1199SEIU

GREATER NEW YORK BENEFIT FUND

NEW JERSEY PLAN

SUMMARY PLAN DESCRIPTION

OF YOUR HEALTH AND WELFARE BENEFITS

ASSISTIVE TECHNOLOGY

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

SMARTPHONE OR TABLET

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

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Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-800-370-4526.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator
P.O. Box 14462, Lexington, KY 40512
(CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711
Fax: 859-425-3379 (CA HMO customers: 860-262-7705),
CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil

Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

LANGUAGE ASSISTANCE

TTY: 711

To access language services at no cost to you, call 1-800-370-4526.

Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526. (Spanish)

如欲使用免費語言服務，請致電 1-800-370-4526。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526. (Tagalog)

T'áá ni nizaad k'ehjí bee níká a'doowol doo bą́ą́h ílínígóó kojį́ hólne' 1-800-370-4526. (Navajo)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an. (German)

Për shërbime përkthimi falas për ju, telefononi 1-800-370-4526. (Albanian)

የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ። (Amharic)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-370-4526. (Arabic)

Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով: (Armenian)

Kugira uronke serivisi z'indimi atakiguzi, hamagara 1-800-370-4526 (Bantu)

আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে এই নম্বরে টেলিফোন করুন: 1-800-370-4526। (Bengali)

Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-800-370-4526. (BisayanVisayan)

သင့်အတွက် အခကြေးငွေ မရှိဘဲ ဘာသာစကားဝန်ဆောင်မှုများကို ဝင်ရောက်အသုံးပြုရန် 1-800-370-4526 သို့ခေါ်ဆိုပါ။ (Burmese)

Per accedir a serveis lingüístics sense cap cost per vostè, telefoni al 1-800-370-4526. (Catalan)

Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526. (Chamorro)

ᏣᎩᏍᏗ ᏕᏬᏂᎯᏍᏗ ᏅᏩᎾᏓᎸᏁᏗ Ꮭ ᎪᎱᏍᏗ ᏗᏟᎬᏩᏔᏁᏗ ᏱᎩ, ᏫᎰᎯᏏᏔᎸᏏ 1-800-370-4526. (Cherokee)

Anumpa tohsholi I toksvli ya peh pilla ho ish I paya hinla, I paya 1-800-370-4526. (Choctaw)

Tajaajiiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526. (Cushite-Oromo)

Voor gratis toegang tot taaldiensten, bell 1-800-370-4526. (Dutch)

Pou jwenn sèvis lang gratis, rele 1-800-370-4526. (French Creole-Haitian)

Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526. (Greek)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો 1-800-370-4526. (Gujarati)

No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i kēia helu kelepona 1-800-370-4526. Kāki 'ole 'ia kēia kōkua nei. (Hawaiian)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, 1-800-370-4526 पर कॉल करें। (Hindi)

Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526. (Hmong)

Iji nwetaòhèrè na ọrụ gasị asụsụ n'efu, kpọọ 1-800-370-4526. (Ibo)

Tapno maaksesyo dagiti serbisio maipapan iti pagsasao nga awan ti bayadanyo, tawagan ti 1- 800-3704526. (Ilocano)

Untuk mengakses layanan bahasa tanpa dikenakan biaya, hubungi 1-800-370-4526. (Indonesian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526 (Italian)

言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。(Japanese)

[illegible]
1-800-370-4526 [illegible]. (Karen)

무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오. (Korean)

M̀ dyi wuɖu-dù kà kò ɖò ɓě dyi mɔ́ɔ̀ǹ nì Pídyi ní, nìí, ɖá nɔ̀ɓà nìà kɛ: 1-800-370-4526. (Kru-Bassa)

بۆ دەسپێڕاگەیشتن بە خزمەتگوزاریی زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی 1-800-370-4526. (Kurdish)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526. (Laotian)

कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-370-4526 वर फोन करा. (Marathi)

Nan etal nan jikin jiban ikijen Kajin ilo an ejelok onen nan kwe, kirlok 1-800-370-4526. (Marshallese)

Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih 1-800-370-4526. (MicronesianPohnpeian)

ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526។ (Mon-Khmer, Cambodian)

निःशुल्क भाषा सेवा प्राप्त गर्न 1-800-370-4526 मा टेलफिोन गर्नुहोस् । (Nepali)

Të kɔɔr yïn wɛ̈ɛ̈r de thokic ke cïn wëu kɔr keek tënɔŋ yïn. Ke cɔl kɔc ye kɔc kuɔny ne nɔmba 1- 800-3704526. (Nilotic-Dinka)

For tilgang til kostnadsfri språktjenester, ring 1-800-370-4526. (Norwegian)

Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526. (Pennsylvania Dutch)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-370-4526تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-370-4526 (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526. (Portuguese)

ਤੁਹਾਡੇ ਲਈ ਬਨਿਾਂ ਕਸਿ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਫ਼ੋਨ ਕਰੋ। (Punjabi)

Pentru a accesa gratuit serviciile de limbă, apelați 1-800-370-4526. (Romanian)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1- 800-3704526. (Russian)

Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-800-370-4526. (Samoan)

