



1199SEIU

NATIONAL BENEFIT FUND

OUR BENEFITS

SUMMARY PLAN

DESCRIPTION

OF YOUR HEALTH AND

WELFARE BENEFITS

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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.

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

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিখরচায় ভাষা সহায়তা পরামর্শ 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.

إف، غللا ركذا شحتت تنك اذا: تقو حلم كل رفاوتت ةيوغللا قدعاسملا تامدخ ناجملاب (646) 473-9200.

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

ಕೆರೆದೊ ವೆಟ್ಲಂಜಿ: ಒಕವೆಳ ಮೆರು ತೆಲುಗು ಭಾಷೆ ಮಾಟ್ಲಾಡುತುನ್ ನೆಲ್ಯೆತೆ, ಮೆ ಕೆರೆಕು ತೆಲುಗು ಭಾಷೆ ಸಹಾಯಕ ನೆವಲು ಒಪ್ಪಿತಾಯೆ. (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.

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 area and other areas covered by this Benefit Fund.

The Plan is administered by the Board of Trustees (the “Trustees”) of the 1199SEIU National Benefit Fund for Health and Human Service Employees (the “Benefit Fund” or “Fund”). No individual or entity, other than the Trustees (including any duly authorized designee thereof), has any authority to interpret the provisions of this SPD 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 SPD. This may happen at any time, even after you retire, if the Trustees decide to terminate the Plan or your coverage under the Plan. In no event will any active employee or retiree become entitled to any vested or otherwise non-forfeitable rights under the Plan.

The Trustees (including any duly authorized designee of the Trustees) reserve the complete authority and discretion to construe the terms of the Plan (and any related Plan documents) including, without limitation, the authority to determine the eligibility for, and the amount of, benefits payable under the Plan. These decisions shall be final and binding upon all parties affected by such decisions.

This SPD and the Benefit Fund staff are your sources of information on the Plan. You cannot rely on information from co-workers or Union or Employer representatives. If you have any questions about the Plan and how its coverage works, the Benefit Fund staff will be glad to help you. Because telephone conversations and other oral statements can easily be misunderstood, they cannot be relied upon if they are in conflict with what is stated in this SPD.



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

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

If the language is not clear to you, you can get assistance by calling the Benefit Fund at (646) 473-9200.

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

¿NECESITA AYUDA CON EL SUMARIO DE DESCRIPCIÓN DEL PLAN?

Este folleto es un sumario en inglés de sus derechos y beneficios bajo el Fondo Nacional de Beneficios de la 1199SEIU.

Si usted no entiende este sumario y necesita ayuda, llame al Fondo al (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 (the “Affordable Care Act”). A grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted in 2010. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for an external review process for claims appeals. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. The Wage Class III plan is not a grandfathered health plan. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan can be directed to the Plan Administrator 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/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

January 2021

Dear 1199SEIU Member:

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

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

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

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

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

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

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

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

The Board of Trustees

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

Refer to the Definitions Section

Section IX lists the terms used in this SPD and explains how they are defined by the Benefit Fund.

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

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

YOUR BENEFIT FUND

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

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

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

Labor-management means that the Benefit Fund is run by Trustees appointed by **1199SEIU** and by **Employers** who make payments to the Benefit Fund on behalf of their employees.

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

The Fund believes it is a “**grandfathered health plan**” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). A grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted in 2010. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for an external review process for claims appeals. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. The Wage Class III plan is not a grandfathered health plan. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan can be directed to the Plan Administrator 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/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

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

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

YOUR EMPLOYER PAYS FOR YOUR BENEFITS

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

The cost of your benefits is paid through **contributions** to the Benefit Fund by your Employer. These payments are called contributions because they go into a large pool of money used to pay for all the benefits for all 1199SEIU members and their families covered by the Plan.

Your Union dues are paid to 1199SEIU to cover the cost of running the Union — not to the Benefit Fund to cover the cost of providing health and welfare benefits.



OVERVIEW OF YOUR BENEFITS

IMPORTANT PHONE NUMBERS

Member Services Department (646) 473-9200

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

Program for Behavioral Health (646) 473-6900

For mental health and alcohol/ substance abuse.

1199SEIU CareReview Program (800) 227-9360

For Prior Authorization of hospital stays.

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

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

The Fund believes that it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”).

OVERVIEW OF WAGE CLASS I AND II BENEFITS

WAGE CLASSES

Wage Class I: Full-time or part-time members who earn 100% of the minimum full-time wage

Wage Class II: Part-time members who earn at least 60%, but less than 100%, of the minimum full-time wage

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

LEGEND

Member	You, the member
Spouse	Your spouse, if eligible
Children	Your children, if eligible
Family	You, your spouse and your children, if eligible

See Section I.A to determine if you, your spouse and/or your children are eligible for benefits.

If you are an employee of the City of New York or an agent or authority of New York City, see Section I.D for a summary of the benefits you are eligible for.

Benefit Coverage	Wage Classes	
	I	II
HOSPITAL CARE	Family	Family
<i>Inpatient Hospital Care</i>		
<ul style="list-style-type: none"> • This benefit is for the hospital's charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered, as described in Section II.H. • Up to 365 days per year • Semi-private room and board • Acute care for Medically Necessary services • Inpatient admissions • Up to 30 days per year for inpatient physical rehabilitation in an acute care facility • Benefits are not provided for care in a sub-acute nursing home or skilled nursing facility 		<p><i>You must call 1199SEIU CareReview at (800) 227-9360 before going to the hospital or within two business days of an Emergency admission.</i></p>
<i>Outpatient Hospital Care</i>		
<ul style="list-style-type: none"> • Ambulatory care • Observation care and services 		
HOSPICE CARE	Family	Family
<ul style="list-style-type: none"> • Coverage for a combined total of up to 210 days per lifetime in a Medicare-certified hospice program in a hospice center, hospital, skilled nursing facility or at home 		<p><i>You must call 1199SEIU CareReview at (800) 227-9360 for Prior Authorization of inpatient hospice care.</i></p>

Benefit Coverage	Wage Classes	
	I	II

<p>EMERGENCY DEPARTMENT VISITS</p> <ul style="list-style-type: none"> • This benefit is for the hospital's charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered, as described in Section II.H. • Use of the Emergency Department must be for a legitimate medical Emergency within 72 hours of an accident, injury, or the onset of a sudden and serious illness • Observation care and services • Benefit Fund pays negotiated rate at Participating Hospital or reasonable charge at Non-participating Hospital 	Family	Family
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Call the Benefit Fund at (646) 473-9200 for more information.

<p>PROGRAM FOR BEHAVIORAL HEALTH</p> <p><i>Mental Health</i></p> <ul style="list-style-type: none"> • Outpatient care • Intensive Outpatient Programs (IOP) • Inpatient care • Partial Hospitalization Programs (PHP) <p><i>Alcohol/Substance Abuse</i></p> <ul style="list-style-type: none"> • Inpatient detoxification and rehabilitation • Outpatient care • Intensive Outpatient Programs (IOP) 	Family	Family
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You must call 1199SEIU CareReview at (800) 227-9360 to Pre-certify inpatient care.

You must call the Benefit Fund at (646) 473-6868 to Pre-certify PHP and IOP services.

<p>SURGERY</p> <ul style="list-style-type: none"> • Inpatient or outpatient (ambulatory) surgery • Benefits based on the Fund's allowance for the surgical procedure • Participating Surgeons bill the Benefit Fund directly and accept the Fund's payment as payment in full 	Family	Family
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You must call 1199SEIU CareReview at (800) 227-9360 before having non-Emergency surgery.

Call the Benefit Fund at (646) 473-9200 to make sure your surgeon is a Participating Provider.

Benefit Coverage	Wage Classes	
	I	II
ANESTHESIA <ul style="list-style-type: none"> • Benefits based on the Fund's Schedule of Allowances 	Family	Family
	<i>Call the Benefit Fund at (646) 473-9200 to make sure your anesthesiologist is a Participating Provider.</i>	
MATERNITY CARE <ul style="list-style-type: none"> • An allowance which 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 Benefit for you, if you are the mother • Lactation consulting by a certified provider • Breast pump 	Family	Family
	<i>Call the Wellness Department at (646) 473-8962 to register for the Prenatal Program.</i>	
	<i>Call the Benefit Fund at (646) 473-9200 for information about breast pump options.</i>	
MEDICAL SERVICES <ul style="list-style-type: none"> • Treatment in a doctor's office, clinic, hospital, Emergency Department or your home • Well-child care for dependent children • Immunizations • Acupuncture: up to 25 visits per year, when performed by a licensed medical physician or licensed acupuncturist • Allergy: up to 20 visits per year, including up to two testing visits • Chiropractic: up to 12 visits per year • Dermatology: up to 20 visits per year • Physical/Occupational/Speech therapy: up to 25 visits per discipline per year • Podiatry: up to 15 visits per year for routine foot care • X-rays and laboratory tests • Durable medical equipment and appliances • Hospice care • Ambulance services 	Family	Family

Benefit Coverage	Wage Classes	
	I	II
MEDICAL SERVICES (continued) <ul style="list-style-type: none"> Participating Providers bill the Benefit Fund directly and accept the Fund's payment as payment in full 	Family	Family
TELEHEALTH VISITS <ul style="list-style-type: none"> Through telehealth, you can have an office visit by phone or video with your own Participating Provider or with the Benefit Fund's telehealth provider, who can diagnose, recommend treatment and prescribe medication for many of your medical or mental health needs If your doctor is unavailable, use the Benefit Fund's telehealth provider for on-demand non-Emergency visits by phone or video (available 24 hours a day, 7 days a week), with doctors and pediatricians licensed in your state If you prefer to access a licensed mental health professional through the Benefit Fund's telehealth provider, you can schedule a phone or video appointment (available 7 days a week), and choose from a variety of board-certified counselors, therapists, psychologists and psychiatrists. You must be age 18 or older to use this benefit. 	Family	Family

Call the Benefit Fund at (646) 473-9200 for information on how to access the Fund's telehealth provider.

Benefit Coverage	Wage Classes	
	I	II
<p>SERVICES REQUIRING PRIOR AUTHORIZATION</p> <ul style="list-style-type: none"> • Home health care • Long-term acute care hospital services • Hospital transfer ambulance services • Durable medical equipment and appliances • Medical supplies • Cellular and gene therapy • Specific medications, including specialty drugs • MRI, MRA, PET and CAT scans, and certain nuclear cardiology tests • Molecular, genomic and other diagnostic laboratory tests • Radiation therapy and medical oncology services • Hospice care • Ambulatory surgery or inpatient admissions • Certain mental health and alcohol/substance abuse services • Certain infusion drugs administered on an outpatient basis 	<p>Family</p> <p><i>You must call the Prior Authorization Department at (646) 473-9200 for Prior Authorization of services, except Emergency ambulance and the services listed below.</i></p> <p><i>You must call eviCore healthcare at (888) 910-1199 for Prior Authorization of radiological tests, molecular and genomic testing, radiation therapy and medical oncology services.</i></p> <p><i>Call One Call Care Management at (800) 398-8999 for a referral to a preferred radiology facility.</i></p> <p><i>You must call 1199SEIU CareReview at (800) 227-9360 for Prior Authorization of inpatient hospice care, ambulatory surgery or inpatient admissions.</i></p> <p><i>You must call CareContinuum at (877) 273-2122 for Prior Authorization of certain infusion drugs administered on an outpatient basis.</i></p>	<p>Family</p>
<p>VISION CARE</p> <ul style="list-style-type: none"> • One eye exam every two years • One pair of eyeglasses every two years; In lieu of eyeglasses, one order of contact lenses every two years • No out-of-pocket costs when using a Participating Provider for lenses and frames included in the Benefit Fund's vision program 	<p>Family</p> <p><i>Call the Benefit Fund at (646) 473-9200 for a referral to a Participating Provider.</i></p>	<p>Family</p>

Benefit Coverage	Wage Classes	
	I	II
<p>HEARING AIDS</p> <ul style="list-style-type: none"> Once every three years Co-payments may apply when using Participating Providers 	Family	Family
	<p><i>Call the Benefit Fund at (646) 473-9200 for a referral to a Participating Provider.</i></p>	
<p>DENTAL BENEFITS</p> <ul style="list-style-type: none"> Coverage through a Plan Network for basic and preventive services, major restorative care and orthodontia treatment Annual benefit limits or network restrictions may apply Network Dentists bill the Benefit Fund's Plan Network Administrator directly and accept the Network Administrator's Schedule of Allowances as payment in full for Covered Services For certain upgrades and materials, co-payments may apply 	Family	Not Covered
	<p><i>Call the Benefit Fund at (646) 473-9200 for a referral to a Participating Provider.</i></p>	
<p>PRESCRIPTION DRUGS</p> <ul style="list-style-type: none"> Coverage of FDA-approved prescription medications for FDA-approved indications, except Plan exclusions No co-payments when you use Preferred Drugs where available Use Participating Pharmacies Use <i>The 1199SEIU 90-Day Rx Solution</i> (Mandatory Maintenance Drug Access Program) for chronic conditions Comply with the Benefit Fund's prescription drug programs, including Prior Authorization where required Please refer to "What Is Not Covered" in Section II.L 	Family	Not Covered
	<p><i>Call Express Scripts at (800) 818-6720 for more information.</i></p>	

Wage Classes

Benefit Coverage

I

II

LIFE INSURANCE

Member Only Member Only

- Wage Class I: During your first year of service, amount is \$1,250. After your first year, benefit is based on your Wage Class and annual base pay up to a maximum amount of \$50,000.
- Wage Class II: During your first year of service, amount is \$1,250. After your first year, maximum amount is \$2,500.

Call the Benefit Fund at (646) 473-9200 for more information.

DISABILITY

Member Only Member Only

- This benefit is a partial salary replacement. Coverage is only for accidents, injuries or illnesses that are not work-related.
- Amount is based on your Average Weekly Earnings or on statutory minimums
- Maximum weekly benefit is \$385
- Maximum duration of 26 weeks leave within a 52-week period
- Your Benefit Fund coverage for all other benefits will continue while you are receiving Benefit Fund Disability Benefits

You must submit a Disability Claim Form to the Benefit Fund within 30 days of your accident, injury or the start of your illness. To get this form, or to make sure you are eligible before you stop working, call the Fund's Member Services Department at (646) 473-9200 or visit www.1199SEIUBenefits.org.

PAID FAMILY LEAVE

Member Only Member Only

- This benefit is a partial salary replacement. Your Benefit Fund coverage for all other benefits may continue while you are receiving Benefit Fund Paid Family Leave Benefits.
- Maximum weekly benefit is 67% of your average weekly earnings or the New York State average weekly wage, whichever is less
- How long you can receive benefits is based on verified need, up to a maximum of 12 weeks leave within a 52-week period

Before you stop working, call the Benefit Fund's Member Services Department at (646) 473-9200 to make sure you are eligible for benefits.

You must submit a Paid Family Leave Benefit Request Form to the Fund within 30 days of your qualifying event. To get this form, call (888) 447-9055 (toll-free), email 1199pfl@alicare.com or visit the Fund's website at www.1199SEIUBenefits.org.

Benefit Coverage	Wage Classes	
	I	II
<p>ACCIDENTAL DEATH AND DISMEMBERMENT</p> <ul style="list-style-type: none"> • For accidental death or dismemberment • Equal to, or half of, your life insurance amount, depending on the loss suffered 	Member Only	Member Only
<p>BURIAL</p> <ul style="list-style-type: none"> • If available, a free burial plot with permanent care or a \$75 payment to your beneficiary • Plots located in New York and New Jersey 	Member and Spouse	Member and Spouse
<p>ANNE SHORE SLEEP-AWAY CAMP PROGRAM</p> <ul style="list-style-type: none"> • For eligible children of Benefit Fund members (ages 9 to 15) • Summer sleep-away camp program provided at no cost to you, except administrative fee • FICA taxes and applicable withholdings paid for by the Benefit Fund (you will be responsible for taxable earnings) 	Children Only	Not Covered
<p>JOSEPH TAUBER SCHOLARSHIP PROGRAM</p> <ul style="list-style-type: none"> • For eligible children of Benefit Fund members (age 22 or younger) • Scholarships provided to attend accredited schools after high school 	Children Only	Not Covered

Benefit Coverage	Wage Classes	
	I	II
SOCIAL SERVICES	Family	Family
Member Assistance Program (MAP)	<i>Call MAP at (646) 473-6900 for more information.</i>	
<ul style="list-style-type: none"> • Help for personal and family problems 		
Citizenship Program	<i>Call the Citizenship Program at (646) 473-8915 for more information.</i>	
<ul style="list-style-type: none"> • Assistance in applying for United States citizenship 		
Earned Income Tax Credit (EITC) Assistance Program	<i>Call the EITC Assistance Program at (646) 473-9200 for more information.</i>	
<ul style="list-style-type: none"> • Tax preparation help 		
Financial Wellness and Homebuyer Education Program	<i>Call the Financial Wellness and Homebuyer Education Program at (646) 473-9200 for more information.</i>	
<ul style="list-style-type: none"> • Help with home ownership, managing credit and financial wellness 		
Monday Night Legal Clinic	<i>Call the Monday Night Legal Clinic at (646) 473-6488 for more information.</i>	
<ul style="list-style-type: none"> • Access to attorneys for free legal consultations regarding various personal legal matters 		
Weekly Workers' Compensation Legal Clinic	<i>Call the Weekly Workers' Compensation Legal Clinic at (646) 473-6717 for more information.</i>	
<ul style="list-style-type: none"> • Assistance to members suffering from a work-related injury or illness 		

OVERVIEW OF WAGE CLASS III BENEFITS

Wage Class III: Part-time members who earn less than 60% of the minimum full-time wage

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

Benefit Coverage	Wage Class III (Member Only)
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DENTAL BENEFIT

- Coverage through a Plan Network for basic and preventive services, major restorative care and orthodontia treatment
- Annual benefit limits or network restrictions may apply
- Network Dentists bill the Benefit Fund's Plan Network Administrator directly and accept the Network Administrator's Schedule of Allowances as payment in full for Covered Services
- For certain upgrades and materials, co-payments may apply

Call the Benefit Fund at (646) 473-9200 for a referral to a Participating Provider.

VISION CARE

- One eye exam every two years
- One pair of eyeglasses every two years; In lieu of eyeglasses, one order of contact lenses every two years
- No out-of-pocket costs when using a Participating Provider for lenses and frames included in the Benefit Fund's vision program

Call the Benefit Fund at (646) 473-9200 for a referral to a Participating Provider.

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

- Maximum life insurance amount of \$1,250
- AD&D is equal to, or half of, your life insurance amount, depending on the loss suffered

Call the Benefit Fund at (646) 473-9200 for more information.

DISABILITY

- This benefit is a partial salary replacement. Coverage is only for accidents, injuries or illnesses that are not work-related.
- Amount is based on your Average Weekly Earnings or on statutory minimums
- Maximum weekly benefit is \$385
- Maximum duration of 26 weeks leave within a 52-week period
- Your Benefit Fund coverage for all other benefits will continue while you are receiving Benefit Fund Disability Benefits

You must submit a Disability Claim Form to the Benefit Fund within 30 days of your accident, injury or the start of your illness. To get this form, or to make sure you are eligible before you stop working, call the Fund's Member Services Department at (646) 473-9200 or visit www.1199SEIUBenefits.org.

PAID FAMILY LEAVE

- This benefit is a partial salary replacement. Your Benefit Fund coverage for all other benefits may continue while you are receiving Benefit Fund Paid Family Leave Benefits.
- Maximum weekly benefit is 67% of your average weekly earnings or the New York State average weekly wage, whichever is less
- How long you can receive benefits is based on verified need, up to a maximum of 12 weeks leave within a 52-week period

Before you stop working, call the Benefit Fund's Member Services Department at (646) 473-9200 to make sure you are eligible for benefits.

You must submit a Paid Family Leave Benefit Request Form to the Fund within 30 days of your qualifying event. To get this form, call (888) 447-9055 (toll-free), email 1199pfl@alicare.com or visit the Fund's website at www.1199SEIUBenefits.org.

HOSPITAL INDEMNITY PAYMENTS

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

Call the Benefit Fund at (646) 473-9200 for more information.

SOCIAL SERVICES***Member Assistance Program (MAP)***

- Help for personal and family problems

Call MAP at (646) 473-6900 for more information.

Citizenship Program

- Assistance in applying for United States citizenship

Call the Citizenship Program at (646) 473-8915 for more information.

Earned Income Tax Credit (EITC) Assistance Program

- Tax preparation help

Call the EITC Assistance Program at (646) 473-9200 for more information.

Financial Wellness and Homebuyer Education Program

- Help with home ownership, managing credit and financial wellness

Call the Financial Wellness and Homebuyer Education Program at (646) 473-9200 for more information.

Monday Night Legal Clinic

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

Call the Monday Night Legal Clinic at (646) 473-6488 for more information.

Weekly Workers' Compensation Legal Clinic

- Assistance to members suffering from a work-related injury or illness

Call the Weekly Workers' Compensation Legal Clinic at (646) 473-6717 for more information.



SECTION I – ELIGIBILITY

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

ELIGIBILITY RESOURCE GUIDE

WHERE TO CALL

Member Services Department (646) 473-9200

Call the Member Services Department to:

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

COBRA Department (646) 473-6815

Call the COBRA Department to:

- Apply for COBRA continuation coverage
- Get more information on COBRA

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

REMINDERS

- You must enroll in the Benefit Fund to be eligible for benefits.
- Check the information on your ID cards and notify the Benefit Fund *immediately* of any incorrect information.
- Fill out all forms completely and attach all the documents required. Otherwise, your claim may be delayed or your benefits denied.
- Notify the Benefit Fund of any change of address, phone number, dependents, etc.
- Notify the Benefit Fund when you change Employers, in order for your coverage to continue.
- File a **Disability Certification Form** every year if your child is disabled and eligible to receive benefits after age 26 (see Section I.A).
- To protect your benefits, contact the Benefit Fund *immediately* if you are not working due to a Workers' Compensation, Disability, Paid Family 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.

NO PRE-EXISTING CONDITION EXCLUSIONS

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

SECTION I. A

WHO IS ELIGIBLE

YOU

You are eligible to participate in the 1199SEIU National Benefit Fund if **all** of the following conditions are met:

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

You may also be eligible for benefits if:

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

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.D).

WHEN YOU WORK FOR 1199SEIU UNITED HEALTHCARE WORKERS EAST AND THE 1199SEIU FAMILY OF FUNDS

Employees of 1199SEIU United Healthcare Workers East and the 1199SEIU Family of Funds (and their eligible dependents) who work in the New York tri-state area and participate in the Benefit Fund, are entitled to receive Benefit Fund Plan coverage when they meet the eligibility criteria described in this section. For employees of 1199SEIU United Healthcare Workers East and the 1199SEIU Training & Upgrading Fund (and their eligible dependents) who participate in the Benefit Fund and work in selected regions outside of the tri-state area, Aetna administers the Medical, Dental and Vision Benefits described in this Plan (except Teladoc telehealth services, which are available through the Benefit Fund). Employees of 1199SEIU United Healthcare Workers East and the 1199SEIU Training & Upgrading Fund who work in Massachusetts are **not eligible** for Benefit Fund Plan coverage. Instructors, tutors, teachers, assessors and proctors who work for the 1199SEIU Training & Upgrading Fund are **not eligible** for this Plan.

YOUR SPOUSE

Your **spouse** may be eligible if **all** of the following conditions are met:

- You and your spouse are legally married; or
- You are eligible for family coverage, based on your Wage Class (see Section I.D); and
- You have provided documents as requested by the Benefit Fund.

