1199SEIU National Benefit Fund for NYC Employees

Summary of Benefits and Coverage: What This Plan Covers & What You Pay For Covered Services

Coverage Period: Beginning 12/01/2017
Coverage for: NBF NYC Employees
Plan Type: Prescription, Dental and Vision

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered healthcare services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, including a copy of the Fund's Summary Plan Description (SPD), call (646) 473-9200 or visit www.1199SEIUBenefits.org. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider or other underlined terms, see the Glossary. You can view the Glossary at www.1199SEIUBenefits.org or call (646) 473-9200 to request a copy.

The 1199SEIU National Benefit Fund plan for New York City Employees is a supplemental benefit plan providing prescription, dental and vision benefits only for members and their eligible family members, as indicated in the Limitations, Exceptions & Other Important Information column.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	This plan covers all items and services without a deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See www.1199SEIUBenefits.org or call (646) 473-9200 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Not applicable.	This plan does not cover physician services.

The 1199SEIU National Benefit Fund for NYC Employees considers itself a "grandfathered health plan" under the Patient Protection and Affordable Care Act.

All co-payment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	**Non-Participating Provider** (You will pay the most)	
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	Excluded service
	Specialist visit	Not covered	Not covered	Excluded service
	Preventive care/ screening/ immunization	Not covered	Not covered	Excluded service
If you have a test	Diagnostic test (X-ray, blood work)	Not covered	Not covered	Excluded service
	Imaging (CT/PET scans, MRIs, MRAs)	Not covered	Not covered	Excluded service
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.1199SEIUBenefits.org	Generic drugs	No charge	Provider charges	This is a pharmacy benefit only and excludes drugs administered in a physician's office or an outpatient setting. Participating Providers are pharmacies that accept Express Scripts. If you use a Non-Participating Pharmacy, you may be charged the amount the provider bills above the Fund's payment. For drugs not on the Fund's Preferred Drug List (non-preferred drugs), you must also pay the difference between the preferred and non-preferred drug price. Prior approval is required for certain medications. Certain medications are subject to clinical program management. Prescriptions for chronic conditions must be filled through *The 1199SEIU 90-Day Rx Solution*. Medications that are not pre-approved in accordance with the terms of the SPD will not be covered. Certain classes of drugs are covered through the health program provided by New York City and are **not covered** through the National Benefit Fund prescription benefit. For limitations, exceptions and other important information, see the SPD at www.1199SEIUBenefits.org.
	Preferred brand drugs	No charge	Provider charges	
	Non-preferred brand drugs	You will be charged a differential	Provider charges	
	Specialty drugs	You will be charged a differential for non-preferred brand drugs	Provider charges	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	Excluded service
	Physician/ surgeon fees	Not covered	Not covered	Excluded service
If you need immediate medical attention	Emergency room care	Not covered	Not covered	Excluded service
	Emergency medical transportation	Not covered	Not covered	Excluded service
	Urgent care	Not covered	Not covered	Excluded service
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	Excluded service
	Physician/ surgeon fees	Not covered	Not covered	Excluded service
If you need mental health, behavioral health or substance abuse services	Outpatient services	Not covered	Not covered	Excluded service
	Inpatient services	Not covered	Not covered	Excluded service
If you are pregnant	Office visits	Not covered	Not covered	Excluded service
	Childbirth/delivery professional services	Not covered	Not covered	Excluded service
	Childbirth/delivery facility services	Not covered	Not covered	Excluded service

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	**Non-Participating Provider** (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	Excluded service
	Rehabilitation services	Not covered	Not covered	Excluded service
	Habilitation services	Not covered	Not covered	Excluded service
	Skilled nursing care	Not covered	Not covered	Excluded service
	Durable medical equipment	Not covered	Not covered	Excluded service
	Hospice services	Not covered	Not covered	Excluded service
If your child needs dental or eye care	Children's eye exam	No charge when using a Participating Provider in the Vision Care network	Provider charges. You are eligible to receive a reimbursement of $18.	Maximum of one exam every two years. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Children's glasses/ contact lenses	No charge for frames or lenses that are included in the Fund's program	Provider charges. You are eligible to receive a reimbursement of $57.	Coverage is limited to one pair of Fund program prescription glasses or one order of contact lenses every two years. Scratch-resistant and ultraviolet lens treatments are not covered. Payment for exam and glasses or contact lenses that are not included in the Fund's program will be limited up to the Fund's allocation of $75. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Children's dental check-up	No charge	Provider charges	Lifetime maximum benefit of $3,300/person if you use a Participating Provider or $1,130/person if you use a Non-Participating Provider for orthodontics up to age 19. Maximum benefit of $3,000/ person/year for non-orthodontic dental services. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.

