psychotherapy and/or psychotropic drugs.

**Newly Organized**

Those employees in a bargaining unit when 1199SEIU United Healthcare Workers East concludes a Union contract that for the first time requires payment to the National Benefit Fund for employees in that bargaining unit. It does not include employees covered under expired contracts that 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.

**Network**

See Participating Provider.

**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 they are 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.

**Participating Pharmacy**
A licensed, registered pharmacy that has signed an agreement with the Benefit Fund’s Prescription Benefit Manager (PBM).

**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.

**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.

**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 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.
Podiatrist
A person licensed by the appropriate department of the state to practice within the podiatric profession for which they have been licensed.

Pre-Authorization
See Prior Approval.

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 or outpatient services or treatment, admissions for mental health or substance abuse, admissions for physical rehabilitation, certain prescription drugs, all non-emergency hospital admissions and surgical procedures. There may be certain penalties, as described in this booklet, if you fail to obtain 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 they have been licensed.

Psychologist
A person licensed by the appropriate department of the state to practice within the psychology profession for which they have been licensed.

Retired Member or Retiree
A person who is currently receiving a pension from the National Pension Fund for Hospital and Health Care Employees or its successors, including the 1199SEIU Health Care Employees Pension Fund.

Same-sex Partner
The individual with whom you are in a same-sex partner relationship that meets the criteria set forth in Section I.A.

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.
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. Generally, wherever the term “your spouse” is used in this booklet, it is intended to refer to your same-sex partner as well, except where noted otherwise or the context would indicate that such usage was not intended.

Surgeon
A person licensed by the appropriate department of the state to practice within the surgical profession for which they have been licensed.

Totally Disabled
See Permanently Disabled.

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

Trustees
The Benefit Fund Trustees acting pursuant to the Agreement and Declaration Trust establishing the Benefit Fund, and any successor Trustees, duly designated in the manner set forth in the Agreement and Declaration of Trust.

Unemployed Member
Any employee covered by the Plan whose employment has been terminated and who immediately qualified for and continues to receive statutory unemployment insurance.

Wage 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.

Years of Credited Service
Periods of time for which an employee earns 12 months of credited service towards a pension under the rules described in the Plan and Summary Plan Description of the National Pension Fund for Hospital and Health Care Employees or its successors, including the 1199SEIU Health Care Employees Pension Fund (the “1199PF”), including credited service recognized by the 1199PF for purposes of pension eligibility in accordance with the terms of a reciprocity agreement between the 1199PF and another pension plan.

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.