If you and your spouse are divorced or legally separated, your spouse cannot enroll in the Benefit Fund. Benefit Fund coverage of a spouse ends upon legal separation or divorce except to the extent your spouse timely elects and pays for COBRA continuation coverage (see Section I.K).

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

YOUR CHILDREN

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

- They are your biological children; or
- They are your legally adopted children (coverage for legally adopted children starts from placement); or
- You are their legal parent identified on their birth certificate; and
- You have provided updated information about their coverage under other benefit plans as requested by the Fund; 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. A child of your spouse cannot be covered by the Benefit Fund unless you are the child's legally recognized parent or the child is legally adopted by you or placed for adoption with you.

CHILDREN WITH DISABILITIES

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

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

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

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

SECTION I. B

WHEN YOUR COVERAGE BEGINS

IF YOU ARE A NEW EMPLOYEE

You can start receiving benefits from the Benefit Fund after **all** of the following conditions are met:

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

IF YOU ARE A NEWLY ORGANIZED EMPLOYEE

Your coverage begins after **all** of the following conditions are met:

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

IF YOU CHANGE JOBS OR RETURN TO WORK AFTER A LEAVE

If you stop working in Covered Employment and then begin working again in Covered Employment, or return to work for a Contributing Employer after the last day of an employment leave with Benefit Fund coverage:

- **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 returned to Covered Employment; or
- **After six months**, you must meet the same requirements as a new employee.

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

IF YOU HAVE FAMILY COVERAGE

Coverage for your spouse and/or your children starts at the same time your coverage begins if **all** of the following conditions are met:

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

NOTE: You are eligible for Disability Benefits after four 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** (to enroll yourself), a **Life Insurance Beneficiary Selection Form** (to designate your beneficiary) and **Coordination of Benefits forms** (to enroll your dependents). Send them to the 1199SEIU Family of Funds' Eligibility Department before you will be eligible for benefits.

To enroll in the Benefit Fund:

1. Get these forms from the Benefit Fund by calling the Member Services Department at (646) 473-9200, or by clicking on the link to My Account when visiting **www.1199SEIUBenefits.org**.
2. Fill out the forms completely.

These forms 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 family member you wish to enroll
- The name and address of your designated life insurance beneficiary

- Your spouse's Employer
 - Information on other insurance coverage
3. Sign and date the completed forms.
 4. 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.
 5. Send the completed forms and any related documents to the 1199SEIU Family of Funds' Eligibility Department *immediately*.

The Benefit Fund will not be able to process your forms if you do not include all the information and documents required. That means you will not be eligible to receive benefits. Members have to sign forms in order to enroll their spouse and/or dependents. However, a custodial parent, legal guardian or authorized state agency may apply for Fund coverage of your children, even if you do not, if the Plan Administrator has qualified a Medical Child Support Order (QMCSO) directing enrollment.

LET THE BENEFIT FUND KNOW OF ANY CHANGES

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

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

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

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

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

- Birth certificate(s) if you are adding your child(ren)
- Adoption papers if you are adding your child(ren)
- A marriage certificate if you are adding your spouse
- Separation or divorce papers if you are legally separated or divorced

- Any other documents required by the Benefit Fund

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

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

NOTE ABOUT NEWBORN CHILDREN:

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

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

SECTION I. 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”).

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 MORE THAN ONE CONTRIBUTING EMPLOYER

Your earnings from all Contributing Employers are combined to determine your Wage Class.

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 1199SEIU League Training and Upgrading Fund or the 1199SEIU League Job Security Fund.

NEW YORK CITY EMPLOYEES

If you are an employee of 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;
- Hearing aids;
- Dental care;
- Prescription drugs;
- Disability;
- Life insurance;
- Accidental death and dismemberment;
- Burial (if available);
- 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.

NOTE: Certain retirees of New York City Employers may be eligible for Retiree Health Benefits, as described in Section VI.A.

HOW YOUR WAGE CLASS IS CALCULATED

Your Employer reports your earnings to the Benefit Fund. To determine your Wage Class, the Benefit Fund averages your weekly earnings over a 16-week testing period. Your **Average Weekly Earnings** are then compared to wage levels stated in the Collective Bargaining Agreement with your Employer.

If there is a change in your Wage Class, your Wage Class will be immediately adjusted, retroactive to the date of the earnings period submitted by your Employer.

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

YOUR WAGE CLASS DETERMINES WHO IS ELIGIBLE...

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

If you are in Wage Class III, only you (the member) can receive benefits. Your spouse 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 Wage Class I and Wage Class II Benefits.
See page 22 for an Overview of Wage Class III Benefits.

SECTION I. E

YOUR ID CARDS

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

- **An 1199SEIU Health Benefits ID card** for your Medical and Prescription Benefits; and
- **A Dental Benefits ID card** for your Dental Benefit.

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

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

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

Your ID 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 Fund benefits. If you do, the Fund will deny payment and you may be personally responsible to the provider for the charges. If the Fund has already paid for these benefits, you will have to reimburse the Fund. The Fund may deny benefits to you and your eligible dependents and/or may initiate civil or criminal actions against you until you repay the Fund.

If you suspect that someone is using an 1199SEIU Health Benefits ID card fraudulently, call the Fund's Fraud and Abuse Hotline at (646) 473-6148.

SECTION I. F

COORDINATING YOUR BENEFITS

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

Here's how it works:

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

If the Benefit Fund is:

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

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

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

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

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

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

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

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

For your care:

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

For your spouse's care:

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

For your child's care:

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

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

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

Your spouse must:

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

WHEN CHILDREN ARE COVERED BY BOTH PARENTS

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

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

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

In the case of a divorce or legal separation, these rules will continue to apply.

WHEN YOUR SPOUSE OR CHILD IS COVERED BY AN IN-NETWORK-ONLY PLAN

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

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

WHEN YOU ARE COVERED BY MEDICARE

The Benefit Fund is the **primary payer** for working members and their spouses age 65 or older 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 must sign up for Medicare Part A and Part B as well. That way, Medicare will become your **secondary payer.**

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

WHEN YOU, YOUR SPOUSE OR YOUR CHILD IS COVERED BY NO-FAULT INSURANCE

If you, your spouse and/or your child sustains injuries in an accident involving a motor vehicle, including cars, buses, school buses, taxis, and fire and police vehicles, 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 your health insurance protection, even if you, your spouse or your child selects secondary coverage under the motor vehicle insurance policy.

MEDICARE AND END-STAGE RENAL DISEASE (ESRD)

A person with end-stage renal disease (ESRD) will be entitled to Medicare Benefits. **Initially, during the Medicare Coordination Period, the Benefit Fund will be the primary payer of benefits. Thereafter, the Benefit Fund will be secondary to Medicare.**

To protect your benefits, you must enroll in Medicare Part A and Part B during the Medicare Coordination Period, and you must maintain Medicare coverage prior to and after your transplant as required by law, unless you have verified that the Fund is your primary insurer. The Fund will provide reimbursement for 50% of the standard Medicare Part B premium for

months where the Fund is secondary to Medicare. You are **not eligible** for this reimbursement for any month in which the Fund is providing primary coverage. To get this benefit, you must file a claim form with the Benefit Fund once each quarter but no later than two years after the premium payment.

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

SECTION I. G

WHEN OTHERS ARE RESPONSIBLE FOR YOUR ILLNESS OR INJURY

If someone else is responsible for your illness or injury, for example, because of an accident or medical malpractice, you may be able to recover money from that person or entity, their insurance company, an uninsured motorist fund, a no-fault insurance carrier or a Workers' Compensation insurance carrier.

Expenses such as disability, hospital, medical, prescription or other services resulting from such an illness or injury caused by the conduct of a third party are *not covered* by this Plan.

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

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

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

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

eligibility for benefits or bring a court action against you to enforce the terms of the Plan.

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

WHEN MOTOR VEHICLE OR NO-FAULT INSURANCE PROVIDES COVERAGE

This provision is expressly intended to avoid the possibility that 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, if you become disabled as a result of a motor vehicle accident, the Benefit Fund will be the **primary payer** for Disability Benefits, which will be paid at the statutory disability rate.

NOTE: All remedies and appeals must be exhausted through your no-fault insurance carrier before the Benefit Fund will consider any payments on a primary basis. All payments advanced by the Benefit Fund for medical expenses and disability benefits resulting from a motor vehicle accident are subject to the Fund’s first right of recovery described above. You are obligated to reimburse the Benefit Fund for any medical expenses and disability benefits 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 statutorily required no-fault insurance.

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

SECTION I. H

WHEN YOU ARE ON WORKERS' COMPENSATION LEAVE

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

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

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

However, the Benefit Fund will:

- Continue to cover you and your family for benefits **not related to the job accident, injury or illness** while you are receiving Workers' Compensation Benefits, up to a maximum of 26 weeks leave within a 52-week period.
- Advance you 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 Fund has advanced you Disability Benefits, you must repay the Fund from those benefits.

- Pay you the difference in Disability Benefits if the amount paid in lost wage replacement benefits by Workers' Compensation is less than the Disability Benefit you would have received from the 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 (see Section I.I). However, you may be eligible to receive certain benefits under COBRA continuation coverage (see Section I.K).

NOTIFY THE BENEFIT FUND

In addition to notifying your Employer, you need to contact the Benefit Fund within 30 days when you are not working due to a work-related illness, injury or quarantine. Call the Member Services Department at (646) 473-9200 to find out which forms need to be filed with the 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 Fund does not know that you are out on Workers' Compensation Leave.

See Section III for more information.

SECTION I. I

WHEN YOUR BENEFITS STOP

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

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

** This may include contributions based on family leave, 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 provide health 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 may be terminated or reduced.

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

IF YOU ARE ON DISABILITY LEAVE, PAID FAMILY LEAVE, FAMILY MEDICAL LEAVE OR WORKERS' COMPENSATION LEAVE

Unless you return to work immediately, all of your Benefit Fund coverage will end 30 days after:

- The last day of your Benefit Fund Disability Benefits and/or Paid Family Leave Benefits (up to a combined maximum of 26 weeks leave within a 52-week period);

- The last day of your Family Medical Leave (up to a maximum of 12 weeks leave); or
- The last day of your Workers' Compensation Benefits (up to a maximum of 26 weeks leave within a 52-week period).

However, if you are covered by Medicare as of the last day of your Disability Leave or Workers' Compensation Leave (up to a maximum of 26 weeks leave within a 52-week period), or the last day of your Family Leave, then there shall be no 30-day extension, and your Benefit Fund coverage will end immediately on that date.

If you are unable to return to work when your Benefit Fund coverage ends, call the Benefit Fund's COBRA Department at (646) 473-6815.

See Section I.K for more information on COBRA continuation coverage.

NOTE: If your Benefit Fund coverage ends, it will not begin again until you return to work for a Contributing Employer (see Section I.B), regardless of the status of your employment leave.

OTHER COVERAGE OPTIONS FOR YOU AND YOUR FAMILY

There may be other coverage options for you and your family when you lose group coverage under the Benefit Fund. **Under the Affordable Care Act, within 60 days from the date your coverage ended or during any open enrollment period, you and**

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

WHEN YOU RETURN TO WORK

If you stop working in Covered Employment and then begin working again in Covered Employment, or return to work for a Contributing Employer after the last day of an employment leave with Benefit Fund coverage:

- **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 returned to Covered Employment; or
- **After six months**, you must meet the same requirements as a new employee.

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

UPON YOUR DEATH

Your spouse and eligible children will continue to receive benefits:

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

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

SECTION I. J

CONTINUING YOUR COVERAGE

WHILE RECEIVING UNEMPLOYMENT INSURANCE

Beyond the dates described in Section I.I, the Benefit Fund may provide you with extended benefits for one additional month for each full year you were covered by the Fund, up to a maximum of six 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.

For the purposes of this section, the number of years you were covered by the Benefit Fund is calculated from when you were last considered a new employee under Section I.B.

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 Training and Upgrading Fund, call (212) 643-9340 or visit our website at www.1199SEIUBenefits.org.

WHILE COVERED BY THE JOB SECURITY FUND

You may continue to be covered by the Benefit Fund if you receive benefits from the 1199SEIU League Job Security Fund, which makes contributions on your behalf.

WHILE TAKING FAMILY AND MEDICAL LEAVE (FMLA)

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

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

- The birth of your child and to care for the baby within one year of birth
- When you adopt a child or become a foster parent within one year of placement
- When you need to care for your spouse, your child or your parent who has a serious health condition (but not your parent-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 workweeks of unpaid leave during a 12-month period.

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

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

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

NOTE: Your Employer — not the Benefit Fund — has the sole responsibility for determining whether you are granted leave under FMLA. If you are eligible for leave under FMLA during the same period of time you take a Paid Family Leave or Disability Leave, depending on your Employer’s policy, your leave may also be designated as FMLA Leave, and in that case, will run concurrently with Paid Family Leave or Disability Leave.

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

WHILE TAKING UNIFORMED SERVICES LEAVE

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

If you take a leave of absence under USERRA, health 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 continuation coverage provisions.

When you are discharged from service in the uniformed services (not less than honorably), your full eligibility will be reinstated on the day you return to work with a Contributing Employer, provided that you return to work: within 90 days from the date of discharge if the period of military service was more than 181 days; or within 14 days from the date of discharge if the period of military service was more than 30 days but less than 180 days; or at the beginning of the first full regularly scheduled working period on the first calendar day following discharge if the period of military service was less than 31 days. If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended for up to 24 months. Call the Benefit Fund at (646) 473-9200 if you have any questions regarding coverage during a military leave.

The Benefit Fund may apply exclusions and/or waiting periods permitted by law, including for any disabilities that the Veterans Administration (“VA”) has determined

to be service-related. This includes any injury or illness found by the VA to have been incurred in, or aggravated during, the performance of service in the uniformed services.

WHILE TAKING DISABILITY, PAID FAMILY OR WORKERS’ COMPENSATION LEAVES

You may continue to be covered by the Benefit Fund during your qualified Disability, Paid Family or Workers’ Compensation Leaves (see Section III).

WHEN YOUR COVERAGE WOULD OTHERWISE END

After your coverage under the Benefit Fund would otherwise end, in certain circumstances, you may continue to be covered by the Fund on a self-pay basis under the federal law commonly known as COBRA (see Section I.K).

SECTION I. K

YOUR COBRA RIGHTS

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

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

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

If you elect to continue your coverage, you, your spouse and your eligible children will receive the same health coverage that you were receiving right before you lost your coverage. This may include hospital, medical, surgical, dental, vision and prescription drug coverage.

However, note that life insurance, accidental death and dismemberment, and burial are **not covered** by COBRA continuation coverage.

A child born to you or placed for adoption with you while you are receiving COBRA continuation coverage will also be covered for benefits by the Benefit Fund. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the child's birth or adoption).

WHEN AND HOW LONG YOU ARE COVERED

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

18 MONTHS OF COVERAGE FOR YOU, YOUR SPOUSE AND YOUR ELIGIBLE CHILDREN

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

- The number of hours you work is reduced, resulting in a change in your Wage Class; or

- Your employment terminates for reasons other than gross misconduct on your part.

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

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

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

36 MONTHS OF COVERAGE FOR YOUR SPOUSE

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

- You die (unless you were a member retiring on or after October 1, 1998 — see Section VI);
- You and your spouse become divorced or legally separated; or

- You become entitled to Medicare.

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

36 MONTHS OF COVERAGE FOR YOUR ELIGIBLE CHILDREN

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

- You die;
- Your child is no longer an eligible dependent; or
- You become entitled to Medicare.

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

EXTENDED COVERAGE

Second Qualifying Event Extension

Additional qualifying events can occur while COBRA continuation coverage is in effect. If your family experiences another qualifying event while receiving 18 months (or in the case of a Disability extension, 29 months) of COBRA continuation coverage, your spouse and children receiving COBRA continuation coverage can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Benefit Fund.

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

- You die;
- You become entitled to Medicare;
- You and your spouse become divorced or legally separated; or
- Your child is no longer an eligible dependent;

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, through this SPD or the COBRA notice, of the responsibility to notify the Plan and the procedures for doing so.

Uniformed Services Leave Extension

If you take a leave of absence under USERRA (see Section I.J) and are on active duty for 31 days or more, you, your spouse and your eligible children may have the right to elect COBRA continuation coverage for a maximum of 24 months while you are on active duty.

Disability Extension

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

The continuation period will not extend past the last day of the next calendar month after the SSA determines that you, your spouse or your child is no longer disabled.

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

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

- The date of the Social Security Disability determination;
- The date of the qualifying event;

- The date on which the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event; or
- The date on which the qualified beneficiary is informed of the responsibility to provide the plan notice of the Social Security Disability determination, but before the end of the first 18 months of COBRA continuation coverage.

YOU MUST NOTIFY THE BENEFIT FUND TO OBTAIN COBRA CONTINUATION COVERAGE

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

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

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

- The date of the qualifying event;
- The date on which the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event; or
- The date on which the qualified beneficiary is informed, through this SPD or the COBRA notice, of the responsibility to notify the Plan and the procedures for doing so.

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 eligible children.

If you decide to elect COBRA coverage, you, your spouse or your children must 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 **COBRA Election Form** must be:

- Actually received by the Benefit Fund on or before the 60-day period noted in this section; or

- Mailed to the Benefit Fund at PO Box 1036, New York, NY 10108-1036, and postmarked on or before the 60-day period noted in this section.

If you, your spouse or your dependent children do not elect COBRA continuation coverage in a timely manner, your group health coverage under the Fund will end as described in Section I.I, and you will lose your right to elect continuation coverage.

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

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

COST OF COBRA COVERAGE

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

WHEN COBRA COVERAGE ENDS

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

- Your Employer ceases to be a Contributing Employer to the Benefit Fund, except under circumstances giving rise to a qualifying event for active employees;
- The Benefit Fund is terminated;
- Your premium for your coverage is not paid on time (within any applicable grace period);
- You, your spouse or your children get coverage under another group health plan that does not include a pre-existing condition clause that applies to you, your spouse or your children (as applicable);
- Your end-stage renal disease (ESRD) Medicare Coordination Period ends;
- A qualified beneficiary becomes entitled to Medicare; or
- Coverage has been extended for up to 29 months due to a disability but there has been a final determination that the qualified beneficiary is no longer disabled.

Continuation coverage may also be terminated for any reason the Benefit Fund would terminate coverage of a

participant or beneficiary not receiving continuation coverage (such as fraud or changes in the Plan's eligibility requirements). The Plan Administrator reserves the right to end your COBRA continuation coverage retroactively if you are found to be ineligible for coverage.

You must notify the Benefit Fund within 30 days of any change in your Medicare, SSA or group health plan status. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event.

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

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

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

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

Remember to notify the Benefit Fund *immediately* if:

- You get married
- You get divorced or legally separated
- You or your spouse move
- 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 to the insurance administrator 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

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- B. Using Your Benefits Wisely
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 - Program for Behavioral Health
 - Emergency Departments Are for Emergencies
 - Care Management Program
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 - Wellness and Disease Management Programs
- C. Hospital Care and Hospice Care
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HEALTH BENEFITS RESOURCE GUIDE

HOW TO REACH THE FUND

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

WHERE TO CALL

For Member Services

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

Also call for:

- A list of Participating Providers in your area
- A list of Participating Hospitals in your area
- A Schedule of Allowances for Non-participating Providers
- A list of Participating Dentists in your area
- A list of Participating Pharmacies in your area
- A list of Preferred Drugs, also known as a Preferred Drug List (PDL)

For Ambulatory/Outpatient Surgery Pre-certification

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

For Prior Authorization

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

- You have questions about the treatment your doctor is recommending
- You require home care services
- You require certain radiological tests
- You need Prior Authorization for certain medications, including specialty drugs

For the Prenatal Program

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

HEALTH BENEFITS RESOURCE GUIDE

For the Program for Behavioral Health

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

For Inpatient Hospital Stays

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

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

HEALTH BENEFITS RESOURCE GUIDE

REMINDERS

- If you use a Non-participating Provider, you can be billed the difference between the Benefit Fund's allowance and whatever the provider normally charges, which could result in a significant cost to you. Also, a Non-participating Provider cannot file a lawsuit on your behalf more than three years from the date of service.
- You must call 1199SEIU CareReview to Pre-certify your hospital stay **before** going to the hospital for non-Emergency care, or **within two business days** of an Emergency admission.
- Use the Emergency Department only in the case of a **legitimate medical Emergency**. If it is an Emergency, your Emergency Department visit must be **within 72 hours** of an accident, injury, or the onset of a sudden and serious illness.
- Show your 1199SEIU Health Benefits ID card when you go to the Emergency Department or when you are admitted to the hospital. The Benefit Fund will pay the hospital directly.
- If you are pregnant, register with the Benefit Fund's Prenatal Program.
- You must call the Prior Authorization Department to get certain services and supplies approved **in advance**. The Benefit Fund will pay only for Medically Necessary services.
- Show your 1199SEIU Health Benefits ID card to the pharmacist when you have a prescription filled.

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

QUALITY CARE ASSESSMENT

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

SECTION II. A

PARTICIPATING PROVIDERS

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 network hospital-based lab), certain radiology (X-ray) facilities and certain durable medical equipment vendors as **preferred**. You must use these Participating Providers to avoid out-of-pocket expenses and to help control costs.

Participating Providers:

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

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

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

The Benefit Fund has designated certain laboratory facilities (including your network hospital-based lab), certain radiology (X-ray) 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 radiological tests, please call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org for the listing and locations of these facilities.

HOW IT WORKS

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

If your doctor is unavailable, you can use the Benefit Fund's telehealth provider to visit Participating Providers by phone or video.

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

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

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

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

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

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

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

SECTION II. B

USING YOUR BENEFITS WISELY

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

1199SEIU CAREREVIEW PROGRAM

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

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

Call the 1199SEIU CareReview Program at (800) 227-9360.

Pre-certification is a review of Medical Necessity of Covered Services only. Pre-certification of the above services does not mean you are eligible on the date of service or that a Non-participating Provider will accept the Benefit Fund's payment as payment in full.

WHEN YOU USE NON-PARTICIPATING PROVIDERS

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

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

Questions?

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

NON-EMERGENCY TREATMENT CAN BE COSTLY TO YOU

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

For non-Emergency treatment, you will be responsible for the difference between some of the Benefit Fund's payment and the actual cost of the care you receive in the Emergency Department — 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 and your family receive behavioral health care. **All calls and treatment information are kept strictly confidential. To Pre-certify Partial Hospitalization Program and Intensive Outpatient Program services, you must call the Benefit Fund at (646) 473-6868.**

To Pre-certify inpatient mental health or alcohol/substance abuse treatment, you must call 1199SEIU CareReview at (800) 227-9360 before going to the hospital for inpatient care.

EMERGENCY DEPARTMENTS ARE FOR EMERGENCIES

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

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

If you or your covered family require ongoing medical treatment from a catastrophic or severe illness or injury, including after-hospital care, the Care Management ("CM") staff may consult with your doctor and/or hospital during the planning of Medically Necessary and appropriate care. CM works with you and your doctors to optimize your treatment plan to delay the onset of complications from chronic conditions. CM aims to coordinate your care under the terms of the Plan to help ensure utilization of Covered

Services by Participating Providers to minimize out-of-pocket costs.

Information related to CM is strictly confidential.

UTILIZATION REVIEW

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

The review process can be:

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

PRENATAL PROGRAM

Having a Healthy Baby

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

WELLNESS AND DISEASE MANAGEMENT PROGRAMS

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

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

PREFERRED LABORATORY FACILITIES

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

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

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

PREFERRED RADIOLOGY (X-RAY) FACILITIES

Prior Authorization is required for certain high-end imaging tests (such as MRI, MRA, PET scans, CAT scans) and certain nuclear cardiology tests. If your doctor prescribes one of these tests, you or your doctor must call (888) 910-1199 for Prior Authorization. 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 One Call Care Management at (800) 398-8999 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.