Excluded Services and Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your SPD for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Care provided in a skilled nursing facility or nursing home
- Chiropractic care
- Cosmetic surgery
- Diagnostic tests
- Durable medical equipment
- Emergency medical transportation
- Emergency room care
- Facility fees for inpatient stays or outpatient surgery
- Habilitation services
- Hearing aids
- Home health care
- Hospice services
- Imaging
- Infertility treatment
- Long-term care
- Mental/Behavioral health inpatient or outpatient services
- Non-emergency care when traveling outside the U.S. (except for covered prescription drugs)
- Physician/Surgeon fees for inpatient stays or outpatient surgery
- Prenatal care, postnatal care and related delivery and inpatient services
- Preventive care/Screening/Immunization
- Primary, specialist and other practitioner office visits
- Private-duty nursing
- Rehabilitation services
- Routine foot care
- Skilled nursing care
- Substance abuse inpatient or outpatient services
- Urgent care
- Weight-loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your SPD.)

- Dental care (adult): Maximum benefit of $3,000/person/year
- Routine eye care (adult): One eye exam every two years; One pair of glasses or one order of contact lenses every two years

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The Fund's plan at (646) 473-9200. You may also contact the U.S Department of Labor's Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services' Center for Consumer Information and Insurance Oversight at (877) 267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact: The Fund's Appeals Department at (646) 473-8951. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? No.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? No.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services: Para obtener asistencia en español, llame al (646) 473-9200.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost-sharing amounts (deductibles, co-payments and co-insurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

The plan's overall deductible	$0
Specialist co-payment	n/a
Hospital (facility) co-insurance	n/a
Other co-insurance	0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/delivery professional services
Childbirth/delivery facility services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)
Total Example Cost **$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Co-payments	$0
Co-insurance	$0
What Isn't Covered	
Limits or exclusions	$12,600
The total Peg would pay is	**$12,600**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist co-payment	n/a
Hospital (facility) co-insurance	n/a
Other co-insurance	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)
Total Example Cost **$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Co-payments	$0
Co-insurance	$0
What Isn't Covered	
Limits or exclusions	$1,400
The total Joe would pay is	**$1,400**

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

The plan's overall deductible	$0
Specialist co-payment	n/a
Hospital (facility) co-insurance	n/a
Other co-insurance	0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic tests (*X-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)
Total Example Cost **$1,900**

In this example, Mia would pay*:

Cost Sharing	
Deductibles	$0
Co-payments	$0
Co-insurance	$0
What Isn't Covered	
Limits or exclusions	$1,900
The total Mia would pay is	**$1,900**

*This condition is not covered, so patient pays 100 percent.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Discrimination Is Against the Law

The 1199SEIU Benefit Funds comply with applicable federal civil rights laws and do not discriminate against or exclude people on the basis of race, color, national origin, age, disability or sex. The Funds provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats). The Funds provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Compliance Coordinator. If you believe the Funds have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Compliance Coordinator, 330 West 42nd Street, New York, NY 10036; (646) 473-6600 (phone); (646) 473-8959 (fax); PrivacyOfficer@1199Funds.org (email). You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Compliance Coordinator can help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201; (800) 368-1019 or (800) 537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (646) 473-9200.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (646) 473-9200。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (646) 473-9200.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (646) 473-9200.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다(646) 473-9200.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (646) 473-9200.

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט -(646) 473-9200.

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ (646) 473-9200.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (646) 473-9200.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (646) 473-9200.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez (646) 473-9200.

శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషా సహాయక సేవలు ఉచితంగా లభిస్తాయి. (646) 473-9200.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (646) 473-9200.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (646) 473-9200.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në (646) 473-9200.