RADIATION THERAPY

Prior Authorization is required for radiation therapy services. Your doctor must call (888) 910-1199.

PREFERRED DURABLE MEDICAL EQUIPMENT (DME) VENDORS

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

CERTAIN OUTPATIENT LABORATORY PROCEDURES

Prior Authorization is required for certain outpatient laboratory services, such as molecular, genomic and other diagnostic tests. A list of certain outpatient laboratory procedures and tests that require Prior Authorization can be found on the Benefit Fund's website at **www.1199SEIUBenefits.org** under the "For Providers" tab. If your doctor prescribes one of these tests, your doctor or the laboratory must call (888) 910-1199 for Prior Authorization. In addition, Prior Authorization may be requested by your provider by logging into the "Portal Login" at www.Evicore.com.

See Section II.I for more information on Prior Authorization. Other benefits may also require Prior Authorization, so please refer to the sections describing those specific benefits for more information.

SECTION II. C

HOSPITAL CARE AND HOSPICE CARE

BENEFIT BRIEF

Inpatient Hospital Care

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

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

Outpatient Hospital Care

- Ambulatory care
- Observation care and services

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

Wage Class I: Family Coverage

Wage Class II: Family Coverage

Wage Class III: Not Covered

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, as described in this section. If you are in Wage Class III, you, your spouse and your children are **not covered** for this benefit. See Section V.D for a description of Wage Class III Benefits.

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 per calendar year, in a semi-private room in a hospital, if Medically Necessary to treat your medical condition. If you need hospital care, you must:

- Call the 1199SEIU CareReview Program at (800) 227-9360; and
- Show your 1199SEIU 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 1199SEIU CareReview, the Benefit Fund's designated agent, if your doctor feels a longer hospital stay is needed.

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

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

CARE COVERED

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

These may include:

- Room and board, including special diets
- Use of operating and cystoscopic rooms and equipment

- Lab work that is needed for the diagnosis and treatment of the condition for which you are in the hospital, including pre-admission testing within seven days of the admission
- X-rays that are needed for the diagnosis and treatment of the condition for which you are in the hospital, including pre-admission testing within seven days of admission
- Use of cardiographic equipment
- Use of physiotherapeutic and X-ray therapy equipment
- Oxygen, and use of equipment for administering oxygen
- A fee for administration of blood for each hospital stay
- Recovery room charges for care immediately following an operation

ACUTE INPATIENT REHABILITATION

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

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

ELECTIVE/SCHEDULED ADMISSIONS

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

OUTPATIENT OBSERVATION CARE AND SERVICES

Observation Care Benefits cover Medically Necessary services before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient or if 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 Benefit Fund will reimburse the member directly for reasonable costs of Medically Necessary services rendered outside of the country. The member must provide proof of payment, an itemized bill and other pertinent information, which may include a copy of the member's passport or airline tickets, and a certified translation, if requested by the Fund.

PAYMENT TO A HOSPITAL

The Benefit Fund has negotiated rates with many hospitals in the metropolitan New York area. These are called **Participating Hospitals**.

When you go to our network of Participating Hospitals 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 a large out-of-pocket cost for the balance of the hospital bill.

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

WHAT IS NOT COVERED

The Benefit Fund **does not cover**:

- Admissions for cosmetic services
- Care or service in a nursing home, skilled nursing facility, rest home or convalescent home
- Custodial care or sub-acute care in a hospital, skilled nursing facility or any other institution

- Hospitalization covered under federal, state or other laws, except where otherwise required by law
- Personal or comfort items
- Private rooms
- Rest cures
- Services related to a claim filed under Workers' Compensation
- Services that are not Medically Necessary
- Services that are not pre-authorized in accordance with the terms of the Plan
- 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.

BENEFIT BRIEF

Inpatient and Outpatient Hospice Care

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

Wage Class I: Family Coverage

Wage Class II: Family Coverage

Wage Class III: Not Covered

HOSPICE CARE

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered for hospice care, as described in this section. If you are in Wage Class III, you, your spouse and your children are **not covered** for this benefit. See Section V.D for a description of Wage Class III Benefits.

Hospice care is a type of care and a philosophy of care that focuses on bridging comfort and relief of symptoms to patients nearing the end of life. The Benefit 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 received during a stay for pain control and other acute and chronic symptom management

- Services and supplies given to you on an outpatient basis
- Part-time or intermittent nursing care by an RN (Registered Nurse) or LPN (Licensed Practical Nurse) for up to eight hours a day
- Part-time or intermittent home health aide services for up to eight hours a day
- Physical and occupational therapy
- Consultation or case management services by a physician
- Psychological counseling
- Respite care (care received during a period of time when your family or usual caretaker cannot attend to your needs)

WHAT IS NOT COVERED

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

- Bereavement counseling
- Daily room and board charges over the semi-private room rate
- Financial or legal counseling, including estate planning and the drafting of a will
- Funeral arrangements
- Homemaker or caretaker services (services that are not solely related to your care; these may include, but are not limited to, transportation, sitter or companion services, or maintenance of your residence)
- Pastoral counseling

- Services that were not pre-authorized (see Section II.I)

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

SECTION II. D

EMERGENCY DEPARTMENT VISITS

BENEFIT BRIEF

Emergency Department Visits

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

- Use of the Emergency Department must be **within 72 hours** of an accident, injury, or the onset of a sudden and serious illness
- Benefit Fund pays negotiated rate at Participating Hospital or reasonable charge at Non-participating Hospital

Wage Class I: Family Coverage

Wage Class II: Family Coverage

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 Emergency Department care, as described in this section. If you are in Wage Class III, you, your spouse and your children are **not covered** for this benefit. See Section V.D for a description of Wage Class III Benefits.

The Benefit Fund has negotiated Emergency Department rates with many hospitals in the metropolitan New York area. If you go to the Emergency Department of a Participating Hospital, you will have no out-of-pocket cost for the hospital's charge for the use of its facility.

EMERGENCY DEPARTMENTS ARE FOR EMERGENCIES

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

When you go to the Emergency Department, you must:

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

If you go to the Emergency Department in a hospital with which the Benefit Fund does not have an Emergency Department contract, you may incur out-of-pocket costs.

If you have any questions about a bill for Emergency Department treatment, call the Benefit Fund's Member Services Department at (646) 473-9200.

NON-EMERGENCY TREATMENT CAN BE COSTLY TO YOU

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

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

CALL YOUR DOCTOR FIRST

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

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

If you do not have a Primary Care Doctor or cannot reach your doctor, call (646) 473-9200 during the Benefit Fund's normal working hours for a referral to a Participating Provider. For accidents, injuries and illnesses that aren't life threatening, go to a participating urgent care center, or use the Benefit Fund's telehealth provider to visit board-certified doctors and pediatricians by phone or video, 24 hours a day, 7 days a week.

SECTION II. E

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

BENEFIT BRIEF

Inpatient Mental Health

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

Inpatient Alcohol/Substance Abuse

- Medically Necessary services for inpatient detoxification and rehabilitation

Outpatient Mental Health and Alcohol/Substance Abuse

- Outpatient visits
- Intensive Outpatient Programs

Wage Class I: Family Coverage

Wage Class II: Family Coverage

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 inpatient and outpatient mental health treatment, and inpatient and outpatient alcohol/substance abuse treatment, as described in this section. If you are in Wage Class III, you, your spouse and your children are **not covered** for this benefit. See Section V.D for a description of Wage Class III Benefits.

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

GET THE HELP YOU NEED

If you or a family member is struggling with stress, anxiety, relationship or family problems, emotional difficulties, work pressures or alcohol/substance abuse, you have options to get help. All information is kept strictly confidential in accordance with privacy law.

You can call the Benefit Fund's Member Assistance Program to help you and your family receive treatment for alcohol/substance abuse or mental health problems. The Benefit Fund's social workers will discuss your problems and concerns with you, and refer you to appropriate resources and licensed professionals as needed. Call the Member Assistance Program at (646) 473-6900.

You can also connect with a counselor, therapist, psychologist or psychiatrist by phone or video to get the help you need. To access this benefit, check with your Participating Provider for more information, or if you are age 18 or older, use the Benefit Fund's telehealth provider, available 7 days a week.

NOTE: Telehealth should not be used for emergency medical situations.

MENTAL HEALTH BENEFITS

Outpatient Care

- Outpatient visits
- Intensive Outpatient Programs
- Physical/Occupational/Speech therapy for conditions associated with autism or developmental delay

Inpatient Care

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

ALCOHOL/SUBSTANCE ABUSE BENEFITS

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

Outpatient Care

- Outpatient visits
- Intensive Outpatient Programs

Inpatient Care

- Medically Necessary services for inpatient detoxification and rehabilitation

PARTIAL HOSPITALIZATION PROGRAMS (PHP) FOR MENTAL HEALTH AND INTENSIVE OUTPATIENT PROGRAMS (IOP) FOR MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE

PHPs and IOPs provide intermediate levels of coordinated care and can help prevent hospitalizations and restore maximum function in a clinically appropriate setting. To Pre-certify these services, call the Fund at (646) 473-6868.

IF YOU NEED TO GO TO THE HOSPITAL

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

- **Before** going to the hospital for non-Emergency care (to Pre-certify your hospital stay); or
- **Within two business days** of an Emergency admission.

If you need hospital care, the 1199SEIU CareReview staff will authorize your hospital stay and may refer you to the Benefit Fund for additional follow-up.

In the case of an Emergency admission, you or a member of your family must call 1199SEIU CareReview **within two business days.**

YOUR RIGHTS UNDER THE MENTAL HEALTH PARITY ACT

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

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

SECTION II. F

SURGERY AND ANESTHESIA

BENEFIT BRIEF

Surgery and Anesthesia

- Inpatient or outpatient (ambulatory) surgery
- Anesthesia

Wage Class I: Family Coverage

Wage Class II: Family Coverage

Wage Class III: Not Covered

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered if you have surgery, as described in this section. If you are in Wage Class III, you, your spouse and your children are **not covered** for this benefit. See Section V.D for a description of Wage Class III Benefits.

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

SURGERY

You are covered for surgery when performed:

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

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

YOUR BENEFIT IS DETERMINED BY THE TYPE OF SURGERY YOU NEED

The Benefit Fund can only pay up to a certain amount for each type of surgical procedure. Your benefit is the 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 Fund allowance for all your procedures will be determined based upon the Fund's allowance and its claims processing rules for multiple or related operations.

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

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

Assistant Surgeon

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

- No surgical residents were available; and
- Use of the assistant surgeon was Medically Necessary.

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, ambulatory care center or office-based surgery suite. If your procedure can be safely performed in one of these settings, you must have it performed on an ambulatory or outpatient basis, and the Benefit Fund will cover the procedure under the terms of this Plan.

If the procedure is performed in a hospital or ambulatory surgery center certified under Article 28 of the New York Public Health Law, the Benefit Fund also pays for:

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

NOTE: The Fund does not cover operating room charges, or facility fees, to office-based surgery suites regulated under Section 230-d of the New York Public Health Law.

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

ANESTHESIA

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered if you need anesthesia, as described in this section. If you are in Wage Class III, you, your spouse and your children are **not covered** for this benefit. See Section V.D for a description of Wage Class III Benefits.

The amount of reimbursement for anesthesia under the Benefit Fund's Schedule of Allowances varies depending upon:

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

Coverage includes:

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

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

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

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

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

WHAT IS NOT COVERED

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

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

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

SECTION II. G

MATERNITY CARE

BENEFIT BRIEF

Maternity Care

- An allowance which includes all prenatal and postnatal visits and delivery charges
- Hospital Benefit for the mother, if the mother is you or your spouse
- Hospital Benefit for the newborn, if the mother is you or your spouse
- Lactation consulting by a certified provider
- Breast pump
- Disability Benefit for you, if you are the mother

Wage Class I: Family Coverage

Wage Class II: Family Coverage

Wage Class III: Not Covered

If you are in Wage Class I or Wage Class II, Surgical and Hospital Benefits are available for maternity care, as described in this section.

If you are the mother, you are covered for Disability Benefits, as described in this section.

If you are in Wage Class III, you, your spouse and your children are **not covered** for Maternity Care Benefits. See Section V.D for a description of Wage Class III Benefits.

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

FOR YOU OR 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;
- Hospital Benefit for the mother and newborn;
- Lactation consulting by a certified provider (up to three consultations per calendar year); and
- Rental of one hospital-grade breast pump (Prior Authorization required; for details, call the Benefit Fund at [646] 473-9200); or
- Reimbursement for one electric or manual retail breast pump (prescription required; for details, call the Benefit Fund at [646] 473-9200).

If you are the mother, 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.

FOR YOUR DEPENDENT CHILD

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

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

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

The Benefit Fund complies with federal law in that:

- A mother and their 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 their provider may still decide that the mother and newborn should be discharged before 48 (or 96) hours.

PRENATAL PROGRAM

Having a Healthy Baby

Complications can occur during your pregnancy that could lead to premature birth, low birth weight, birth defects or possibly even death for your baby. With regular prenatal care, which includes visits to your doctor and medical care you receive while you are pregnant, complications can be detected early and treated to reduce the risk of harming your baby.

Through the Benefit Fund's Prenatal Program, you can get important information, take part in practical workshops and receive supportive advice. You'll also learn about making healthier choices and get tips on what to expect during your pregnancy and on caring for your baby. **To participate in the Prenatal Program, register by calling (646) 473-8962 or register online at www.1199SEIUBenefits.org.**

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

SECTION II. H

MEDICAL SERVICES

BENEFIT BRIEF

Medical Services

- Treatment in a doctor's office, clinic, hospital, Emergency Department or your home
- Well-child care for dependent children
- Immunizations
- Acupuncture: up to 25 visits per year, when performed by a licensed medical physician or licensed acupuncturist
- Allergy: up to 20 visits per year, including up to two testing visits
- Chiropractic: up to 12 visits per year
- Dermatology: up to 20 visits per year
- Physical/Occupational/Speech therapy: up to 25 visits per discipline per year
- Podiatry: up to 15 visits per year for routine foot care
- X-rays and laboratory tests
- Durable medical equipment and appliances
- Hospice care
- Ambulance services

Wage Class I: Family Coverage

Wage Class II: Family Coverage

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, your spouse and your children are **not covered** for this benefit. See Section V.D for a description of Wage Class III Benefits.

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

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

PARTICIPATING PROVIDERS

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

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

GET THE CARE YOU NEED

Doctor Visits

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

A licensed medical provider must provide your care. Specialists must be board-certified or board-eligible in their area of specialty. You are also covered for telehealth and videoconferencing visits with Participating Providers.

For accidents, injuries and illnesses that don't need to be treated immediately, make an appointment with a Participating Doctor's office. If your doctor is unavailable, you can use the Benefit Fund's telehealth provider to visit board-certified doctors and pediatricians by phone or video, 24 hours a day, 7 days a week. For accidents, injuries and illnesses that need to be treated right away but aren't life threatening, if your doctor is not available, go to a participating urgent care center. To find a participating urgent care center, visit www.1199SEIUBenefits.org.

NOTE: Telehealth should not be used for emergency medical situations.

Therapy Visits

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

- **Acupuncture:** up to 25 visits per year, when performed by a licensed medical physician or licensed acupuncturist
- **Allergy:** up to 20 visits per year, including up to two testing visits
- **Chiropractic:** up to 12 visits per year
- **Dermatology:** up to 20 visits per year
- **Podiatry:** up to 15 visits per year for routine foot care
- **Physical/Occupational/Speech therapy:** up to 25 visits per discipline per year. Includes Habilitative and Rehabilitative Services.

If it is determined by the Benefit Fund that additional treatment is Medically Necessary and in compliance with the Fund's clinical guidelines, policies, protocols and procedures, the Fund may provide benefits for additional treatment. To be covered, these treatments must be authorized **in advance** by the Plan Administrator. Habilitative Services provided in an educational setting are **not covered**.

PREVENTIVE CARE

Regular medical checkups 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 easier to treat.
- **Immunizations**
Immunizations help protect your children against disease and are required for entrance into the public school system.
- **Well-child care**
Your dependent children are covered for regular exams.

X-RAY AND LABORATORY SERVICES

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

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

In order to avoid out-of-pocket costs, call the Benefit Fund at (646) 473-9200 or visit our website at 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. Your Primary Care Doctor gets to know you and your medical history, sees you when you are sick and provides regular checkups and immunizations.

This way, they are 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 freestanding labs in addition to your network hospital-based lab. You must use these providers to avoid out-of-pocket costs. If you require lab work:

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

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

PREFERRED RADIOLOGY (X-RAY) FACILITIES

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

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 One Call Care Management at (800) 398-8999 for a referral to a preferred radiology facility. All radiological tests must be performed by a radiologist or a non-radiology provider within the specialty for your particular test.

PREFERRED DURABLE MEDICAL EQUIPMENT (DME) VENDORS

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

HOSPICE CARE

Coverage for a combined total of up to 210 days per lifetime in a Medicare-certified hospice program in a hospice

center, hospital, skilled nursing facility or at home. See Section II.C for details. For Prior Authorization of inpatient hospice care, call 1199SEIU CareReview at (800) 227-9360. See Section II.I for details.

AMBULANCE SERVICES

The Plan covers Emergency transportation and services to the closest hospital where you can be treated in the case of an accident, injury, or the onset of a sudden and serious illness.

Ambulance transportation between hospitals, including air transportation where necessary, is covered to the closest acute care hospital where you can be treated, if you need specialized care that the first hospital cannot provide. Prior Authorization is required for transportation between hospitals.

For international air ambulance transportation, the closest acute care hospital will be in the same country or a neighboring country. The Benefit Fund does not cover ambulance transportation to a different hospital or back to the U.S. for the sake of patient or family preferences rather than medical necessity.

NOTE: If you use an international air ambulance transportation provider, you could face high out-of-pocket costs. Plan reimbursements are limited. Consider purchasing travel health insurance for overseas travel.

WHAT IS NOT COVERED

The Benefit Fund **does not cover:**

- Acupuncture when administered by anyone other than a licensed medical physician or licensed acupuncturist
- Air ambulance transportation to a facility that is not the nearest appropriate acute care hospital
- Charges for your co-payments
- Charges for telehealth services not provided in compliance with applicable state laws or the Benefit Fund's telehealth policy
- Charges in excess of the Benefit Fund's Schedule of Allowances
- Charges related to refractions when performed by an ophthalmologist
- Employment or return-to-work physicals
- Experimental, unproven or non-FDA-approved treatments, procedures, facilities, equipment, drugs, devices or supplies (see definition of "Experimental" and exceptions for clinical trials in Section IX)
- Habilitative Services (except physical, occupational or speech therapy)
- Habilitative Services provided in an educational setting
- Infertility treatment, including, but not limited to, in vitro fertilization, artificial insemination, embryo storage, cryosterilization and reversal of sterilization
- Laboratory tests that are not FDA-approved
- Private physicians when care is given in a government or municipal hospital
- Treatment for illness or injury covered by Workers' Compensation
- Treatment that is cosmetic in nature
- Treatment that is custodial in nature
- Treatment that is determined to be not Medically Necessary
- Venipuncture
- 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
- Long-term acute care hospital services
- Hospital transfer ambulance services
- Durable medical equipment and appliances
- Medical supplies
- Cellular and gene therapy
- Specific medications, including specialty drugs
- Certain radiological tests
- Certain outpatient laboratory procedures
- Radiation therapy and medical oncology services
- Hospice care
- Ambulatory surgery or inpatient admissions
- Certain mental health and alcohol/substance abuse services
- Certain infusion drugs administered on an outpatient basis

Wage Class I: Family Coverage

Wage Class II: Family Coverage

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, your spouse and your children are **not covered** for this benefit. See Section V.D for a description of Wage Class III Benefits.

Doctors and health professionals who are part of the Benefit Fund's Participating Provider programs accept the Fund's allowance as payment in full.

If you use a Non-participating Provider, you could face high out-of-pocket costs. You have to pay the difference between the Benefit Fund's allowance and whatever the provider normally charges. Prior Authorization reviews Medical Necessity of Covered Services only. Authorization of services does not mean a Non-participating Provider will accept the Benefit Fund's payment as payment in full. Before you receive services from a Non-participating Provider, you should ask the provider to find out the total Benefit Fund allowance for the planned service by calling (646) 473-7160, and to notify you of what your out-of-pocket expenses will be.

WHAT IS COVERED

To be covered, services in this section must be:

- Ordered by your physician;
- Medically Necessary to treat your condition;
- Not considered Experimental (see definition of “Experimental” in Section IX);
- In compliance with the Benefit Fund’s clinical guidelines, policies, protocols and procedures; and
- Authorized **in advance** by the Benefit Fund’s Prior Authorization Department.

In addition, new technology/treatment that requires Prior Authorization must offer a significant benefit or a cost-effective alternative over conventional treatment.

PRIOR AUTHORIZATION NEEDED

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

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

Prior Authorization determinations are not contracts or promises to pay benefits. For more information about

getting Prior Authorizations, see Section VII.A.

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

HOME HEALTH CARE

Home health care services will be covered up to the maximum amount of benefits available. This includes a combined total of up to 60 visits per calendar year for:

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

Coverage may be provided for private-duty skilled nursing care for up to an additional 120 hours per calendar year.

LONG-TERM ACUTE CARE HOSPITAL

Long-term acute care hospital services will be covered up to the maximum amount of benefits available, which is 60 days per calendar year. Call (646) 473-9200 for Prior Authorization.

HOSPITAL TRANSFER AMBULANCE SERVICES

Ambulance transportation between hospitals, including air transportation where necessary, is covered to the closest acute care hospital where you can be treated, if you need specialized care that the first hospital cannot provide.

NOTE: Even where authorized, international hospital-to-hospital transportation is only reimbursable at a limited rate, and to limited destinations.

DURABLE MEDICAL EQUIPMENT AND APPLIANCES

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

Equipment may be bought only if:

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

MEDICAL SUPPLIES

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

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

CELLULAR AND GENE THERAPY

The Plan covers cellular therapies and gene therapies approved by the Food and Drug Administration (FDA), which are medically needed to treat your disease and are received at a certified hospital or certified outpatient facility.

SPECIFIC MEDICATIONS

You must get Prior Authorization before benefits can be provided for certain prescriptions, including specialty drugs. Call CareContinuum at (877) 273-2122 if you require certain infusion drugs administered on an outpatient basis. Call eviCore healthcare at (888) 910-1199 if you require certain oncology infusion drugs administered on an outpatient basis.

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

For a list of these drugs, call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org. See Section II.L for details.

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

AMBULATORY SURGERY OR INPATIENT ADMISSIONS

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

CERTAIN RADIOLOGICAL TESTS

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

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 One Call Care Management at (800) 398-8999 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.

MENTAL HEALTH AND ALCOHOL/ SUBSTANCE ABUSE TREATMENT

Prior Authorization is required for Partial Hospitalization Programs (PHP) and transcranial magnetic stimulation (TMS) for mental health. Prior Authorization is also required for Intensive Outpatient Programs (IOP) and inpatient admissions for mental health and alcohol/substance abuse. PHPs and IOPs provide intermediate levels of coordinated care and can help prevent hospitalizations and restore maximum function in a clinically appropriate setting.

Physical/Occupational/Speech therapies beyond 25 visits per discipline per year for conditions related to autism and developmental delay must be authorized **in advance** by the Plan Administrator.

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

CERTAIN OUTPATIENT LABORATORY PROCEDURES

Prior Authorization is required for certain outpatient laboratory services, such as molecular, genomic and other diagnostic tests. A list of certain outpatient laboratory procedures and tests that require Prior Authorization can be found on the Benefit Fund's website at www.1199SEIUBenefits.org under the "For Providers" tab. If your doctor prescribes one of these tests, your doctor or the laboratory must call (888) 910-1199 for Prior Authorization. In addition, Prior Authorization may be requested by your provider by logging into the "Portal Login" at www.Evicore.com.

RADIATION THERAPY AND MEDICAL ONCOLOGY SERVICES

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

HOSPICE CARE

Hospice care coverage is provided for a combined total of up to 210 days per lifetime in a Medicare-certified hospice program in a hospice center, hospital, skilled nursing facility or at home. See Section II.C for details.

For Prior Authorization of inpatient hospice care, call 1199SEIU CareReview at (800) 227-9360.

Other benefits may require Prior Authorization. For more information, please refer to the Benefit Fund's website at **www.1199SEIUBenefits.org**, and select "Prior Authorization" under the "For Providers" tab.

SECTION II. J

VISION CARE AND HEARING AIDS

BENEFIT BRIEF

Vision Care

- One eye exam every two years
- One pair of eyeglasses every two years; In lieu of eyeglasses, one order of contact lenses every two years

Wage Class I: Family Coverage

Wage Class II: Family Coverage

Wage Class III: Coverage for Member Only

Hearing Aids

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

Wage Class I: Family Coverage

Wage Class II: Family Coverage

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 vision care, as described in this section. If you are in Wage Class III, **only you—not your spouse or children—** are covered for vision care, as described in this section. See Section V.D for a full description of Wage Class III Benefits.

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

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

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

VISION CARE

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

- One eye exam every two years; and
- One pair of eyeglasses every two years; In lieu of eyeglasses, one order of 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 vision program with your provider, you may incur out-of-pocket costs.

If you use a Participating Optometrist or Optician, and you incur a large out-of-pocket cost, call the Benefit Fund at (646) 473-9200 before you

pay for your exam, eyeglasses or contact lenses.

Certain Participating Vision Care Providers also provide hearing aids.

If You Use a Non-participating Provider

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

WHAT IS NOT COVERED

The Benefit Fund **does not cover**:

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

HEARING AIDS

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered for hearing aids once every three years. If you are in Wage Class III, you, your spouse and your children are **not covered** for this benefit. See Section V.D for a description of Wage Class III Benefits.

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

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

Co-payments may apply when you use Participating Providers.

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

SECTION II. K

DENTAL BENEFITS

BENEFIT BRIEF

Dental Benefits

- Coverage through a Plan Network for basic and preventive services, major restorative care and orthodontia treatment
- Annual benefit limits or network restrictions may apply
- Network Dentists bill the Benefit Fund's Plan Network Administrator directly and accept the Network Administrator's Schedule of Allowances as payment in full for Covered Services
- For certain upgrades and materials, co-payments may apply

Wage Class I: Family Coverage

Wage Class II: Not Covered

Wage Class III: Coverage for Member Only

If you are in Wage Class I, you, your spouse and your children are covered for Dental Benefits, as described in this section. If you are in Wage Class II, you, your spouse and your children are **not covered** for Dental Benefits. If you are in Wage Class III, **only you—not your spouse or children**— are covered for Dental Benefits, as described in this section. See Section V.D for a full description of Wage Class III Benefits.

Your dental benefits are provided through partnerships with the Benefit Fund's contracted Networks and their providers—either a Preferred Provider Organization (“PPO”) or a Dental Maintenance Organization (“DMO”). Benefits are paid according to the actual charges or the Plan Network Administrator's Schedule of Allowances, whichever is less. In the PPO, the maximum benefit is \$3,000 per person per year (excluding orthodontia and essential oral pediatric services).

The PPO maximum benefit is per calendar year, based on the date of treatment—not the date of payment or when your claim is filed.

Benefits in the DMO are not subject to the annual maximum, but only cover eligible services provided by Network Dentists that participate with the DMO Network Administrator.

All dental treatment is subject to the applicable 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 annual maximum benefit indicated in this section:

- 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.

MAJOR RESTORATIVE CARE

- Periodontics (treatment of gum disease): periodontal surgery subject to a three-year visit/quadrant limitation in the PPO, or a five-year limitation in the DMO;
- Endodontics (treatment of the tooth's nerve system);
- Removable prosthetics (partial and complete dentures), subject to a five-year limitation; and
- Crowns, fixed bridgework and other methods of replacing individual teeth, subject to a five-year limitation.

ORTHODONTICS

- Orthodontics (treatment and appliances to correct tooth misalignment) for eligible dependent children

- Benefits covered for limited, interceptive and comprehensive treatment
- Orthodontia treatment in the PPO is subject to lifetime maximums and treatment limitations, and must be pre-authorized by the Plan Network Administrator
- Orthodontia treatment in the DMO is limited to one course of treatment per lifetime

THE PRIOR AUTHORIZATION PROCESS

If your dentist is planning Major Restorative Care or Orthodontics, ask the Plan Network Administrator 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 receive a predetermination form which will indicate:

- What treatment will be covered, if any; and
- What the Plan Network Administrator will pay.

If the Plan Network Administrator authorizes the procedure, it will be covered based upon your continued eligibility throughout the period of treatment. You will be responsible for charges in excess of your applicable annual maximum or, for members in the DMO, for charges incurred by Out-of-Network Dentists.

IN CASE OF EMERGENCY

If you need Emergency treatment in your dentist's office, Prior Authorization is not required. Co-payments will apply, if applicable.

However, you must file the following information with the Plan Network Administrator together with the claim for benefits:

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

GETTING YOUR BENEFITS

When Using a Network Dentist

Network Dentists receive payment directly from the Plan Network Administrator. They have agreed to accept the Network Administrator's allowance as payment in full up to the applicable annual maximum for each individual.

Do not make any other payments to a Network Dentist without verifying them with the Network Administrator.

When Using an Out-of-Network Dentist

Members enrolled in the DMO are not eligible for reimbursement for services provided by Out-of-Network Dentists.

If you are in the PPO and use an Out-of-Network Dentist who does not participate with the Plan Network Administrator, you will be reimbursed up to the Network Administrator's Schedule of Allowances for Out-of-Network Dentists up to a maximum of \$3,000 per year.

The Network Administrator reimburses no more than its allowance or the provider's charge, whichever is less. You are responsible for the balance. Before you receive services from an Out-of-Network Dentist, you should make sure that the provider submits a form for Prior Authorization, if required, so the provider can notify you of what your out-of-pocket expenses will be.

To receive your benefits, you must pay the bill yourself and send a completed claim form to the Network Administrator for reimbursement. You must pay any charges not covered under the Schedule of Allowances.

Multiple Services or Multiple Dentists

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

The Network Administrator 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.

WHAT IS NOT COVERED

The Network Plans **do not cover:**

- Any dental treatment inconsistent with the Plan Network Administrator's approved protocols, procedures, restrictions and time limits
- Deep or intravenous conscious sedation and general anesthesia services in the PPO which are not performed by a board-certified or board-eligible oral surgeon, or a dental anesthesiologist
- Dental treatment of temporomandibular joint (TMJ) disorder in the PPO
- Emergency Department differential charges for non-Emergency treatment
- Implants and services, supplies, appliances or restorations incurred in connection with implants are usually not covered by the Plan Network Administrator unless they meet the Network Administrator's clinical guidelines and approved protocols
- Lost or stolen appliances
- Periodontal splinting of otherwise healthy teeth with crowns or inlays/onlays
- Services, supplies or appliances which are not Medically Necessary
- Services that are cosmetic in nature
- Temporary services, including, but not limited to, crowns, restorations, dentures or fixed bridgework
- Treatment provided by someone other than a dentist (except for cleanings performed by a licensed dental hygienist under the supervision of a dentist)
- All general exclusions listed in Section VII.D

CALL THE BENEFIT FUND FOR MORE INFORMATION

Call the Benefit Fund 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 when you use Preferred Drugs where available
- Use Participating Pharmacies
- Use *The 1199SEIU 90-Day Rx Solution* (Mandatory Maintenance Drug Access Program) for chronic conditions
- You must comply with the Benefit Fund’s prescription drug programs, including Prior Authorization where required. For a complete list of these programs, please call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

Wage Class I: Family Coverage

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, as described in this section. If you are in Wage Class II or Wage Class III, you, your spouse and your children are **not covered** for this benefit. See Section V.D for a description of Wage Class III Benefits.

WHAT IS COVERED

There are no co-payments when you use Preferred Drugs where available.

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

- Have been approved for treating your specific condition;
- Have been prescribed by a licensed prescriber;
- Are filled by a licensed pharmacist; and
- Are not excluded by the Plan.

Benefits for prescriptions for FDA-approved drugs that are not approved for treatment of your condition must be submitted to the Benefit Fund 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 Preferred Drugs whenever possible, as per the Benefit Fund's prescription drug programs
- Use Participating Pharmacies for short-term medications
- Show your 1199SEIU Health Benefits ID card to the pharmacist when you pick up your medication

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

- *The 1199SEIU 90-Day Rx Solution*
- Mandatory Generic Drug Program
- Preferred Drug List
- Prior Authorization for certain medications
- Quantity and day supply limitations
- Step therapy
- Specialty Care Pharmacy: Use this 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.

PREFERRED DRUGS

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

Drugs are selected based on how well they work and their safety, and include generic prescription drugs (“Preferred Drugs”) and certain brand-name drugs (“Preferred Brand-name Drugs”). All Participating Providers are provided with a copy of the PDL. It should be used when prescription medication is required.

If a drug on the PDL is a therapeutic alternative to a non-Preferred Brand-name Drug, your doctor must prescribe the Preferred Drug. If there is no preferred alternative, or if the Benefit Fund’s Prescription Review Department determines that a non-Preferred Brand-name Drug is necessary, your prescription will be filled with the non-Preferred Drug. Otherwise, if your doctor prescribes a non-Preferred Drug, you will have to pay the difference in cost between the Preferred Drug and the non-Preferred Drug.

If you would like a copy of the PDL, please call the Benefit Fund at (646) 473-9200 or download it from our website at www.1199SEIUBenefits.org.

PRIOR AUTHORIZATION FOR CERTAIN MEDICATIONS

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

If your doctor prescribes any of those drugs, call the Benefit Fund’s Pharmacy Benefit Manager at (800) 753-2851, as some drugs require Prior Authorization from the Pharmacy Benefit Manager. Visit our website at www.1199SEIUBenefits.org for a comprehensive list of drugs that require Prior Authorization.

NOTE: You may have to pay the entire cost of the prescription if you don’t get Prior Authorization. These claims **will not** be reimbursed.

QUANTITY AND DAY SUPPLY LIMITS

These prescription drug 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 Authorization if your doctor prescribes one of these drugs for more than a 90-day period.

PRESCRIPTION DRUG PROGRAMS

Migraine Medications – Coverage is limited to a specific quantity. Prescriptions must be in compliance with the standards and criteria established by the FDA and with accepted clinical guidelines for standard of care.

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

Personalized Medicine – A voluntary program where you can help physicians determine which drug and dosage are clinically appropriate.

Quantity Duration – The FDA-recommended amount of medication that is clinically appropriate over a stated period of time.

SPECIALTY CARE

You must use the Specialty Care Pharmacy Program for injectables and other drugs that require special handling. Call the Benefit Fund’s Specialty Care Pharmacy at (800) 803-2523 or visit our website at www.1199SEIUBenefits.org for a listing of drugs included in this program.

Specialty care drugs are available only through mail-delivery service.

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-name Drugs.

PROTECT YOUR CARD

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

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

USE A PARTICIPATING PHARMACY

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

If you use a Non-participating Pharmacy, you will have to:

1. Pay for your prescription when it is filled.
2. Call the Benefit Fund's Member Services Department at (646) 473-9200 and ask for a **Prescription Drug Reimbursement/Coordination of Benefits Claim Form**, or download it from our website at www.1199SEIUBenefits.org.
3. Complete this form and along with an itemized paid receipt for your prescription, submit it as directed on the form.

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

FILLING YOUR PRESCRIPTIONS

For Short-term Illnesses

If you need medication for a short period of time, such as an antibiotic, have your doctor transmit the prescription to your local Participating Pharmacy, where you can pick it up once it's been filled.

For Chronic Conditions

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

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

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

- Submitting the prescription to your Participating Mail-order Pharmacy, where it will normally be delivered to you; or
- Transmitting the prescription to your local Participating Pharmacy, where you can pick it up once it's been filled.

For new maintenance medications, ask your doctor for two prescriptions: one for a 30-day supply (with one refill) and another for a 90-day supply (with three refills) that can be filled through *The 1199SEIU 90-Day Rx Solution* 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 1199SEIU 90-Day Rx Solution*, or to determine if the drug you are taking is a maintenance medication.

COORDINATING PRESCRIPTION DRUG BENEFITS

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

Although your spouse's name will appear on your 1199SEIU Health Benefits ID card, your spouse must use their primary prescription insurer first.

WHAT IS NOT COVERED

The Benefit Fund **does not cover:**

- Cold and cough prescription products
- Compound drugs (except reformulations for injection or administration)

- Cost differentials for drugs that are not approved through the Benefit Fund's prescription drug programs
- Drugs obtained without a prescription
- Experimental drugs
- Medications for cosmetic purposes
- Migraine medications in excess of FDA guidelines for strength, quantity and duration
- Non-prescription items, such as bandages or heating pads, even if your physician recommends them
- Non-sedating antihistamines
- Oral erectile dysfunction agents (except for penile functional rehabilitative therapy for up to six months immediately following prostatic surgery)
- Over-the-counter drugs (except diabetic supplies)
- Over-the-counter vitamins
- Prescriptions for drugs not approved by the FDA for the treatment of your condition
- Proton pump inhibitors in excess of a 90-day supply for FDA-approved indications by diagnosis
- 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.

NEW YORK CITY PICA PROGRAM

For New York City employees, certain injectable and chemotherapy drugs will be covered through the PICA Program of prescription drug benefits provided to you through the City, and will **not be covered** through the Benefit Fund's Prescription Drug Benefit. For a list of these drugs, please call the Benefit Fund's Prescription Department at (646) 473-9200, or visit our website at **www.1199SEIUBenefits.org**.



SECTION III – DISABILITY AND PAID FAMILY LEAVE BENEFITS

- A. When You Are Eligible for Disability or Paid Family Leave Benefits
- B. Disability Benefits
- C. Paid Family Leave Benefits
- D. Workers' Compensation Leave Benefits

DISABILITY AND PAID FAMILY LEAVE BENEFITS RESOURCE GUIDE

WHERE TO CALL

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

Call the Member Services Department to:

- Request a **Disability Claim Form** or **Accident Report Form**
- Request a **Paid Family Leave Benefit Request Form**
- Notify the Benefit Fund when you return to work
- Receive advice on benefits available from other sources if your leave lasts longer than 26 weeks within a 52-week period
- Receive help with filing a claim for Workers' Compensation from your Employer's insurer

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

REMINDERS

For accidents, injuries or illnesses that are not work-related:

- Disability Benefits are available only when your accident, injury or illness is not work-related.
- File your claim within 30 days of your accident or 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, injury, illness or work-related incident to your Employer *immediately*.
- File a Disability claim when you are out on Workers' Compensation Leave to protect your Fund benefits.
- 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 OR PAID FAMILY LEAVE BENEFITS

If you are unable to work because of an accident, injury or illness that is not related to your job, you may be eligible to receive a partial salary replacement benefit called **Disability Benefits**. Once you are enrolled in the Benefit Fund, you may receive Benefit Fund Disability Benefits, which exceed the amount of statutory disability benefits required by state law (see Section III.B).

If you are unable to work due to a qualifying family event, you may be eligible to receive a partial salary replacement called **Paid Family Leave** (see Section III.C). The duration of your Paid Family Leaves and Disability Leaves can never exceed a combined total of 26 weeks within a 52-week period.

WHEN YOU ARE ELIGIBLE FOR DISABILITY BENEFITS

Statutory Disability Benefits Through Your State

If you are not eligible for Benefit Fund Disability Benefits, you may be eligible to receive statutory disability benefits from the Benefit Fund based upon the state maximum and other provisions of your state's disability law, if:

- You are working in Covered Employment in New York State and become disabled after working for

more than four consecutive weeks but less than 90 days;

- You were working in Covered Employment in New York State and become disabled within four weeks after your last day of work; or
- You become disabled as a result of a motor vehicle accident covered by a “no-fault” state insurance law or similar statute.

Once you are enrolled in the Benefit Fund, you may receive Disability Benefits when you are unable to work because of an accident, injury or illness **that is not related to your job**.

Your spouse and children are **not eligible** for this benefit.

Before you stop working, call the Benefit Fund's Disability Department at (646) 473-9200 to make sure you are eligible for benefits.

WORK-RELATED ACCIDENT, INJURY OR ILLNESS

If your illness, accident 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.

MOTOR VEHICLE OR WORK-RELATED ACCIDENT, INJURY OR ILLNESS

If your illness, accident or injury is work-related, you are covered by your Employer's Workers' Compensation insurance. See Section III.D for more information.

If your accident or injury was caused by a motor vehicle, you may be entitled to health insurance and wage replacement benefits under motor vehicle insurance or "no-fault" policies held by your household, the owner or operator of the vehicle, or a state fund. See Sections I.F and III.B for more information.

However, you must still contact the Benefit Fund to protect your health benefits and to collect Disability Benefits at the statutory rate.

a "qualifying event" — in accordance with the eligibility provisions of New York's Paid Family Leave Benefits Law.

WHEN YOU ARE ELIGIBLE FOR PAID FAMILY LEAVE BENEFITS

Once you are enrolled in the Benefit Fund and have been employed by a Contributing Employer for at least 26 weeks, you may receive Paid Family Leave Benefits in certain circumstances when you are unable to work because of a qualifying event.

Your spouse and children are **not eligible** for this benefit.

The Benefit Fund determines your entitlement for Paid Family Leave Benefits — the amount and duration of the benefit, and whether your need is

SECTION III. B

DISABILITY BENEFITS

BENEFIT BRIEF

Benefit Fund Disability Benefits

This benefit is a partial salary replacement. Coverage is only for accidents, injuries or illnesses that are not work-related.

- Amount is based on your Average Weekly Earnings or on statutory minimums
- Maximum weekly benefit is \$385
- Maximum duration of 26 weeks leave within a 52-week period
- Your Benefit Fund coverage for all other benefits will continue while you are receiving Benefit Fund Disability Benefits

Wage Class I: Coverage for Member Only

Wage Class II: Coverage for Member Only

Wage Class III: Coverage for Member Only

WHO IS COVERED

Once you are enrolled in the Benefit Fund, you may receive Benefit Fund Disability Benefits when you are unable to work because of an accident, injury or illness **that is not related to your job**. Your Benefit Fund Disability Benefit is based on your Average Weekly Earnings before your accident, injury or illness, as described in the chart on page 115.

WHEN YOUR BENEFITS BEGIN

When your Disability Benefits begin is determined by:

- Whether you have an accident, injury or illness; and
- When you were first examined by a doctor for that accident, injury or illness.

If someone else is responsible for your illness, accident or injury, see Section I.G. Read this important information on special Benefit Fund requirements for you to receive benefits.

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

Family Leave, sick leave or wages from any other Employer.

If You Have an Accident or Injury

Your Disability Benefits start:

- From the day of your accident or injury, if you are examined by a doctor within eight days of the date of your accident or injury; 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 or injury.

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 were first examined by a doctor, if it was not within the first eight days of the date of you became ill.

If You Are Pregnant

You are eligible for the same benefits provided for other temporary physical disabilities if you can't work because of pregnancy complications or childbirth.

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

YOUR WAGE REPLACEMENT BENEFIT

Your Employer reports your earnings to the Benefit Fund. To calculate your weekly Benefit Fund Disability Benefit, the Fund averages your reported recent weekly earnings, and determines your weekly benefits according to the chart on page 115. How long you can receive benefits is based on your medical condition and your previous use of Disability and/or Paid Family Leave. Members may receive up to 26 weeks of Disability Benefits within a 52-week period while they are unable to work due to a qualifying illness or injury, but may not receive more than 26 weeks of Disability and Paid Family Leave Benefits combined during a 52-week period.

NOTE: Members employed by New Jersey Employers and working in New Jersey will receive weekly Disability Benefits based upon the chart on page 115 or the New Jersey rate schedule, whichever is greater. Members disabled as a result of a motor vehicle accident covered by a "no-fault" state insurance law will be paid at their applicable state's statutory disability rate schedule.

Average Weekly Earnings	Weekly Disability Benefit
Less than \$338	2/3 of Average Weekly Earnings
\$338 – \$449	\$225
\$450 – \$599	\$245
\$600 – \$749	\$280
\$750 – \$899	\$310
\$900 – \$1,049	\$340
\$1,050 – \$1,199	\$375
More than \$1,200	\$385 (maximum weekly benefit)

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 taxes (Social Security and Medicare) from your disability payments.

Disability payments are considered taxable earnings. They will be included in an IRS Form W-2 that you will receive from your Employer after the end of the year.

Contact the Benefit Fund if you want income taxes withheld from your payments.

FILING YOUR DISABILITY CLAIM

You must fill out a **Disability Claim Form** and send it to the Benefit Fund within 30 days of your accident or injury, or the start of your illness.

1. Call the Benefit Fund's Member Services Department at (646) 473-9200 or visit our website at **www.1199SEIUBenefits.org** to download the 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 we 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.

Generally, you will be notified of the Plan Administrator's approval or denial of your Request for Disability Benefits within 45 days of the date the Benefit Fund receives the request. This period may be extended by the Plan Administrator when the documents are incomplete.

WORK-RELATED ACCIDENT, INJURY OR ILLNESS

If your illness, accident 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 leave within a 52-week period.

It is important that the Benefit Fund receive your Disability Claim Form within 30 days of your illness, accident or injury. Otherwise, you may jeopardize your Disability Benefits 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

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

If Your Disability Continues

If your disability continues beyond the maximum 26-week period, your

coverage through the Benefit Fund will stop (see Section I.I). For more information on COBRA continuation coverage, see Section I.K.

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

SECTION III. C

PAID FAMILY LEAVE BENEFITS

BENEFIT BRIEF

Benefit Fund

Paid Family Leave Benefits

This benefit is a partial salary replacement. Your Benefit Fund coverage for all other benefits may continue while you are receiving Benefit Fund Paid Family Leave Benefits.

- Maximum weekly benefit is 67% of your average weekly earnings or the New York State Average Weekly Wage (SAWW), whichever is less
- How long you can receive benefits is based on verified need, up to a maximum of 12 weeks leave within a 52-week period

Wage Class I: Coverage for Member Only

Wage Class II: Coverage for Member Only

Wage Class III: Coverage for Member Only

The Benefit Fund determines your entitlement for Paid Family Leave Benefits — the amount and duration of the benefit, and whether your need is a “qualifying event” — in accordance with the eligibility provisions of New York’s Paid Family Leave Benefits Law.

WHO IS COVERED

Once you are enrolled in the Benefit Fund and have been employed by a Contributing Employer for at least 26 weeks, you may receive Paid Family Leave Benefits in certain circumstances when you are unable to work because of a qualifying event.

Your spouse and children are **not eligible** for this benefit.

WHEN YOUR BENEFITS BEGIN

Paid Family Leave Benefits may be used when you are unable to work due to the following **qualifying events**:

- To bond with a newly born, adopted or fostered child during the first 12 months of birth or placement.
- To care for a sick family member with a serious health condition. Family members include spouse, domestic partner, child, parent, parent in-law, grandparent and grandchild. Self-care is excluded. **Serious health condition** means an illness, injury, impairment, or physical or mental

condition that involves: inpatient care in a hospital, hospice or residential healthcare facility; or continuing treatment or continuing supervision by a healthcare provider.

- To take care of urgent needs that arise when a family member in the armed forces is called to service.

Your Paid Family Leave Benefits start the first day of your approved family leave.

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

Before you stop working, call the Benefit Fund's Member Services Department at (646) 473-9200 to make sure you're eligible for benefits.

YOUR WAGE REPLACEMENT BENEFIT

Effective January 1, 2021, eligible members are entitled to Paid Family Leave Benefits in full workday or workweek increments for up to 12 weeks.

Your weekly Paid Family Leave Benefit is 67% of your average weekly earnings or the New York State Average Weekly Wage (SAWW), whichever is less.

IMPORTANT TAX NOTE

Paid Family Leave payments are subject to certain federal taxes. The payments will be reported in an IRS Form 1099 that you will receive from the Benefit Fund after the end of the year.

Call (888) 447-9055 (toll-free) if you want income taxes withheld from your payments.

FILING YOUR PAID FAMILY LEAVE CLAIM

To get a **Paid Family Leave Benefit Request Form:**

1. Call (888) 447-9055 (toll-free), email 1199pfl@alicare.com or visit the Benefit Fund's website at **www.1199SEIUBenefits.org**.
2. Complete Part A as soon as you receive the form.
3. Have the care recipient complete a Release of Personal Health Information, if applicable.
4. Have a healthcare provider complete the applicable certification and return it to you.
5. Have your Employer fill out Part B and send the completed forms and supporting documentation to the Benefit Fund's Network Administrator within three days. Email to 1199pfl@alicare.com or fax to (914) 367-5374.

Generally, you will be notified of the Network Administrator's approval or denial of your Request for Paid

Family Leave Benefits within 18 days of the date the Network Administrator receives the request. This period may be extended by the Network Administrator when the documents are incomplete.

PROTECT YOUR PAID FAMILY LEAVE AND HEALTH BENEFITS

While you are receiving Benefit Fund Paid Family Leave Benefits, you and your family are still eligible for the same Benefit Fund coverage you had before your qualifying event. It is important that the Benefit Fund receive your Paid Family Leave Benefit Request Form and required documentation within 30 days of your qualifying event. Otherwise, you may jeopardize your Paid Family Leave 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 family leave.

WHEN YOU RETURN TO WORK

Call the Benefit Fund at (646) 473-9200. Remember to let the Benefit Fund know when you return to work after being out on a Paid Family Leave. This will allow the Fund to update its records to reflect that you are once again an active member. You must also notify the Fund if you do not return to work following a leave.

IF YOUR FAMILY LEAVE CONTINUES

If your family leave continues beyond the maximum Paid Family Leave Benefit period, your coverage through the Benefit Fund will stop (see Section I.I). For more information on COBRA continuation coverage, see Section I.K.

SECTION III. D

WORKERS' COMPENSATION LEAVE BENEFITS

If you are injured at work or suffer from a work-related illness, you are covered by Workers' Compensation, which is provided through 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 through the Benefit Fund.

NOTE: You must file a Workers' Compensation claim with your Employer as soon as possible after your injury, quarantine or illness diagnoses. Otherwise, you will jeopardize your rights to Workers' Compensation and your benefits from the Benefit Fund for yourself and your eligible family.

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

WHAT WORKERS' COMPENSATION COVERS

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

- Prevents you from working;
- Causes a permanent defect or death, whether or not you lost time from work; or

- Requires you to seek medical attention or treatment.

Workers' Compensation Benefits provided through your Employer or Employer's carrier include:

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

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

NOTE: Lost wages may be paid from the first day of your illness or accident/injury if you are unable to work for 14 or more days.

An incident report must be filed with your Employer within 30 days of workplace accidents and injuries, including exposure to infections, to protect your rights to Workers' Compensation Benefits. You or your Employer must also file a claim with the carrier and the appropriate agency within your state's labor department.

WHAT THE BENEFIT FUND COVERS

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

However, the Benefit Fund will:

- Continue to cover you and your family for benefits **not related to the job illness, accident or injury** while you are receiving Workers' Compensation Benefits, up to a maximum of 26 weeks leave within a 52-week period.
- Advance your 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 Fund has advanced your Disability Benefits, you must repay the Fund from those benefits.
- Pay you the difference in Disability Benefits if the amount paid by Workers' Compensation to replace lost wages is less than the Disability Benefit you would have received from the 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 (see Section I.I). 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, injury, illness 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 Claim Form**.
4. Complete the Benefit Fund's **Disability Claim Form** and send it to the Benefit Fund's Disability Department within 30 days of the date of the accident, injury or onset of the illness to continue receiving benefits for care not associated with your work-related accident, injury or illness. Include copies of all correspondence you have received, including any electronic communications you receive from Workers' Compensation, which indicates that your benefits have begun. This electronic communication

may be a **First Report of Injury (FROI) Form**.

» **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.

5. Continue to send copies of all correspondence (including electronic communications) you receive in connection with your Workers' Compensation claim to the Benefit Fund's Disability Department. This includes a **Supplementary Report of Injury (SROI) Form**, which indicates that your benefits have been stopped or modified. This will help the Benefit Fund keep up to date on the status of your Workers' Compensation claim.
6. If your Workers' Compensation claim is denied or disputed, notify the Benefit Fund *immediately* at (646) 473-9200.

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

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

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

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



SECTION IV – LIFE INSURANCE BENEFITS

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

LIFE INSURANCE BENEFITS RESOURCE GUIDE

WHERE TO CALL

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

Call the Member Services
Department to:

- Request a **Life Insurance Beneficiary Selection Form** or an **Enrollment Change Form**
- Request a claim form for life insurance

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

REMINDERS

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

SECTION IV. A

LIFE INSURANCE ELIGIBILITY

WHO IS COVERED

Once you are enrolled in the Benefit Fund and eligible for benefits, no matter your Wage Class, **only you—not your spouse or children**— are covered for Life Insurance Benefits. Your benefits end in accordance with Section I.I. Some retirees are eligible for Life Insurance Benefits (see Sections IV.A and VI).

If you are in Wage Class I or Wage Class II, you and your spouse are eligible for the Burial Benefit (if available). Your spouse is **not eligible** for Accidental Death and Dismemberment Benefits. Your children are **not eligible** for any benefits in Section IV. If you are in Wage Class III, you and your spouse are **not eligible** for the Burial Benefit. Your spouse is **not eligible** for Accidental Death and Dismemberment Benefits. Your children are **not eligible** for any benefits in Section IV. See Section V.D for a description of Wage Class III Benefits.

CONTINUING YOUR LIFE INSURANCE

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

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

CHOOSING YOUR BENEFICIARY

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

When you fill out your **Life Insurance Beneficiary Selection Form**, list at least one person as your beneficiary.

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

1. Call the Benefit Fund's Member Services Department at (646) 473-9200 and ask for an **Enrollment Change Form**, or download it from our website at **www.1199SEIUBenefits.org**.
2. Fill out the form.
3. Return it to the Fund. The change of beneficiary will not be effective until it's received by the Fund.

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

HOW YOUR BENEFICIARY APPLIES FOR BENEFITS

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

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

IF THERE IS NO BENEFICIARY

If you do not list a beneficiary; if your beneficiary dies before your death; or if 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 Benefit and Accidental Death and Dismemberment Benefit is less than \$20,000 and no estate exists, benefits will be paid to your survivors in the following order:

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

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

IF THERE IS A DISPUTE

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

If the dispute is not timely resolved by and between the parties claiming a right to this benefit, the Plan Administrator shall, in its discretionary authority, make a determination regarding entitlement to benefits and/or deposit the benefits into a court-monitored account.

IF YOU BECOME PERMANENTLY DISABLED

If you become permanently disabled before age 60, you will continue to be covered for life insurance if **all** of the following conditions are met:

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

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

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

ASSIGNMENTS

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

SECTION IV. B

LIFE INSURANCE BENEFIT

BENEFIT BRIEF

Life Insurance

- Based on your Wage Class and annual base pay
- First year maximum amount of \$1,250
- Death from any cause

Wage Class I: Coverage for Member Only

Wage Class II: Coverage for Member Only

Wage Class III: Coverage for Member Only

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

Your life insurance amount is **\$1,250 during the first year** you are covered by the Benefit Fund.

If you are in Wage Class I, your Life Insurance Benefit is based upon your annual base pay, up to a maximum amount of \$50,000. See the table below.

If you are in Wage Class II, your maximum life insurance amount is \$2,500; however, your amount is \$1,250 during your first year of employment.

If you are in Wage Class III, your maximum life insurance amount is \$1,250.

Annual Base Pay	Weekly Wage	Life Insurance Amount
Less than \$20,800	Less than \$400	Maximum of \$15,000
\$20,801 – \$26,000	\$401 – \$500	\$16,000
\$26,001 – \$31,200	\$501 – \$600	\$18,000
\$31,201 – \$36,400	\$601 – \$700	\$20,000
\$36,401 – \$41,600	\$701 – \$800	\$22,000
\$41,601 – \$46,800	\$801 – \$900	\$24,000
\$46,801 – \$52,000	\$901 – \$1,000	\$32,000
\$52,001 – \$57,200	\$1,001 – \$1,100	\$40,000
More than \$57,200	More than \$1,100	\$50,000 (maximum benefit)

RETIRED MEMBERS

If you are eligible for Life Insurance Benefits as a retiree under Section VI, 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 of \$1,250 (or less if you retired before July 1, 1983).

NOTE: If you retire at or after age 65 with at least 15 years of consecutive coverage by the Benefit Fund immediately prior to retirement but do not participate in the 1199SEIU Health Care Employees Pension Fund, you may be eligible for Life Insurance Benefits.

PERMANENTLY DISABLED MEMBERS

If you became eligible for Life Insurance Benefits as a permanently disabled member before age 60 under Section IV.A, when you reach age 65, your life insurance amount is immediately reduced by 20%. Then every year thereafter, your Life Insurance Benefit is further reduced by 20% until you reach the minimum life insurance amount of \$1,250.

SECTION IV. C

ACCIDENTAL DEATH AND DISMEMBERMENT

BENEFIT BRIEF

Accidental Death and Dismemberment

- For accidental death or dismemberment
- Equal to, or half of, your life insurance amount, depending on the loss suffered

Wage Class I: Coverage for Member Only

Wage Class II: Coverage for Member Only

Wage Class III: Coverage for Member Only

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

Once you're enrolled in the Benefit Fund and eligible for benefits, you are covered for Accidental Death and Dismemberment (AD&D) Benefits. AD&D Benefits are paid only if your death or dismemberment:

- 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 or injury; and
- Occurs while you are employed and covered by the Benefit Fund.

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

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

Your **Accidental Dismemberment Benefit** is:

- **Half of your life insurance amount** for the loss of one hand, one foot or sight in one eye;
- **Equal to your life insurance amount** for the 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 above.

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

AD&D Benefits are **not available** for losses resulting from:

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

SECTION IV. D

BURIAL

BENEFIT BRIEF

Burial

- If available, a free burial plot with permanent care **or** a \$75 payment to your beneficiary

Wage Class I: Coverage for Member & Spouse

Wage Class II: Coverage for Member & Spouse

Wage Class III: Not Covered

If you are in Wage Class I or Wage Class II, you and your spouse are covered for a free non-sectarian burial plot with permanent care, if available. 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.

If you are in Wage Class III, you and your spouse are **not covered** for this benefit. See Section V.D for a description of Wage Class III Benefits. If you are eligible for Retiree Health Benefits in Section VI.B or Section VI.C, only you are eligible for a burial plot. Your spouse is **not covered** for this benefit. See Section VI for a description of Retiree Health Benefits.



SECTION V – OTHER BENEFITS

- A. Anne Shore Sleep-Away Camp Program
- B. Joseph Tauber Scholarship Program
- C. Social Services
- D. Wage Class III Benefits

OTHER BENEFITS RESOURCE GUIDE

WHERE TO CALL

**Anne Shore Sleep-Away
Camp Program**
(212) 564-2220

Joseph Tauber Scholarship Program
(646) 473-8999

These programs are for eligible children of Benefit Fund members. They are administered by the 1199SEIU Child Care Corporation.

Call to request an application or for more information.

Member Assistance Program
(646) 473-6900

Call the Member Assistance Program to:

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

Citizenship Program
(646) 473-8915

Call the Citizenship Program to learn about assistance available for USCIS applications, including United States citizenship.

**Earned Income Tax Credit
Assistance Program**
(646) 473-9200

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

**Financial Wellness and Homebuyer
Education Program**
(646) 473-9200

For help with home ownership, managing credit and financial wellness. For information, visit our website at www.1199SEIUBenefits.org or refer to the 1199SEIU Health Care Employees Pension Fund SPD.

Monday Night Legal Clinic
(646) 473-6488

Provides free legal assessment and referral services by an attorney for various personal legal matters.

**Weekly Workers' Compensation
Legal Clinic**
(646) 473-6717

Provides free legal consultation services by an attorney for Workers' Compensation claims.

Wage Class III Benefits
(646) 473-9200

Call the Benefit Fund's Member Services Department for information on Wage Class III Benefits.

OTHER BENEFITS RESOURCE GUIDE

REMINDERS

- To be considered for the Anne Shore Sleep-Away Camp Program, an application must be completed and submitted to the 1199SEIU Child Care Corporation by the last day of January. The application is available upon request by calling (212) 564-2220, emailing AnneShoreCampProgram@1199Funds.org or visiting www.1199SEIUBenefits.org/anne-shore-camp.
- To be considered for the Joseph Tauber Scholarship Program, an **Official Application and College Release Form** must be requested in January, and completed and submitted to the 1199SEIU Child Care Corporation by the due date in May. If your child is receiving a scholarship from the Benefit Fund, your child must re-apply each year. The form is available upon request by calling (646) 473-8999, emailing 1199JTSP@1199Funds.org or visiting www.1199SEIUBenefits.org/jtsp.

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

SECTION V. A

ANNE SHORE SLEEP-AWAY CAMP PROGRAM

BENEFIT BRIEF

Camp

- For eligible children of Benefit Fund members (ages 9 to 15)
- Summer sleep-away camp program provided at no cost to you, except administrative fee
- FICA taxes and applicable withholdings paid for by the Benefit Fund (you will be responsible for taxable earnings)

Wage Class I: Coverage for Children Only

Wage Class II: Not Covered

Wage Class III: Not Covered

- Your child must be between the ages of 9 and 15 at the start of camp;
- Your child must be listed as a dependent on your 1199SEIU National Benefit Fund benefits; and
- Your child must be eligible for benefits as described in Section I.A.

Camps, including camps for children with special needs, are located throughout the Northeast. The Camp Benefit is provided at no cost to you, except for a nominal administrative fee. The value of the Camp Benefit is considered taxable earnings. They will be included in an IRS Form W-2 that you will receive from the Benefit Fund at the end of each year.

However, the other taxes that are normally taken out of your paycheck, like FICA (Social Security and Medicare) and applicable withholdings, will be paid for by the Fund.

CRITERIA APPROVED BY TRUSTEES

The number of children who can participate in the camp program is based upon criteria adopted by the Camp and Scholarship Committee of the Board of Trustees. Criteria for selection are announced by the Plan Administrator.

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

- You must currently work for a Contributing Employer and be eligible for Wage Class I benefits for at least one year;
- You must submit a program application by the required deadline;
- You must not have an outstanding administrative fee balance from your child's prior participation in the camp program;

As part of the camp program's selection criteria, priority is given to first-time applicants. Typically, one child per family is awarded a summer camp experience, with the exception of multiple-birth children (e.g., twins). When enough space and funding are available, additional children from a family are given the opportunity to participate in the camp program.

ONLINE APPLICATION

The application for the Anne Shore Sleep-Away Camp Program must be completed and submitted to the 1199SEIU Child Care Corporation by the last day of January.

The application is available online at **www.1199SEIUBenefits.org/anne-shore-camp**.

For more information, or to request a paper application, call (212) 564-2220 or email AnneShoreCampProgram@1199Funds.org.

SECTION V. B

JOSEPH TAUBER SCHOLARSHIP PROGRAM

BENEFIT BRIEF

Scholarship

- For eligible children of Benefit Fund members (age 22 or younger)
- Scholarships provided to attend accredited schools after high school

Wage Class I: Coverage for Children Only

Wage Class II: Not Covered

Wage Class III: Not Covered

- Your child must be enrolled full time in an accredited undergraduate college/university;
- Your child must be age 22 or younger (those who turn age 23 during the award year may only be eligible for a partial award);
- Your child must apply for *both* state and federal aid each academic year, if eligible; and
- Your child must be eligible for benefits as described in Section I.A.

Your children may be considered for the Benefit Fund’s Joseph Tauber Scholarship Program if **all** of the following conditions are met:

- You must currently work for a Contributing Employer and be eligible for Wage Class I benefits for at least one year (if your eligibility changes after receiving the program application, your child may no longer be eligible for an award at the time the application is processed);
- You must submit a program application by the required deadline;
- Your child must be a high school graduate or post-secondary school student;

Any accredited school is acceptable, including:

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

This award can be used for books, personal expenses, transportation, room and board, or for reducing student loan debt. Scholarships are not available for postgraduate studies, or to students who have already received the award for the maximum four years of payment.

However, consideration is given to students pursuing medical careers where five years of undergraduate work may be required.

The Scholarship Benefit is considered taxable earnings. They will be included in an IRS Form W-2 that you will receive from the Benefit Fund at the end of each year. However, the other taxes that are normally taken out of your paycheck, like FICA (Social Security and Medicare) and applicable withholdings, will be paid for by the Fund.

APPLICATION

The **Official Application and College Release Form** for the Joseph Tauber Scholarship Program must be requested in January, and completed and submitted to the 1199SEIU Child Care Corporation by the due date in May.

For more information, or to request a form, call (646) 473-8999, email 1199JTSP@1199Funds.org or visit www.1199SEIUBenefits.org/jtsp.

YOUR CHILD MUST RE-APPLY EVERY YEAR

If your child is receiving a Scholarship Benefit, they must re-apply every year for the next year. A leave of absence from school of more than one year will jeopardize a student's eligibility for this benefit.

STUDY INCENTIVE PROGRAM

To encourage academic achievement and reward academic excellence, there is a Study Incentive Program for Joseph Tauber Scholarship awardees who maintain full-time status and a grade point average of 3.0 or higher per semester. There is no application for the program. To be considered for the additional monetary incentive award, scholarship awardees must submit an official transcript at the end of the school year for review.

CRITERIA APPROVED BY TRUSTEES

The number of scholarship grants and the amount of these grants is based upon criteria adopted by the Camp and Scholarship Committee of the Board of Trustees. Criteria for selection are announced by the Plan Administrator.

SECTION V. C

SOCIAL SERVICES

BENEFIT BRIEF

Member Assistance Program

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

Citizenship Program

- Assistance in applying for United States citizenship

Earned Income Tax Credit Assistance Program

- Tax preparation help

Financial Wellness and Homebuyer Education Program

- Help with home ownership, managing credit and financial wellness

Monday Night Legal Clinic

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

Weekly Workers' Compensation Legal Clinic

- Assistance to members suffering from a work-related injury or illness

Wage Class I: Family Coverage

Wage Class II: Family Coverage

Wage Class III: Coverage for Member Only

MEMBER ASSISTANCE PROGRAM

The Benefit Fund's Member Assistance Program (MAP) offers help with personal and family problems. If you are having a problem, speak to one of the Fund's social workers or other staff. They can work with you to try to get you information on community resources or the help you need to cope with a broad range of problems. Some of the areas in which assistance can be provided are:

- Adjustment to life changes
- Alcohol, tobacco, opiates, and substance abuse and addiction
- Domestic violence
- Family/Relationship issues
- Job is in jeopardy (early intervention before job loss)
- Mental health concerns, such as anxiety and depression
- Referrals to entitlement programs (food stamps, Medicaid, public assistance, etc.)
- Stress or emotional difficulties

The MAP staff will help coordinate care for members, spouses and dependents who have been hospitalized for psychiatric care or substance abuse detoxification or rehabilitation.

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.

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

CITIZENSHIP PROGRAM

The 1199SEIU Citizenship Program, jointly administered by the 1199SEIU Benefit and Pension Funds and the 1199SEIU Training and Employment Funds, provides support to you and your eligible family members as you navigate the U.S. Citizenship and Immigration Services (USCIS) application processes, including:

- Assistance with U.S. citizenship application preparation
- One-on-one counseling and legal advice
- Classes to prepare you for the naturalization interview and test
- Classes for English as a Second Language (ESL)
- Help with other needs, such as adjustment of status and consular processing, Green Card renewals and more

For more about program assistance, and to obtain up-to-date immigration-related information, call (646) 473-8915 or email 1199SEIUCitizenship.Program@1199Funds.org. Appointments are available throughout the week and on select Saturdays. Services are

available in English, Spanish, Russian, Mandarin, Cantonese, Haitian Creole and French. Services are free of charge but do not include USCIS filing fees.

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 (EITC) and for tax return assistance at a free or discounted rate. EITC reduces the amount of tax you owe and may give you a refund. For more information, call (646) 473-9200.

FINANCIAL WELLNESS AND HOMEBUYER EDUCATION PROGRAM

For help with home ownership, managing credit and financial wellness. For more information, call (646) 473-9200, visit our website at www.1199SEIUBenefits.org or refer to the 1199SEIU Health Care Employees Pension Fund SPD.

MONDAY NIGHT LEGAL CLINIC

Provides eligible Benefit Fund members with access to attorneys for free legal consultations regarding various personal legal matters. The clinic operates on Mondays from 6:00 pm to 7:30 pm. For more information, call (646) 473-6488.

**WEEKLY WORKERS'
COMPENSATION LEGAL CLINIC**

The Benefit Fund Workers' Compensation walk-in legal clinic provides assistance to eligible members suffering from a work-related injury or illness. The clinic operates on Wednesdays from 4:00 pm to 6:00 pm. For more information about this clinic, call the Workers' Compensation/Liens Department at (646) 473-6717.

SECTION V. D

WAGE CLASS III BENEFITS

BENEFIT BRIEF

Wage Class III Benefits

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

- Dental Benefit
- Vision care
- Life insurance and accidental death and dismemberment
- Disability and Paid Family Leave
- Hospital indemnity payments
- Social services

Members in Wage Class III are eligible for a **member-only** package of benefits which includes a Dental Benefit, vision care, life insurance, accidental death and dismemberment, disability, Paid Family Leave, a program that provides hospital indemnity payments if you are hospitalized, and social services.

These benefits are **member-only – not for your spouse or children** – and are briefly described here and in greater detail throughout this SPD.

DENTAL BENEFIT

- Coverage through a Plan Network for basic and preventive services, major restorative care and orthodontia treatment

- Annual benefit limits or network restrictions may apply
- Network Dentists bill the Benefit Fund’s Plan Network Administrator directly and accept the Network Administrator’s Schedule of Allowances as payment in full for Covered Services
- For certain upgrades and materials, co-payments may apply

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

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

VISION CARE

- One eye exam every two years; and
- One pair of eyeglasses every two years; In lieu of eyeglasses, one order of contact lenses every two years.

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

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

- Maximum life insurance amount of \$1,250

- AD&D is equal to, or half of, your life insurance amount, depending on the loss suffered

See Section IV for more information on the Benefit Fund's Life Insurance and AD&D Benefits.

DISABILITY AND PAID FAMILY LEAVE BENEFITS

- For Disability Benefits, amount is based on your Average Weekly Earnings or on statutory minimums
- For Paid Family Leave Benefits, maximum weekly benefit is 67% of your Average Weekly Earnings or the New York State average weekly wage, whichever is less
- Coverage up to a combined maximum of 26 weeks leave within a 52-week period

See Section III for more information on the Benefit Fund's Disability and Paid Family Leave Benefits.

HOSPITAL INDEMNITY PAYMENTS

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

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

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

SOCIAL SERVICES

- Member Assistance Program (MAP)
- Citizenship Program
- Earned Income Tax Credit (EITC) Assistance Program
- Financial Wellness and Homebuyer Education Program
- Monday Night Legal Clinic
- Weekly Workers' Compensation Legal Clinic

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

RETIREE BENEFIT

If you retired with Wage Class III Benefits and are receiving a pension from the 1199SEIU Health Care Employees Pension Fund, you are eligible to participate in the Retired Members Programs described in Section VI.E.

If you retired after October 1, 2014, with Wage Class III Benefits and at least 10 Years of Pension Fund Credited Service under the 1199SEIU Health Care Employees Pension Fund, and otherwise meet the eligibility criteria listed in Section VI.A, you are eligible for Vision Benefits as a retired pensioner.

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



SECTION VI – RETIREE HEALTH BENEFITS

- A. Retiree Health Benefit Eligibility
- B. Retiree Health Benefits for Medicare-eligible Retirees
- C. Unreduced Early or Disability Retiree: Continued Benefit Fund Health Coverage
- D. Reduced Early Retiree: Limited Benefit Fund Health Coverage
- E. Retired Members Programs

RETIREE HEALTH BENEFITS RESOURCE GUIDE

WHERE TO CALL

Retiree Services Call Center (646) 473-8666

Call Retiree 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 after you retire through COBRA
- For a list of Participating Pharmacies
- For Prior Authorization for private-duty skilled nursing care at home
- For Prior Authorization for other Medical Benefits

1199SEIU Medicare Advantage Plan Member Services

(866) 429-3585

<https://1199seiu.aetnamedicare.com>

Call the Network Administrator (Aetna) or visit its website for general questions about your 1199SEIU Medicare Advantage Plan.

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; or
- 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.

RETIREE HEALTH BENEFITS RESOURCE GUIDE

REMINDERS

- Retiree Health Benefits differ by Wage Class.
- Your benefits as a retired member can't exceed the coverage you had just before you retired.
- You must get Prior Authorization for certain services and supplies.
- 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.

When you become Medicare-eligible:

- Your benefits must be coordinated with Medicare. Keep CMS and the Benefit Fund informed of address changes.
- You and your spouse must apply for Medicare **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 Prescription Drug Benefits through a Benefit Fund program, you must comply with the program's limits.
- You must timely file a claim form to get the Medicare Part B quarterly premium reimbursement.
- You must be enrolled in Medicare Part A and Part B to be eligible for Retiree Health Benefits from the Benefit Fund.

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

SECTION VI. A

RETIREE HEALTH BENEFIT ELIGIBILITY

The Benefit Fund partners with a Medicare Advantage health plan to offer Medicare-eligible retirees and their spouses a comprehensive health benefit package.

The Benefit Fund also offers health coverage for eligible retirees and their spouses who retire early with an Unreduced Pension. In certain circumstances, limited health benefit coverage is available for 1199SEIU pensioners and their spouses who are not eligible for full health coverage through the Benefit Fund. The benefits for which you are eligible depend on your age, the year you retire and your Years of Pension Fund Credited Service.

If your spouse was not covered while you were in active employment, they are not eligible for Retiree Health Benefits. Dependent children are **not covered** for these benefits regardless of their age.

YOU MUST RETIRE FROM COVERED ACTIVE SERVICE AND BE ELIGIBLE FOR A PENSION

To be eligible for Retiree Health Benefits, you must retire directly from covered active service with a pension from the 1199SEIU Health Care Employees Pension Fund. This means you must have left covered active service with Wage Class I or Wage Class II Benefit Fund coverage

and at least 10 Years of Pension Fund Credited Service, and have begun receiving a pension or have your application in process:

- Within one year of the date your Employer was no longer obligated to make contributions to the Benefit Fund on your behalf because you stopped working in this position; **or**
- Within one year of the date your Employer has withdrawn or was terminated as a Contributing Employer to the Benefit Fund; **or**
- Within one year of the date you ceased receiving Benefit Fund Disability Benefits; **or**
- While receiving COBRA continuation coverage or an award of permanent partial 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; **or**
- On or after January 1, 2013, when you were Medicare-eligible, even though you would have been eligible for continued healthcare following early retirement with an Unreduced Pension under Section VI.C.

WHEN YOUR HEALTH BENEFITS START AND STOP

In most cases, Retiree Health Benefits for you and your eligible spouse start 30 days after you retire and stop if you go back to work. If you or your spouse are covered by Medicare as of the last day that your Employer is required to make contributions to the Benefit Fund on your behalf, your Retiree Health Benefits start immediately upon retirement (see Section I.I). However, if you are entitled to active Benefit Fund coverage after your retirement, generally, your Retiree Health Benefits will start after that coverage ends. For example, if your retirement causes a reduction in benefits, you may extend the coverage you had as a working member immediately before you retired through COBRA, and your Retiree Health Benefits will start when COBRA coverage ends (see Section I.K). If you are covered as the spouse of an active member in the Benefit Fund, your enrollment in the Benefit Fund's Medicare Advantage Plan, if you are eligible, will start when your active spousal coverage ends.

If you retired with a pension from the 1199SEIU Health Care Employees Pension Fund:

- On or after October 1, 1998, and were receiving an Early or Normal Retirement Pension at the time of your death, benefits for your eligible spouse will continue for the remainder of their life.
- Before October 1, 1998, your eligible spouse's benefits will stop 30 days after your death.
- And were receiving a Disability Pension at the time of your death, your eligible spouse's benefits will stop 30 days after your death.
- And 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.

WHAT YOU NEED TO DO TO BE ELIGIBLE FOR RETIREE HEALTH BENEFITS

Your health benefits must be coordinated with any other health insurance that you or your spouse may have, including Medicare.

If you and/or your spouse are age 65 or older, or you are eligible for Medicare as a result of receiving a Disability Pension through Social Security, Medicare will be the primary coverage for your care. The Benefit Fund enriches the benefit coverage available to you through Medicare.

Enroll in Medicare 90 Days Before You Become Medicare-eligible

You and your spouse must enroll in Medicare Part A and Part B **at least** 90 days before you retire if you are Medicare-eligible, before you reach age 65 after you retire, or before you become Medicare-eligible following

the effective date of your Disability Award from Social Security. Keep your address up to date with the Fund and the Centers for Medicare and Medicaid Services (CMS).

A delay in enrolling or updating your address may:

- Delay your Medicare coverage; and
- Result in a financial penalty charged by Medicare or result in out-of-pocket costs to you for care, which Medicare does not pay.

You and your spouse must also enroll in the Benefit Fund's 1199SEIU Medicare Advantage Program, as described in Section VI.B.

NO VESTED RIGHTS

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. See Section VIII.B.

IF YOU ARE A CITY OF NEW YORK RETIREE

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; and
- 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

RETIREE HEALTH BENEFITS FOR MEDICARE-ELIGIBLE RETIREES

WAGE CLASS I RETIREE BENEFIT BRIEF

Medicare Advantage Benefits

- Hospital
- Medical
- Prescription drugs
- Dental
- Vision care
- Hearing

Other Benefits

- Medicare Part B 50% reimbursement
- Life insurance (member only)
- Burial (member only)

WAGE CLASS II RETIREE BENEFIT BRIEF

- Limited hospital and medical (secondary to Medicare)
- Vision care
- Hearing
- Medicare Part B 50% reimbursement
- Life insurance (member only)
- Burial (member only)

ELIGIBILITY FOR 1199SEIU MEDICARE-ELIGIBLE RETIREE HEALTH BENEFIT PLANS

You

To be eligible for Retiree Health Benefits when you are Medicare-eligible, in addition to having at least 10 Years of Pension Fund Credited Service under the 1199SEIU Health Care Employees Pension Fund and meeting the other eligibility criteria in Section VI.A, you must meet **all** of the following criteria:

- Leave covered active service with Wage Class I or Wage Class II Benefits:
 - » At or after age 65; **or**
 - » Between ages 60–64 on or after October 1, 1998, and be receiving early retiree health coverage through the Benefit Fund (Section VI.D); **or**
 - » Between ages 62–64 with at least 20 Years of Pension Fund Credited Service and be receiving continued health coverage through the Benefit Fund (Section VI.C); **or**
 - » Before age 65 with a Disability Pension from the 1199SEIU Health Care Employees Pension Fund; **or**

- » Before age 65 on or after January 1, 2013, with an Unreduced Pension from the 1199SEIU Health Care Employees Pension Fund; **and**
- Be at least 65 years old (or be eligible for Medicare disability if under 65); **and**
- Be receiving a pension from the 1199SEIU Health Care Employees Pension Fund or have your application in process; **and**
- Be enrolled in Medicare Part A and Part B.

Eligibility to receive an Unreduced Pension or a Disability Pension is set forth under the terms of the 1199SEIU Health Care Employees Pension Fund plan.

Your Spouse

Your spouse is eligible if you are eligible, and if they were enrolled before you retired; your children are **not eligible**.

When your spouse reaches age 65 or is covered by Medicare, they will receive the same benefits you receive, except for life insurance and burial.

If your spouse has a Medicare plan available through a previous employer, the Benefit Fund will provide limited coverage secondary to that plan.

If your spouse is not covered by Medicare, they will be eligible for the Early Retiree Dental Plus Plan, as described in Section VI.D, unless they select, **on a one-time-only**

basis, coverage for the Early Retiree Prescription Plan, as described in Section VI.D.

BENEFIT FUND 1199SEIU MEDICARE ADVANTAGE PLAN

If you retire from covered active service with Wage Class I Benefits, are enrolled in Medicare Part A and Part B, and live in the U.S. (excluding U.S. territories), you are eligible to receive comprehensive health benefits from the Benefit Fund through the 1199SEIU Medicare Advantage Plan. The 1199SEIU Medicare Advantage Plan is a partnership with a nationwide health plan, which includes hospital, medical, and prescription drugs and other benefits.

Your Benefits

You are required to enroll in the 1199SEIU Medicare Advantage Program, if you are eligible, in order to receive Retiree Health Benefits from the Benefit Fund. Your health benefits are provided through the 1199SEIU Medicare Advantage Program, including hospital, medical and prescription drugs. Your benefits may also include dental, vision, hearing and/or non-Emergency transportation for medical appointments (subject to change). Certain services and supplies require Prior Authorization by the Network Administrator; call (866) 429-3585 or visit **<https://1199seiu.aetnamedicare.com>** for more information.

If you decline this coverage for any reason, you and your spouse will no longer be eligible to receive Retiree Health Benefits from the Benefit Fund as described in this SPD.

If you decline coverage, the Fund will send you an Opt-Out Form or Letter confirming that you will lose your Retiree Health Benefits.

In certain circumstances, you may request a waiver of this requirement by calling the Benefit Fund at (646) 473-8666, only if you meet **all** of the following criteria as determined by the Plan Administrator:

- You are currently under treatment for a serious and/or chronic medical condition; **and**
- Your doctor does not participate in the 1199SEIU Medicare Advantage Plan; **and**
- A change in physician would put your health in serious jeopardy.

If you do not opt out or obtain an annual or permanent waiver, you will be enrolled automatically in the 1199SEIU Medicare Advantage Program.

BENEFIT FUND SECONDARY HEALTH COVERAGE

If you have been granted a waiver, live in a U.S. territory or abroad, or left covered active service with Wage Class II Benefits, you are eligible for the benefits described below.

Your Benefits

The Benefit Fund will supplement your Medicare coverage by providing Part D prescription drug coverage, sponsored by the Fund and its Pharmacy Benefit Manager (excluding retirees that retire with Wage Class II Benefits). For a description of the Prescription Drug Benefit, see Section II.L. If you are eligible for this benefit but enroll in a different Medicare Part D Prescription Drug Plan, that plan will be your primary coverage and will pay your prescription claims first, and the Benefit Fund will provide prescription benefit coverage for your prescriptions not covered by your primary plan.

The Benefit Fund will also provide Vision, Hearing, and limited Hospital and Medical Benefits secondary to Medicare. For Medically Necessary inpatient hospital care, the Fund pays your Part A first-day deductible, your Part A co-insurance and reserve days, and additional coverage up to a total of 365 calendar days after you have exhausted your Medicare Part A, up to the Fund's Schedule of Allowances. In addition, if you are enrolled in Medicare Part B, the Fund will pay the difference between what Medicare pays and the Fund's Schedule of Allowances for Medically Necessary anesthesia, drugs and certain other services covered by Medicare Part B (durable medical equipment, medical supplies, rehabilitative therapies, facility charges related to ambulatory/outpatient surgery, Part B covered drugs and Emergency ambulance). The Fund also

covers Medically Necessary private-duty skilled nursing care at home, in accordance with the Fund’s nursing protocol and Schedule of Allowances, and in coordination with Medicare.

Call the Prior Authorization Department at (646) 473-9200 for Prior Authorization on private-duty skilled nursing care at home and all benefits secondary to Medicare Part B, except Emergency ambulance and anesthesia.

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

OTHER BENEFITS

Eligible retirees with either the 1199SEIU Medicare Advantage Plan or secondary health coverage with the Benefit Fund also receive additional benefits through the Fund, including reimbursement for 50% of the standard Medicare Part B premium, Life Insurance and Burial Benefits.

Medicare Part B Premium

If you retire with Wage Class I or Wage Class II Benefits, you will be reimbursed for 50% of the standard Medicare Part B premium.

You may file a claim annually or once each quarter to get this benefit. The Benefit Fund will not reimburse for claims that are more than two years old. File your claim form through the My Account section of the Benefit Fund’s website at www.1199SEIUBenefits.org.

Medicare Part D Premium — Income-related Adjustment

If you retire with Wage Class I or Wage Class II Benefits, you will be reimbursed for your Medicare Part D Income-related Monthly Adjustment Amount (IRMAA).

You may file a claim annually or once each quarter to get this benefit. The Benefit Fund will not reimburse for claims that are more than two years old. File your claim form through the My Account section of the Benefit Fund’s website at www.1199SEIUBenefits.org.

Life Insurance

See Section IV.B for a description of your Life Insurance Benefit. Your spouse is **not eligible** for this benefit.

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:

Date of Retirement	Life Insurance Amount
April 1, 1961 – June 30, 1973	\$500
July 1, 1973 – June 30, 1983	\$1,000
After July 1, 1983	\$1,250

Burial

If available, you are covered for a free burial plot. Your spouse is **not eligible** for this benefit.

SECTION VI. C

UNREDUCED EARLY OR DISABILITY RETIREE: CONTINUED BENEFIT FUND HEALTH COVERAGE

BENEFIT BRIEF

Early or Disability Retiree Continuation Coverage

- Health benefits
- Prescription drugs
- Vision care
- Hearing
- Medicare Part B 50% reimbursement
- Life insurance (member only)
- Burial (member only)

Wage Class I: Coverage for Member & Spouse; Dependents Not Covered

Wage Class II: Coverage for Member & Spouse (excluding prescription drugs); Dependents Not Covered

If you retire before age 65 with an Unreduced Pension or a Disability Pension, and you meet the eligibility criteria in Section VI.A, you are eligible for the same health benefits you were receiving as a working member just before you retired, except as otherwise described in this Plan.

Your spouse is eligible if you are eligible, and if they were enrolled before you retired; your children are **not eligible**.

YOUR BENEFITS

Your health benefits include hospital, medical, prescription drugs, vision and hearing. You are also eligible for Life Insurance and Burial Benefits; your spouse is **not eligible** for those benefits. For detailed information about your health coverage and Life Insurance Benefit, see Section II – Health Benefits (excluding Dental Benefits) and Section IV.B – Life Insurance Benefit.

ELIGIBILITY FOR CONTINUED FULL COVERAGE

Eligibility to receive an Unreduced Pension or a Disability Pension is set forth under the terms of the 1199SEIU Health Care Employees Pension Fund plan (the Pension Plan).

Under the Pension Plan, you are eligible to receive an Unreduced Pension when you retire from covered active service and your last hour of credited service occurred:

- Between ages 62.5–64 with at least 25 Years of Pension Fund Credited Service; or
- Between ages 62–64 with at least 20 Years of Pension Fund Credited Service before January 1, 2019 (or after January 1, 2019, if you were born before July 1, 1959).

In the event of a conflict between this SPD and the Pension Plan, the eligibility terms of the Pension Plan shall govern.

When you become eligible for Medicare, you will age-in and receive the 1199SEIU Medicare Advantage Plan or the Benefit Fund's secondary health coverage given to members who retired at or after age 65 with at least 10 Years of Pension Fund Credited Service, as described in Section VI.B. **At that time, if your spouse is not eligible for Medicare**, they will be eligible for the Early Retiree Dental Plus Plan, as described in Section VI.D, unless they select, **on a one-time-only basis**, coverage for the Early Retiree Prescription Plan, as described in Section VI.D.

When your spouse becomes eligible for Medicare, they will receive the same benefits that members who retired at or after age 65 with at least 10 Years of Pension Fund Credited Service receive, as described in Section VI.B, except for life insurance and burial.

However, if you or your spouse have ESRD and are in the 30-month Medicare Coordination Period as of the last day of your continued coverage under this section, the ESRD patient's Benefit Fund coverage continues until the Coordination Period is over, then ESRD Medicare will become the primary payer.

SECTION VI. D

REDUCED EARLY RETIREE: LIMITED BENEFIT FUND

HEALTH COVERAGE

WAGE CLASS I RETIREE BENEFIT BRIEF

Early Retiree Dental Plus Plan

- Dental
- Hospital indemnity payments
- Vision care

Early Retiree Prescription Plan

- Prescription drugs
- Vision care
- Hearing

WAGE CLASS II RETIREE BENEFIT BRIEF

- Vision care
- Hearing

ELIGIBILITY FOR REDUCED EARLY RETIREE LIMITED COVERAGE

Your spouse is eligible if you are eligible, and if they were eligible before you retired; your children are **not eligible**.

To be eligible for this package of benefits, in addition to meeting the eligibility criteria in Section VI.A, you must meet **all** of the following criteria:

- Retire at or after age 55 and before age 65; **and**

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

NOTE: See Section VI.C if you retired between ages 62.5–64 with at least 25 Years of Pension Fund Credited Service (or between ages 62–64 with at least 20 Years of Pension Fund Credited Service before January 1, 2019).

Effective October 1, 2014, you and your spouse will be eligible for the Early Retiree Dental Plus Plan, as described in this section, unless you and your spouse select, **on a one-time-only basis**, coverage for the Early Retiree Prescription Plan, as described in this section, consisting of Prescription Drug, Vision and Hearing Benefits only.

YOUR BENEFITS

Early Retiree Dental Plus Plan

If you meet the above eligibility requirements and retire with Wage Class I Benefits, you will be eligible for the Dental Benefits described in Section II.K, the Vision Benefits described in Section II.J and the Hospital Indemnity Benefits described here, unless you select, **on a one-time-only basis**, coverage for the Early Retiree Prescription Plan, described later in this section.

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

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

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

Early Retiree Prescription Plan

If you meet the above eligibility requirements, retire with Wage Class I Benefits and select coverage in the Early Retiree Prescription Plan, you will be eligible for the Vision and Hearing Benefits described in Section II.J and the Prescription Drug Benefit described in Section II.L.

Early Retiree Wage Class II Benefits

If you meet the above eligibility requirements and retire with Wage Class II Benefits, you and your spouse will be eligible for the Vision and Hearing Benefits described in Section II.J.

WHEN YOU BECOME MEDICARE-ELIGIBLE

If you retired with Wage Class I Benefits between ages 60–64 on or after October 1, 1998, you and your spouse **will be eligible** for the Retiree Health Benefits described in Section VI.B when you become Medicare-eligible.

If you retired with Wage Class I Benefits between ages 55–64 before October 1, 1998, or between ages 55–59 after October 1, 1998, when you become Medicare-eligible, you and your spouse **will be eligible** for the Vision and Hearing Benefits described in Section II.J and the Prescription Drug Benefit described in Section II.L (as Part D Prescription Drug coverage), but you must enroll in Medicare Part A or Part B.

If you retired with Wage Class II Benefits, you and your spouse will continue to receive only the Vision and Hearing Benefits described in Section II.J when you become Medicare-eligible.

SECTION VI. E

RETIRED MEMBERS PROGRAMS

Each year, the Board of Trustees approves a budget allocation 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 — Appeal Procedure
- 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 the Member Services Department if:

- You need a claim form
- You have questions about completing your claim form
- You have questions about what is not covered by the Benefit Fund
- You have questions about the processing of your claim

Appeals Department Hotline (646) 473-8951

Call the Benefit Fund's Appeals Hotline if you need information on appealing your claim.

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

SECTION VII. A

GETTING YOUR HEALTHCARE BENEFITS

PAYMENT INFORMATION FOR PROVIDERS

If you are a Non-participating Provider, any disputes regarding payment for services from the Benefit Fund are “claims” subject to the U.S. Department of Labor Claims Regulations, and no communications should be construed as a contract or promise to pay outside this Plan. If you are a Participating Provider, payment disputes shall be handled exclusively 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 so that:

- Your doctor, hospital or healthcare provider can be paid; or
- You can be reimbursed if you paid your doctor, hospital or healthcare provider.

If You Use a Participating Provider

Your doctor, hospital or healthcare provider will submit the claim to the Benefit Fund.

If You Use a Non-participating Provider

You may need to submit a claim form to the Benefit Fund. If your provider does not have a claim form, you may obtain one by calling our Member Services Department at (646) 473-9200. You can also obtain a claim form from the “Benefits & Resources” section of our website at www.1199SEIUBenefits.org. To expedite processing, your claim form should be submitted as directed on the form.

For the Benefit Fund to pay your claim to a Non-participating Provider, you must sign the “Assignment of Benefits” authorization on your claim form. This way, you are giving the Benefit Fund your consent to have the payment sent to your doctor, hospital or healthcare provider. However, the Benefit Fund will only pay a claim according to its Schedule of Allowances. You may be responsible for any charges over the Benefit Fund’s allowance.

NOTE: The assignment feature of the Benefit Fund is only for payment of your benefits to providers. No other rights may be assigned or transferred.

There is no further liability for any claim by any provider or third party, and no such claims may be brought against the Benefit Fund. The Plan Administrator reserves the right to deny certain assignments. Assignments of Benefits to Non-participating Neurosurgery and Orthopedic Surgery Practices are not permitted without express authorization from 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 “Benefits & Resources” section of our website at www.1199SEIUBenefits.org. Submit your claim form with the bill from your provider as directed on the form, and make sure the bill lists the amount you have paid. The Benefit Fund will only pay a claim according to its Schedule of Allowances. You may be responsible for any charges over the Benefit Fund’s allowance.

If You Receive an Overpayment

If you (or your provider by assignment) receive an overpayment from the Benefit Fund as a result of an improperly billed claim for benefits, the overpaid funds belong to the Benefit Fund, and you agree to hold that money in trust for the Fund and to reimburse the Fund within 30 days of receiving the overpayment.

It Is Very Important to File Your Claim with the Benefit Fund Promptly

- Disability claims must be filed within 30 days of the start of your disability.
- Claims for reimbursement for 50% of the standard Medicare Part B premium must be filed within two years of the premium payment.
- All other claims will be denied if they are filed more than one year after the services were provided.
- Life insurance and accidental death and dismemberment claims must be filed no longer than one year after the date of death or loss.

A claim that is 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 why, 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 on hold from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information. If you fail to provide the additional information within 45 days, the initial decision on your claim will be made based on the information available to the Plan Administrator.

If your claim is totally or partially denied, you can appeal by requesting an Administrative Review. See "Administrative Review of Adverse Decision" in Section VII.B.

INITIAL CLAIM DECISION FOR PRE-SERVICE AND CONCURRENT CARE BENEFITS

In order to receive certain Fund benefits, you must get Fund approval — **Pre-certification** or **Prior Authorization** — before treatment. You may file any request for Pre-certification or Prior Authorization yourself, or you may designate another person as your authorized representative, in which case, all subsequent notices

will be provided to you through your authorized representative.

The Plan Administrator will make an initial claim decision on your request for Pre-certification or Prior Authorization, which is a determination about whether the services are Medically Necessary to treat your condition and are in compliance with the Benefit Fund's clinical coverage guidelines, policies, protocols and procedures. A Prior Authorization determination is not an independent contract or promise to pay benefits.

The Plan Administrator will provide a written decision on your initial Request for Benefits. If your request is denied, you will be notified of the reasons why your benefits have been denied (or reduced), and the specific provisions of the Plan on which the decision was based. The timeline for requesting Pre-certification or Prior Authorization depends on the category of the request:

Pre-service Care Requests

Pre-service Care Requests are requests for those benefits that require 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 radiological or genetic tests, 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, the Fund's designated agent, review your request.

You or your authorized representative generally will be notified of the Plan Administrator's (or 1199SEIU CareReview's) approval or denial of your Request for Benefits no later than 15 days from the date the Benefit Fund receives the request. This 15-day period may be extended by the Plan Administrator (or 1199SEIU CareReview) for an additional 15 days due to matters beyond the Plan Administrator's (or 1199SEIU CareReview's) control; you will receive prior written notice of the extension. If your request is incomplete, you will be notified within five days after it is filed. You will then have 45 days to provide any additional information requested of you by the Plan Administrator (or 1199SEIU CareReview). In this case, the period for making the benefit decision will be on hold from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If you fail to provide the additional information within 45 days, the initial decision on your Request for Benefits will be made based on the information available to the Plan Administrator (or 1199SEIU CareReview).

Concurrent Care Requests

Concurrent Care Requests are requests to extend previously approved benefits for an ongoing course of treatment, or a specific number of treatments. These include, for example, requests to receive physical/rehabilitation therapy, or visits

to an allergist, podiatrist or chiropractor beyond the standard number of visits allowed by the Benefit Fund. Where possible, these requests should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.

These claims may be filed by phone or fax (see Section VII.B).

You or your authorized representative generally will be notified of the Plan Administrator's denial of your Request for Benefits sufficiently in advance of the reduction or termination of benefits to allow you to appeal and obtain a decision before the benefit is reduced or terminated (assuming that your request was filed before the end of the course of treatment for which the extension is being sought). If the request to extend the course of treatment or the number of treatments involves urgent care, the Plan Administrator will notify you of its decision, whether adverse or not, within 24 hours after receiving the request, provided that the request is made to the Benefit Fund at least 24 hours before the expiration of benefits. You will be given time to provide any additional information required to reach a decision.

If you fail to provide the additional information in a timely fashion, the initial decision on your Request for Benefits will be made based on the information available to the Plan Administrator.

Urgent Care Requests

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, subject the patient to severe pain that cannot be adequately managed without the care or treatment being requested. These Requests for Benefits are treated as Urgent Care Requests and include those situations commonly treated as Emergencies.

These claims may be filed by phone or fax (see Section VII.B).

You or your authorized representative generally will be orally notified of the Plan Administrator's approval or denial of your Request for Benefits, 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 will then have 48 hours to provide the necessary information, and the Plan Administrator will notify you of its decision within 48 hours of receiving the additional information (or from the time the information was due).

If you fail to provide the additional information in a timely fashion, the initial decision on your Request for Benefits will be made based on the information available to the Plan

Administrator. A written notification will be given to you no later than three days after the oral notification.

SECTION VII. B

YOUR RIGHTS ARE PROTECTED – APPEAL PROCEDURE

If your claim or your Request for Benefits is denied, the Plan provides for two levels of appeal, as described in this section.

1ST STEP – ADMINISTRATIVE REVIEW OF ADVERSE DECISION

If your claim or Request for Benefits is totally or partially denied, you may request an Administrative Review of such denial within 180 days after receipt of the denial notice. Your request for a review must be in writing, unless your request involves urgent care, in which case the request may be made orally. For hospital stays or ambulatory/outpatient procedures, the Plan Administrator will have 1199SEIU CareReview conduct the Administrative Review and appeal procedure. For Dental Benefits, the Network Administrator will conduct the Administrative Review.

NOTE: All claims by you, your spouse, your children or your beneficiaries against the Benefit Fund are subject to the Claims and Appeal Procedure. No lawsuits may be filed until all steps of these procedures have been completed by you or a representative authorized by you, and the benefits requested have been denied in whole or in part. No lawsuits may be filed by providers as an assignee of you, your spouse or

your children after three years from the date of service. All lawsuits must be filed in a federal court in New York City.

2ND STEP – HOSPITAL STAYS OR AMBULATORY/OUTPATIENT PROCEDURES

Non-urgent Care Situations

If the Administrative Review by 1199SEIU CareReview results in a denial of your Request for Benefits, you have the right to make an appeal directly to 1199SEIU CareReview. Such a request must be filed within 60 days after receipt of the denial notice.

If your appeal is denied by 1199SEIU CareReview, you have the right to file a suit under the Employee Retirement Income Security Act of 1974 (“ERISA”) only in a federal court in New York City.

You may also choose to bring a final appeal to the Appeals Committee of the Board of Trustees. Such requests must be filed, in writing, within 60 days after receipt of the denial notice.

If your appeal is denied by the Appeals Committee and you disagree with that decision, you still have the right to file a suit under ERISA only in a federal court in New York City.

Urgent Care Situations

In urgent care situations regarding the Prior Authorization of hospital stays or ambulatory/outpatient procedures, the Administrative Review by 1199SEIU CareReview shall be final and binding on all parties. If this review results in a denial of your Request for Benefits, you have the right to file a suit under ERISA only in a federal court in New York City.

Lien Determinations

If your claim involves a retroactive denial by the Fund as a result of a Lien Determination, your request for review must be made in accordance with Section I.G.

2ND STEP – DENTAL BENEFITS

If your claim for Dental Benefits has been totally or partially denied, you have the right to request an Administrative Review by the applicable Network Administrator. If the Administrative Review of a DMO dental benefit results in a denial, you may file a written 2nd step appeal to the DMO Network Administrator, by mail or fax, within 60 days after receipt of the review denial notice. If the Administrative Review of a PPO dental benefit or the 2nd step appeal of a DMO dental benefit results in a denial, you have the right to file a suit under ERISA only in a federal court in New York City.

You may also choose to bring a final appeal to the Appeals Committee of the Board of Trustees. Such requests must be filed, in writing, within 60 days after receipt of the review denial

notice. If your appeal is denied by the Appeals Committee and you disagree with that decision, you still have the right to file a suit under ERISA only in a federal court in New York City.

2ND STEP – 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 requests must be in writing and filed within 60 days after receipt of the denial notice.

WHAT YOU ARE ENTITLED TO

In connection with your right to appeal, you:

- Are entitled to submit written comments, documents, records or any other matter relevant to your claim
- Are entitled to receive, at your request and free of charge, reasonable access to, and copies of, all relevant documents, records and other information that was relied on in deciding your claim for benefits
- Will be given a review that takes into account all comments, documents, records and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit decision

- Will be provided with the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your Adverse Benefit Decision, without regard to whether the advice was relied upon in making the benefit decision
- Are entitled to have your claim reviewed by a healthcare professional retained by the Plan, if the denial was based on a medical judgment (this individual may not have participated in the initial denial)
- Are entitled to a review that is conducted by a named fiduciary of the Plan, who is not the person that made the benefit decision, and who does not work for that person
- Are entitled to authorize a representative to appeal on your behalf. Except in the case of an Urgent Care Request, in order to authorize anyone, including a provider, to represent you in an appeal of a benefit denial, you must complete and sign a **Benefit Fund Appeal Representation Authorization Form** following the benefit denial. No other form will be accepted by the Fund to show that you are allowing someone else to exercise your right to appeal. A representative authorized by you to appeal on your behalf cannot authorize anyone else to appeal; only you can authorize a representative.
- In the case of an Urgent Care Request, you are entitled to a fast review process in which all necessary information, including the Fund's benefit decision on review, shall be sent to you by telephone, fax or other available expeditious methods

HOW TO REQUEST AN ADMINISTRATIVE REVIEW OR AN APPEAL TO THE APPEALS COMMITTEE OF THE BOARD OF TRUSTEES

<p>Requests for Administrative Review of urgent care for hospitalization or ambulatory/outpatient procedures can be directed to 1199SEIU CareReview by:</p> <ul style="list-style-type: none"> • Phone: (800) 227-9360 • Fax (Medical): (866) 535-8972 • Fax (Behavioral Health): (855) 816-3497 	<p>Requests for Administrative Review of non-urgent care for hospitalization or ambulatory/outpatient procedures should be sent to:</p> <p>1199SEIU CareReview Program CareAllies 150 S. Warner Road, 3rd Floor King of Prussia, PA 19406</p>
<p>Requests for Administrative Review of dental claims in the PPO can be submitted by:</p> <ul style="list-style-type: none"> • Mail: EmblemHealth Grievance and Appeals Department PO Box 2844 New York, NY 10116-2844 • Phone: (800) 624-2414 	<p>Requests for Administrative Review of and appeals of dental claims in the DMO can be submitted by:</p> <ul style="list-style-type: none"> • Mail: Aetna Dental Appeals PO Box 14080 Lexington, KY 40512 • Phone: (877) 238-6200 (1st level only) • Fax: (859) 425-3379
<p>Reviews and appeals of all other claims can be submitted by:</p> <ul style="list-style-type: none"> • Phone (post-service): (646) 473-8951 • Fax (post-service): (646) 473-8958 • Phone (urgent or concurrent care): (646) 473-7446 • Fax (urgent or concurrent care): (646) 473-7447 • Mail: 1199SEIU National Benefit Fund Claim Appeals PO Box 646 New York, NY 10108-0646 	<p>Requests for Administrative Review of claims in the Aetna plan for Union/Funds staff outside the tri-state area can be submitted by:</p> <ul style="list-style-type: none"> • Phone (post-service): (866) 658-2455 • Fax (post-service): (859) 425-3379 • Phone (urgent or concurrent care): (800) 243-5349 • Fax (urgent or concurrent care): (877) 867-8372 • Mail: Aetna PO Box 14463 Lexington, KY 40512

WHAT YOUR PROVIDER IS ENTITLED TO

A Participating Provider has a contract with the Benefit Fund and can only exercise their own right to appeal benefit payments under the contract.

A Participating Provider has a contract with the Benefit Fund agreeing that any payment disputes may only be addressed with the Fund, through its contract, and therefore, it cannot appeal an adverse determination on your behalf, or sue on an assignment of your benefits.

Non-participating Providers have no independent right to appeal an Adverse Benefit Decision, and you cannot assign your right to appeal. However, you can authorize a Non-participating Provider to appeal on your behalf the Fund's determination of your Plan benefits by signing a **Benefit Fund Appeal Representation Authorization Form**.

If an authorized provider completes the administrative appeal process on your behalf, you will no longer have the right to appeal the same claim.

A provider's challenge to the design of the Plan or to the Benefit Fund's Schedule of Allowances is not an appeal, because those "settlor functions" are not the proper subjects of appeal or a lawsuit.

For assignments of rights and benefits, see Section VIII.A.

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. If you request an Administrative Review, you will be notified of the Benefit Fund's 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 Requests**
Each level of review of an Urgent Care Request shall be completed in sufficient time to help ensure that the total period for completing both the Administrative Review and the appeal to the Appeals Committee of the Board of Trustees (if applicable) does not exceed 72 hours after your request for a review is received.
- **Concurrent Care Requests**
Administrative Review of a Concurrent Care Request will be treated as either an Urgent Care Request, a Pre-service Care Request or a Post-service Care Claim, depending on the facts.

For appeals of Administrative Review decisions, the appeal decision of the Appeals Committee shall be final and binding on all parties, subject to your right to file a suit under ERISA only in a federal court in New York City. The decision shall be made at the Committee Meeting following the Plan's receipt of a request (not later than the next scheduled meeting after the month the request is received for post-service care appeals, unless special circumstances require an extension to the following meeting), and the claimant will be notified in writing.

APPEALING DISABILITY AND PAID FAMILY LEAVE CLAIMS

To appeal a denial of your Request for Disability Benefits or Paid Family Leave Benefits, you must send a written request for review within 30 days of receiving the denial notice, by following the directions in the denial notice. If you do not have this notice, call the Benefit Fund at (646) 473-9200.

If after the Administrative Review your claim is totally or partially denied, you may appeal directly to the Appeals Committee of the Board of Trustees by sending a letter to the Benefit Fund within 60 days after receipt of the denial notice. 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 twice 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.

If additional information is needed to resolve your appeal, you will 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 on hold from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information. If you fail to provide the additional information within 45 days, the 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, your spouse or your children were not entitled to receive;
- For claims that you, your spouse or your 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 Fund, or was not repaid to the Fund, as required in Section I.G.

BENEFIT FUND’S RIGHT TO CONFIRM CLAIMS

Before paying any benefits, the Benefit Fund may require that:

- You, your spouse or your children be examined by a doctor or dentist selected by the Benefit Fund as often as required during the period of the claim; or
- An autopsy be performed to determine the cause of death, except where prohibited by law.

SECTION VII. D

WHAT IS NOT COVERED

In addition to the various exclusions and limitations set forth elsewhere in this SPD, to the extent permitted by law, the Benefit Fund **does not cover** the following charges:

- Charges associated with any work-related accidental injuries or diseases that are covered under Workers' Compensation or comparable law
- Charges for care resulting from an act of war
- Charges for claims containing misrepresentations or false, incomplete or misleading information
- Charges for claims submitted more than 12 months after the date of service
- Charges for Experimental or unproven procedures, services, treatments, supplies, devices, drugs, etc. (see definition of "Experimental" and exceptions for clinical trials in Section IX)
- Charges for Habilitative Services provided in an educational setting or that are not physical, occupational or speech therapy
- Charges for infertility treatment including, but not limited to, in vitro fertilization, artificial insemination, embryo storage, cryosterilization and reversal of sterilization
- Charges for in-hospital services that can be performed on an ambulatory or outpatient basis
- Charges for invalid and/or obsolete CPT or HCPCS codes
- Charges for over-the-counter, personal, comfort or convenience items such as bandages or heating pads (even if your physician recommends them)
- Charges for procedures, treatments, services, supplies or drugs for cosmetic purposes, except to remedy a condition that results from an illness or accidental injury
- Charges for service codes that are inconsistent with the diagnosis or service rendered
- Charges for services covered under any mandatory automobile or no-fault insurance policy
- Charges for services in excess of or not in compliance with the Benefit Fund's guidelines, policies or procedures
- Charges for services or materials that do not meet the Benefit Fund's standards of professionally recognized quality
- Charges for services provided and supplies or appliances used before you, your spouse or your children became eligible for Benefit Fund coverage

- Charges for services that are custodial in nature, including Skilled Nursing and Residential Treatment Facilities
- Charges for services that are not covered by the Benefit Fund, even if the service is Medically Necessary
- Charges for services that are not FDA-approved for a particular condition
- Charges for services that are not Medically Necessary
- Charges for services, treatments and supplies covered under any other insurance coverage or plan, or covered 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 pre-authorized in accordance with the terms of the Plan
- Charges for telehealth services not provided in compliance with applicable state laws or the Benefit Fund's telehealth policy
- Charges in excess of the Benefit Fund's Schedule of Allowances
- Charges made by your provider for broken appointments
- Charges related to an illness, accident 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, no-fault insurance carrier or other entity
- Charges related to interest, late charges, finance charges, court or other legal costs
- Charges related to programs for smoking cessation, weight reduction, stress management and other similar programs that are not provided by a licensed medical physician or are not Medically Necessary
- Charges related to an illness, accident or injury that was the result of you committing a criminal act (except as a victim of domestic abuse) or was deliberately self-inflicted (except where attributable to a mental condition)
- Charges that are not itemized
- Charges that are unreasonable, excessive, or beyond the provider's normal billing rate, scope or specialty
- Charges that would not have been made if no coverage existed or charges that neither you nor any of your dependents are required to pay. For example, the Benefit Fund **will not pay** for services provided by members of your or your dependent's immediate family.

SECTION VII. E

ADDITIONAL PROVISIONS

Nothing in this SPD shall be construed as creating any right in any third party to receive payment from this Benefit Fund.

No legal action may be brought against the Benefit Fund or the Trustees until all remedies under the Fund have been exhausted, including requests for Administrative Reviews or appeals.

No legal action may be brought against the Benefit Fund or the Trustees by a provider as an assignee of you, your spouse or your children after three years from the date of service.

No legal action for benefits under the Plan or for a breach of ERISA may be brought in a forum other than a federal court in New York City.

Payments made by the Benefit Fund which are not consistent with the Plan — as described in this SPD or as it may be amended — must be returned to the Fund.

No benefit payable under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, except as expressly provided in Section VIII.

Any such action 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 Benefit 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 their dependents would otherwise be entitled until full restitution has been made. The Trustees reserve the right to turn any such matter over to the proper authorities for prosecution.



SECTION VIII – GENERAL INFORMATION

- A. Your ERISA Rights
- B. Plan Amendment, Modification and Termination
- C. Authority of the Plan Administrator
- D. Information on the Plan

SECTION VIII. A

YOUR ERISA RIGHTS

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

GETTING INFORMATION

You have the right to:

- Request the latest updated Summary Plan Description, Summary of Benefits and Coverage, annual report and trust agreement. You can obtain copies of these documents by writing to the Plan Administrator at PO Box 2661, New York, NY 10108-2661. The Plan Administrator can make a reasonable charge for copies requested by mail. You can also examine these documents, as well as the Schedule of Allowances and any terminal report, without charge at the Benefit Fund’s Headquarters.
- Receive a copy of the Summary Plan Description within 90 days of becoming a Plan participant.
- Receive an updated copy of the Summary Plan Description at least every five years.
- Receive a summary of the Benefit Fund’s annual financial report. Union and Benefit Fund periodicals may be used for this purpose.

NOTE: The above rights may NOT be transferred or assigned to a third party. Only you, as the participant or

beneficiary, are entitled to request the documents described above.

CONTINUE GROUP HEALTH COVERAGE

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

PRIVACY OF PROTECTED HEALTH INFORMATION

A federal law — the Health Insurance Portability and Accountability Act (“HIPAA”) — imposes certain confidentiality and security obligations on the Benefit Fund with respect to medical records and other individually identifiable health information used or disclosed by the Benefit Fund. HIPAA also gives you rights with respect to your health information, including certain rights to receive copies of the health information that the Benefit Fund maintains about you, and knowing how your health information may be used. The 1199SEIU Family of Funds’ Eligibility Department may share eligibility and enrollment information with the Benefit

Fund, your Employer, the Job Security Fund or the Union for enrollment and outreach purposes. The Benefit Fund may share enrollment information with the 1199SEIU Family of Funds' Eligibility Department for enrollment purposes. A complete description of how the Benefit Fund uses your health information, and of your other rights under HIPAA's privacy rules, is available in the Fund's *Notice of Privacy Practices*, which is distributed to all named participants and posted on the Fund's website at www.1199SEIUBenefits.org. Anyone may request an additional copy of this Notice by calling the Benefit Fund at (646) 473-9200.

FIDUCIARY RESPONSIBILITY

In addition to creating rights for Benefit Fund participants, ERISA imposes duties on the people responsible for operating the Benefit Fund, called **fiduciaries**.

The fiduciaries have a responsibility to operate the Benefit Fund prudently and in the interest of all Benefit Fund members and eligible dependents.

No one, including your Employer, may fire you or discriminate against you in any way to prevent you from obtaining a benefit from this 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 the required Benefit Fund documents described in this section from the Plan (by writing to the Plan Administrator at PO Box 2661, New York, NY 10108- 2661), and you do not receive them within 30 days, you have the right to file a suit under ERISA only in a federal court in New York City. In this case, the court may require the Plan Administrator to provide the documents and possibly pay you up to \$110 a day until you receive the materials, unless the documents were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits which is entirely or partially denied or ignored, you have the right to file a suit under ERISA only in a federal court in New York City, after you have completed the appeal procedure (see Section VII.B), if you believe that the decision against you is arbitrary and capricious or violates ERISA.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you have the right to file a suit under ERISA only in a federal court in New York City.

- If the Benefit Fund’s fiduciaries misuse the Fund’s money, or if you are discriminated against for asserting your rights, you may get help from the U.S. Department of Labor, or you have the right to file a suit under ERISA only in a federal court in New York City.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order that you be paid these costs and fees. If you lose, the court may require you to pay these costs and fees (for example, if it finds your claim is frivolous).

For information regarding your federal civil rights, see Section VIII.D.

ASSIGNING YOUR RIGHTS

You may not transfer or assign your Plan rights or benefits to anyone, with one exception: You may assign to Non-participating Providers your right to a Plan benefit and to sue to get a Plan benefit. If you assign to a Non-participating Provider your right to a Plan benefit, the provider will have no greater rights than you have, and may not, in turn, assign the right to anyone else. If the provider exercises your right to the benefit, you will no longer have the right to receive that benefit. A Non-participating Provider can only file a lawsuit disputing an Adverse Benefit Determination:

- As an assignee of your right to Plan benefits and to bring an ERISA claim;
- In a federal court in New York City;

- Within three years from the date of service; and
- After the administrative appeal has been completed, in accordance with Section VII.B.

NOTE: No other rights conferred under the terms of the Plan or ERISA may be transferred or assigned. You cannot assign your right to appeal an Adverse Benefit Determination but you can authorize a representative to appeal on your behalf (see Section VII.B).

QUESTIONS?

If you have any questions about:

- Your Benefit Fund, call the Fund at (646) 473-9200.
- Your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, call the nearest area office of the U.S. Department of Labor’s Employee Benefits Security Administration listed in your telephone directory, or write to: Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Publications Hotline of the Employee Benefits Security Administration at (866) 444-3272.

SECTION VIII. B

PLAN AMENDMENT, MODIFICATION AND TERMINATION

The Plan Administrator reserves the right, within its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies), at any time and for any reason, by action of the Board of Trustees, including 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 non-forfeitable right to receive benefits under the Benefit Fund.

SECTION VIII. C

AUTHORITY OF THE PLAN ADMINISTRATOR

Notwithstanding any other provision in the Plan, and to the full extent permitted by ERISA and the Internal Revenue Code, the Plan Administrator shall have the exclusive right, power and authority, in its sole and absolute discretion:

- To administer, apply, construe and interpret the Plan and any related Plan documents;
- To decide all matters arising in connection with entitlement to benefits, the nature, type, form, amount and duration of benefits, and the operation or administration of the Plan; and
- To make all factual determinations required to administer, apply, construe and interpret the Plan (and all related Plan documents).

Without limiting the generality of the statements in this section, 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;
- (viii) Process and approve or deny benefit claims, and rule on any benefit exclusions; and
- (ix) Deny, restrict or prohibit Assignments of Benefits to Non-participating Providers.

All determinations made by the Plan Administrator (including any duly authorized designee thereof) and/or the Appeals Committee of the Board of Trustees with respect to any matter arising under the Plan and any other Plan documents shall be final and binding on all parties. In addition, the Plan Administrator may bring a court action to enforce the terms of the Plan or to recover benefit overpayments.

SECTION VIII. D

INFORMATION ON THE PLAN

NAME OF THE PLAN

The 1199SEIU 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:

498 Seventh Avenue
New York, NY 10018

SOURCE OF INCOME

Payments are made to the Benefit Fund by your Employer and other Contributing Employers, according to the Collective Bargaining Agreements with 1199SEIU United Healthcare Workers East.

Employers' contribution rates are set forth in the applicable Collective Bargaining Agreements. They are estimated to adequately meet the anticipated cost of claims and administration. Because the Benefit Fund is a multiemployer fund, costs are calculated on a pooled basis.

You may get a copy of any Collective Bargaining Agreement by writing to the Plan Administrator at PO Box 2661, New York, NY 10108-2661, or by examining a copy at the Benefit Fund.

You can find out if a particular Employer contributes to the Benefit Fund by writing

to the Plan Administrator. The address of the Employer will also be given.

ACCUMULATION OF ASSETS

The Benefit Fund's assets are held in trust 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 of the Board of Trustees and other senior employees. If you have any questions, please call our Benefit Fund's Member Services Department at (646) 473-9200.

The Trustees may be contacted at:

c/o Executive Director
1199SEIU National Benefit Fund for Health and Human Service Employees
498 Seventh Avenue, 10th Floor
New York, NY 10018
Phone: (646) 473-9200

FOR SERVICE OF LEGAL PROCESS

Legal process may be served on the Board of Trustees, the Plan Administrator or the Benefit Fund's Counsel.

The Trustees may be contacted at:

c/o Executive Director
1199SEIU National Benefit Fund for
Health and Human Service Employees
498 Seventh Avenue, 10th Floor
New York, NY 10018
Phone: (646) 473-9200

The Benefit Fund's Counsel may be contacted at:

1199SEIU National Benefit Fund for
Health and Human Service Employees
General Counsel's Office
498 Seventh Avenue, 10th Floor
New York, NY 10018
Phone: (646) 473-9200

IDENTIFICATION NUMBER

Employer Identification Number:
13-1628401

ERISA Plan Number: 501

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
498 Seventh Avenue
New York, NY 10018
(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/smartscreen/main.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 www.hhs.gov/ocr/complaints/index.html.

TRUSTEES

The Board of Trustees is composed 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:

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Yvonne Armstrong Senior Executive Vice President 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018	Patrick Forde Vice President 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018
Michael Ashby Vice President 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018	George Gresham President 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018
Lisa Brown Executive Vice President 1199SEIU United Healthcare Workers East 611 North Eutaw Street Baltimore, MD 21201	Tracey Harrison Vice President 1199SEIU United Healthcare Workers East 259 Monroe Avenue Rochester, NY 14607

UNION TRUSTEES

Antonio Howell Executive Vice President 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018	Victor Rivera Vice President 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018
Maria Kercado Executive Vice President 1199SEIU United Healthcare Workers East 99 Church Street, 4th Floor White Plains, NY 10601	Helen Schaub Vice President 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018
Steve Kramer Executive Vice President 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018	Veronica Turner Senior Executive Vice President 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018
Joyce Neil Executive Vice President 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018	Nadine Williamson Vice President 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018

EMPLOYER TRUSTEES

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Susan Bornstein Vice President of Human Resources Menorah Center for Rehabilitation and Nursing Care 1516 Oriental Boulevard Brooklyn, NY 11235	Rebecca Gordon Vice President of Labor and Employee Relations Northwell Health 1111 Marcus Avenue, Ste. LL20 Lake Success, NY 11042
David Brodsky Vice President of Employee and Labor Relations Montefiore Medical Center 111 East 210th Street Bronx, NY 10467	Marc Z. Kramer President League of Voluntary Hospitals and Homes of New York 555 West 57th Street, Ste. 1530 New York, NY 10019
James Carey Executive Director R.A.I.N. Home Attendant Services 811 Morris Park Avenue Bronx, NY 10462	Barbara Logan Consultant League of Voluntary Hospitals and Homes of New York 555 West 57th Street, Ste. 1530 New York, NY 10019
Jeffrey Cohen Vice President of Labor Relations and Human Resources Mount Sinai Medical Center 19 East 98th Street, Ste. 2H New York, NY 10029	Guy Mennonna Senior Vice President, Human Resources The Brooklyn Hospital Center 121 DeKalb Avenue Brooklyn, NY 11201

EMPLOYER TRUSTEES

<p>Brian P. Mitchell Assistant Director, Human Resources St. John's Riverside Hospital 967 North Broadway Yonkers, NY 10701</p>	<p>Paul Stuart Vice President of Human Resources Maimonides Medical Center 4802 Tenth Avenue Brooklyn, NY 11219</p>
<p>Robert Oliver, Jr. Consultant League of Voluntary Hospitals and Homes of New York 555 West 57th Street, Ste. 1530 New York, NY 10019</p>	<p>Audrey Wathen Senior Vice President of Human Resources Jewish Home Lifecare 120 West 106th Street New York, NY 10025</p>
<p>Jordy Rabinowitz Senior Vice President of Human Resources Westchester Medical Center 100 Woods Road – Executive Offices Valhalla, NY 10595</p>	<p>Stacie Williams Vice President of Human Resources NewYork-Presbyterian Hospital 622 West 168th Street New York, NY 10032</p>
<p>Michael N. Rosenblut President and CEO Parker Jewish Institute for Health Care and Rehabilitation 271-11 76th Avenue New Hyde Park, NY 11040</p>	<p>Keith Wolf Senior Vice President of Human Resources St. Barnabas Hospital 4422 Third Avenue Bronx, NY 10457</p>



SECTION IX – DEFINITIONS

DEFINITIONS

Accident

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

Accidental Death and Dismemberment

Plan sponsored by Amalgamated Life Insurance Company under an agreement with the Trustees providing for payments to a beneficiary designated by the employee under the circumstances described in Section IV.C and in the Certificate of Coverage (policy).

Administrative Review

The procedure to appeal a claim that the Benefit Fund has rejected or denied in part. An Administrative Review can be requested by you, your dependents (your spouse or your children) or another individual that has received your written authorization to appeal on your behalf. Your authorized representative cannot, in turn, authorize another party to appeal on their behalf.

Adverse Benefit Decision or Adverse Benefit Determination

A denial or partial denial of a claim for benefits.

Affordable Care Act

The Patient Protection and Affordable Care Act, as amended from time to time.

Ambulance

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Ambulatory Care

Health services that do not require an overnight hospital stay. These services may be performed in the outpatient center of a hospital, surgical center, ambulatory care center or in the operating room at a doctor's office.

Annual Base 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(s) of Benefits

1. The Benefit Fund will pay its allowance to your doctor, dentist, laboratory, etc., directly when you request it to do so by signing the "Assignment of Benefits" authorization on your claim form. The Benefit Fund will only pay those benefits allowed under the Plan. The Benefit Fund pays the hospital directly for the inpatient and Emergency Department care charges allowed by the Plan.
2. See Lien Acknowledgment.

No other rights conferred under the terms of this Plan or ERISA may be assigned.

Average Weekly Earnings

The weekly average of your earnings wages reported to the Benefit Fund by your Employer. The number of weeks averaged varies depending on the Fund determining Wage Class, Disability Benefit amount or Paid Family Leave Benefit amount.

Beneficiary(ies)

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

Benefit(s)

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

Brand-name Prescription Drug

An FDA-approved prescription drug marketed with a specific brand name by the company that manufactures it, usually by the company which develops and patents it.

Calendar Year

The 12-month period beginning January 1 and ending December 31.

Children

Your children who are eligible to receive benefits from the Benefit Fund, as described in Section I.A.

Chiropractor

A person licensed by the appropriate department of the state to practice within the chiropractic profession for which 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 or COBRA Coverage

Coverage provided to a member or eligible dependent for a temporary period under certain circumstances. The member or eligible dependent must pay for this coverage. See Section I.K for more detailed information.

Concurrent Review

A review of a request to extend a course of treatment, as services are being provided to you, to determine whether such services continue to be Medically Necessary Covered Services.

Contributing Employer

1. An Employer who has a Collective Bargaining Agreement with 1199SEIU United Healthcare Workers East, or one of its affiliates, which provides for regular monthly payments in an amount specified by the Trustees to this Benefit Fund on behalf of the employees covered by the agreement for all benefits in this Summary Plan Description.

2. 1199SEIU United Healthcare Workers East, its affiliates, the Benefit Fund or any other Employer accepted as a contributor by the Trustees and its affiliated and related Funds that are obligated to make regular monthly payments in an amount specified by the Trustees to the Benefit Fund on behalf of its employees.

Coordination of Benefits

A method of sharing costs among payers, which sets the order of payment by each. See Section I.F for more detailed information.

Co-payment

A dollar amount paid by you directly to the healthcare provider at the time services are received. Some of the benefits to which you are entitled are subject to co-payments. These co- payments are described on a separate list, which will be supplied to you. Co-payments may be changed by the 1199SEIU National Benefit Fund from time to time.

Cosmetic Surgery

Includes any procedure where the primary purpose is to improve, alter or enhance appearance. Procedures to correct a cosmetic disfigurement due to disease are **not covered** unless the disfigurement causes a functional impairment, or unless the surgical correction of the cosmetic disfigurement due to disease is performed in conjunction with a staged reconstructive surgical procedure to improve or restore bodily function.

Cosmetic surgery for psychological or emotional reasons is **not covered** when no functional impairment is present.

Covered Employment

Employment for which your Employer makes contributions to the Benefit Fund on your behalf pursuant to a Collective Bargaining Agreement or other agreement accepted by the Board of Trustees.

Covered Expenses

Medical, dental, prescription, vision or hearing services and supplies shown as covered under this SPD.

Custodial Care

Care is considered custodial when it is primarily for the purpose of attending to the participant's daily living activities. Custodial care can be prescribed by a physician or given by trained medical personnel, or could be provided by persons without professional skills or training. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected wounds, post-operative or chronic conditions, preparation of special diets and supervision of medication which can be self-administered by the member.

Dentist

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

Dependent

Your spouse or your children who are eligible to receive benefits from the Benefit Fund, as described in Section I.A.

Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated, or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol- or drug-dependent factors; or
- Alcohol in combination with drugs.

Disability Pension

A defined benefit pension plan from the 1199SEIU Health Care Employees Pension Fund you may be entitled to when you have retired from all active employment, are “vested” and have received a Pension Disability Award from Social Security.

Disabled

When you are temporarily unable to work due to an illness, accident or injury.

Doctor

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

Durable Medical Equipment

Equipment that can withstand repeated use, is primarily and usually used to serve a medical purpose and is generally not useful to a person in the absence of illness or injury.

Early Retirement Pension

A defined benefit pension plan from the 1199SEIU Health Care Employees Pension Fund you may be entitled to that is actuarially reduced in accordance with your early retirement date, when you have retired from all active employment before the Normal Retirement Age and have the minimum required Years of Pension Fund Credited Service.

Earnings

Wages reported by a Contributing Employer as the basis for determining the Employer’s payments to the Benefit Fund.

Effective Date of Coverage

The date your and your dependent’s coverage begins under this SPD as noted in your Employer’s records.

Eligible

When you have met the criteria adopted by the Trustees of the Benefit Fund to determine your enrollment, plan of benefits and Wage Class.

Emergency

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

Emergency Admission

An admission to a hospital or treatment facility ordered by a physician within 24 hours after you receive emergency services.

Employer

See Contributing Employer.

Enrollment Form

The form used to provide the Benefit Fund with the personal, employment and beneficiary information needed to determine your benefits and process your claims. Other types of enrollment forms include Life Insurance Beneficiary Selection Form and Coordination of Benefits forms.

ERISA

The Employee Retirement Income Security Act of 1974, as amended from time to time.

Executive Director

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

Any investigational or unproven treatment, procedure, facility, equipment, drug, device or supply which **does not meet any one or more** of the following criteria for use in treating the condition being reviewed:

- If a drug, biological product, 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;

- There must be reliable scientific evidence, including peer-reviewed evidence-based studies and literature meeting nationally recognized requirements, demonstrating that the technology/treatment improves net health outcomes and is safe and effective; or
- The improvement in net health outcomes must be attainable under the usual conditions of medical practice.

Family

Your spouse and your children who are eligible to receive benefits from the Benefit Fund, as described in Section I.A.

FDA (Food and Drug Administration)

The U.S. Department of Health and Human Services agency responsible for ensuring the safety and effectiveness of all food, drugs, biologics, vaccines and medical devices.

Fiduciary

Each of the Trustees and others responsible for directing the administration of the Benefit Fund, and their responsibilities under the law.

Full Time

The number of hours worked in a normal regular workweek, as set forth in the applicable Union contract. Overtime is **not included**.

Fund or Trust Fund

The 1199SEIU National Benefit Fund for Health and Human Service Employees, whose principal office is at 498 Seventh Avenue in New York City, through which benefits are provided.

Generic Prescription Drug

A prescription drug with the same dosage, safety, strength, quality, performance and intended use as the brand-name product. It is defined as therapeutically equivalent by the FDA and is considered to be as effective as the brand-name product.

Habilitative Services

Healthcare services that help you keep, learn or improve skills and functioning for daily living.

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 meets **all** of the following requirements:

- Primarily provides services to diagnose, treat and care for injured, disabled or sick patients by or under the supervision of a doctor;
- Provides 24-hour nursing service with the care given or supervised by a registered professional nurse;

- Maintains complete medical records on all patients;
- Has by-laws in effect with respect to its staff of physicians;
- Has a hospital utilization review plan in effect;
- Is licensed by the federal government and by the state in which the hospital is located; and
- Has accreditation under one of the programs of the Joint Commission.

The term “hospital” **does not include** an institution or part of an institution that is used mainly as:

- A rest or nursing facility;
- A facility for the aged, chronically ill, convalescents, or alcohol or drug addicts; or
- A facility providing custodial, psychiatric, education or rehabilitative care.

Illness

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

Leave

A job-protected leave of absence from your place of employment.

Legal Separation

A marital status whereby spouses, while remaining legally married, have chosen to live separate lives physically and economically, as determined in the sole discretion of the Trustees, and as evidenced by, but not limited to, such circumstances as the following: living separate and apart from each other; maintaining separate legal residences and/or separate finances; having custody arrangements for children; or formally dividing joint legal property, assets and responsibilities.

Legally Separated

See Legal Separation.

Level of Benefit

The 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 and your covered children are entitled.

Lien Acknowledgment

A form that describes and acknowledges the Benefit Fund’s right to recover up to the amount it has paid or will pay for expenses relating to any claims which you or your beneficiary may have against any person or entity responsible for an illness, accident or injury, including illness, accident or injury resulting from medical malpractice, as described in Section I.G.

Lien Determination

A determination that one or more of your claims for benefits is not covered because it is an expense resulting from an illness, accident or injury caused by the conduct of a third party, including expenses for treatment related to an illness, accident or injury that resulted from medical malpractice.

Life Insurance

Plan sponsored by Amalgamated Life Insurance Company under an agreement with the Trustees for the purpose of providing payments to beneficiaries designated by the employee in the event of the death of the employee as described in Section IV and in the Certificate of Coverage (policy).

LPN

A licensed practical or vocational nurse.

Maternity Care

Includes prenatal and postnatal care, as well as care required by childbirth and miscarriages.

Medically Necessary

Services or supplies which are determined by the Plan Administrator as Medically Necessary and rendered at the appropriate level of care to identify or treat the non-occupational illness, non-occupational injury or pregnancy, which a doctor has diagnosed or reasonably suspects. To be Medically Necessary, the Plan Administrator

must determine, in its sole exercise of discretion, that the services or supplies:

- Are consistent with the diagnosis and treatment of the patient's condition;
- Are in accordance with the standards of accepted medical practice;
- Are not solely for the convenience of the patient, physician and/or supplier;
- Are performed at a level of care not greater than required for the patient's condition;
- Will result in a measurable and ongoing improvement in the patient's health. For example, if the maximum therapeutic benefit has been met, then Medical Necessity cannot be established;
- Will result in a change in diagnosis or proposed treatment plan. For example, if other procedures have already established a diagnosis, ongoing procedures are not considered Medically Necessary if their only purpose is confirmatory; and
- Are advanced therapies that have only been rendered after more conservative medical treatments have been attempted without therapeutic improvement.

Medicare

The program of health insurance legislated by the federal government and administered by the Social Security Administration of the U.S. Department of Health and Human Services.

Member

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 their class of former members.

Mental Health Benefits

Services for illnesses typically treated by psychiatrists, psychologists or other licensed therapists using psychotherapy and/or psychotropic drugs.

Network Administrator

As used in this SPD, shall mean an outside company or administrator retained by the Plan to carry out administrative functions such as processing claims, hearing appeals or leasing provider networks.

Network Provider

See Participating Provider.

Newly Organized

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

under expired contracts, which are subsequently renewed or extended, or employees joining a bargaining unit after coverage under the Plan for employees in such a unit has been negotiated.

Non-participating

A duly licensed healthcare professional or other provider who does not have any fee agreement with the Benefit Fund.

Non-urgent Admission

An inpatient admission that is not an Emergency admission or an urgent admission.

Normal Retirement Age

Age 65 or older, if you are “vested” under the terms of the 1199SEIU Health Care Employees Pension Fund.

Normal Retirement Pension

A defined benefit pension plan from the 1199SEIU Health Care Employees Pension Fund you may be entitled to when you have retired from all active employment on or after the Normal Retirement Age and have the minimum required Years of Pension Fund Credited Service.

Occupational (Work-related) Illness, Injury or Disease

An abnormal condition or disorder arising out of employment conditions, including a workplace accident, or employment conditions that are a distinctive feature of the worker’s job.

Orthodontic Treatment

Any medical or dental service or supply, furnished to prevent, diagnose or correct a misalignment of the teeth, bite, or jaws or jaw joint relationship, whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

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.

Part Time

An employee who is regularly scheduled to work a number of hours per week, which is less than the number of hours stipulated in the applicable Union contract for full-time employees performing the same work.

Participating Pharmacy

A licensed, registered pharmacy that has signed an agreement with the Benefit Fund's Pharmacy Benefit Manager.

Participating Provider

A duly licensed health practitioner such as a dentist, dental specialist, physician, board-certified or board-eligible specialist, podiatrist, chiropractor, psychologist, psychiatric social worker, optician, optometrist or medical supplier, who has signed an agreement with the Benefit Fund or with a network with which the Benefit Fund has a contract, to charge no more than the Fund's Schedule of Allowances.

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.

Pharmacy

An establishment where prescription drugs are legally dispensed. Includes a retail pharmacy, mail-order pharmacy and specialty pharmacy network pharmacy.

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 to the 1199SEIU National Benefit Fund for Health and Human Service Employees for the various levels of benefits as adopted and interpreted by the Trustees and the official documents, such as the Trust Agreement and this SPD, including its preface, in which those benefits and rules and regulations are described.

Plan Administrator

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

Podiatrist

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

Pre-certification

Prior Authorization for inpatient hospital admission.

Preferred Brand-name Drugs

Brand-name drugs included in the Benefit Fund's Preferred Drug List.

Preferred Drugs

Generic alternatives to brand-name drugs.

Primary Care Doctor

The doctor having primary responsibility for your medical care. You choose your own Primary Care Doctor in accordance with the 1199SEIU Benefit Fund guidelines, subject to the doctor's acceptance. A Primary Care Doctor generally practices in the area of family medicine, internal medicine or pediatrics.

Prior Authorization

A requirement to submit a treatment plan or call the Benefit Fund or its agents prior to receiving services or supplies. This review process evaluates the Medical Necessity and appropriateness of a proposed service or care. This includes, but is not limited to, some dental claims; certain home care services or treatment; admissions and intermediate care for mental health or alcohol/substance abuse; admissions for physical rehabilitation; certain prescription drugs; and all non-Emergency hospital admissions and surgical procedures. Prior Authorization **does not include** an eligibility determination or a review of a Non-participating Provider's charges. There may be certain penalties, as described in this SPD, if you fail to obtain Prior Authorization.

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.

Referral

A written or electronic authorization made by your Primary Care Doctor to direct you to a specialist for Medically Necessary services or supplies covered under the Plan.

Rehabilitation Facility

A facility, or a distinct part of a facility, which provides rehabilitative services, meets any licensing or certification standards established by the jurisdiction where it is located and makes charges for its services.

Rehabilitative Services

Healthcare services that help you keep, get back or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt or disabled.

Retired Member or Retiree

A person who is currently receiving a pension from the 1199SEIU Health Care Employees Pension Fund.

Retrospective Review

A review of a request, after services have been provided to you, to determine whether such services were Medically Necessary Covered Services and whether and to what extent benefits are payable.

RN

A registered nurse.

Room and Board

Charges made by an institution for room and board and other Medically Necessary services and supplies. The charges must be regularly made at a daily or weekly rate.

Schedule

A list of items covered and/or amounts paid.

Schedule of Allowances

List of fees for each service allowed or paid by the Plan, as established by the Trustees. The Centers for Medicare & Medicaid Services' rules for bundling payments apply.

Semi-private Room Rate

The room and board charge that an institution applies to the most beds in its semi-private rooms with two or more beds.

Skilled Nursing Facility

A facility that provides medical and nursing care and is recognized as such by Medicare.

Skilled Nursing Services

Services that meet **all** of the following requirements:

- The services require medical or paramedical training;
- The services are rendered by a registered nurse or licensed practical nurse within the scope of their license; and
- The services are not custodial.

Specialist

A physician licensed by the appropriate department of the state to practice within the generally accepted medical or surgical sub-specialty for which they have been licensed.

Specialty Care

Healthcare services or supplies that require the services of a specialist.

Specialty Care Drugs

Prescription drugs, typically high-cost, that require special handling, storage, monitoring and/or routes of administration.

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.

Stay

A full-time inpatient confinement for which a room and board charge is made.

Substance Abuse

A physical or psychological dependency, or both, on a controlled substance or alcohol agent. This term **does not include** conditions not attributable to a mental disorder that are a focus of attention or treatment, an addiction to nicotine products, or food or caffeine intoxication.

Surgeon

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

Surgery Center

A freestanding ambulatory surgical facility that meets **all** of the following requirements:

- Meets licensing standards;
- Is set up, equipped and run to provide general surgery;
- Is directed by a staff of physicians (at least one of them must be on the premises when surgery is performed and during the recovery period);

- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period;
- Does not have a place for patients to stay overnight;
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a registered nurse; and
- Is equipped and has trained staff to handle Emergency Conditions.

Telehealth

A consultation between you and a provider who is performing a clinical medical or behavioral health service.

Telehealth (or telemedicine) services can be provided by:

- Two-way audiovisual teleconferencing;
- Telephone calls; or
- Any other method permitted by state law.

Terminally Ill (Hospice Care)

A medical prognosis of six months or less to live.

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 of 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 qualifies for and continues to receive statutory unemployment insurance.

Unreduced Pension

A defined benefit pension plan from the 1199SEIU Health Care Employees Pension Fund you may be entitled to that is equivalent to your Normal Retirement Pension, when you have retired from all active employment before the Normal Retirement Age and have the minimum required Years of Pension Fund Credited Service.

Urgent Admission

A hospital admission by a physician due to:

- The onset of or change in an illness;
- The diagnosis of an illness; or
- An injury.

The condition, while not needing an Emergency admission, is severe enough to require confinement as an inpatient in a hospital within two

weeks from the date the need for the confinement becomes apparent.

Urgent Condition

A sudden illness, injury or condition that meets **all** of the following requirements:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the Emergency Department of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

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 Pension Fund Credited Service

A period of time for which an employee earns service toward a pension under the rules described in the Plan and Summary Plan Description (including credited service recognized by the 1199SEIU Health Care Employees Pension Fund for purposes of pension eligibility in accordance with the terms of a reciprocity agreement between

the Fund and another pension plan) of the 1199SEIU Health Care Employees Pension Fund or its successors.

You or Your

As used in this SPD, the term “You” or “you” (or “Your” or “your”) refers to the member, as an individual, and/or to the member’s dependents, individually or together, depending on the context in which it is used.



1199SEIU NATIONAL BENEFIT FUND

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