Za besplatne prevodilačke usluge pozovite 1-800-370-4526. (Serbo-Croatian)

Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-800-370-4526. (Sudanic-Fulfulde)

Kupata huduma za lugha bila malipo kwako, piga 1-800-370-4526. (Swahili)

[illegible] (Syriac-Assyrian) 1-800-370-4526

మీరు భాష సేవలను ఉచితంగా అందుకునేందుకు, 1-800-370-4526 కు కాల్ చేయండి. (Telugu)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526 (Thai)

Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1- 800370-4526. (Tongan)

Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-800-370-4526. (Trukese)

Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-800-370-4526 numarayı arayın. (Turkish)

Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526. (Ukrainian)

بلاقیمت زبان سے متعلق خدمات حاصل کرنے کے لیے ، 1-800-370-4526. پر بات کریں۔(Urdu)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526. (Vietnamese)

צו צוטריט שפראך באַדינונגען אין קיין צָאָהלונג פאר, רופט 1-800-370-4526. (Yiddish)

Lati wọnú awọn isẹ̀ èdè l'ọfẹ fun ọ, pe 1-800-370-4526. (Yoruba)

This booklet serves as both a Summary Plan Description ("SPD") and Plan Document for participants in the 1199SEIU Greater New York Benefit Fund who are employed by New Jersey Employers.

The Plan is administered by the Board of Trustees (the "Trustees") of the 1199SEIU Greater New York Benefit Fund New Jersey Plan (the "Benefit Fund" or "Fund"). No individual or entity, other than the Trustees (or their duly authorized designees), 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 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 *sole* sources of information on the Plan. You cannot rely on information from co-workers or Union or Employer representatives. If you have any questions about the Plan and how its coverage works, the Benefit Fund staff will be glad to help you. Because telephone conversations and other oral statements can easily be misunderstood, they cannot be relied upon if they are in conflict with what is stated in this SPD.

NEED HELP WITH THE SUMMARY PLAN DESCRIPTION ("SPD")?

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

If the language is not clear to you, you can get assistance by calling the Benefit Fund at (646) 473-9200. Outside New York City, call (800) 575-7771.

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

¿NECESITA AYUDA CON EL SUMARIO DE DESCRIPCIÓN DEL PLAN?

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

Si usted no entiende este sumario y necesita ayuda, llame al Fondo al (646) 473-9200. Fuera de la ciudad de Nueva York, llame al (800) 575-7771.

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. 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. 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. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

January 2025

Dear 1199SEIU Member:

Your Benefit Fund provides a wide range of benefits for both full-time and part-time eligible participants. Medical Benefits under this Plan are provided by contract with Aetna. Dental Benefits under this Plan are provided by contract with Cigna. These benefits are described in this SPD and in information provided to you by Aetna and Cigna, respectively. Prescription and Life Insurance Benefits are provided by the Benefit Fund and are described in this SPD.

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 Aetna and Cigna Network Providers, you and your family can receive comprehensive care at little or no cost. Other than for Emergencies, benefits are not provided for any services rendered by non-Network Providers.

If you have any questions or concerns about your Medical Benefits, you may call Aetna Member Services at (866) 658-2455. If you have any questions or concerns about your Dental Benefits, you may call Cigna Member Services at (800) 244-6224. If you have any questions or concerns about your Prescription Drug Benefits, you may call the Benefit Fund's Member Services Department at (646) 473-9200 or, if you are outside New York City, (800) 575-7771.

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, as well as for other participants and their families.

The Board of Trustees

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NEED TO KNOW WHAT CERTAIN TERMS MEAN 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 Plan. Most defined terms are capitalized throughout this SPD.

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 the Benefit Fund’s Member Services Department at (646) 473-9200. Outside New York City, call (800) 575-7771.

INTRODUCTION

YOUR BENEFIT FUND

The 1199SEIU Greater New York Benefit Fund New Jersey Plan is a self-funded, labor-management, Taft-Hartley Trust Fund. Your coverage is provided as a result of a Collective Bargaining Agreement between your New Jersey Employer and your Union, 1199SEIU United Healthcare Workers East ("1199SEIU"). This Plan meets or exceeds the requirements for "minimum essential coverage" and provides coverage that is "affordable" and exceeds "minimum value," as those terms are defined by the Patient Protection and Affordable Care Act (the "Affordable Care Act").

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 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. 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. 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. 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.

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.

YOUR EMPLOYER PAYS FOR YOUR BENEFITS

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

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

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

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

OVERVIEW OF YOUR BENEFITS

IMPORTANT PHONE NUMBERS

Benefit Fund Member Services Department
(646) 473-9200 or (800) 575-7771

For answers to questions about your eligibility or Prescription Drug Benefit.

You can also visit our website at **www.1199SEIUBenefits.org** for forms, directories and other information. In addition, you can log into **MyAccount** (www.My1199Benefits.org) to check your eligibility, find out whether a claim has been paid, change your address or update other information.

Aetna Member Services
(866) 658-2455

For answers to questions about your Medical Benefits.

Cigna Member Services
(800) 244-6224 (CIGNA24)

For answers to questions about your Dental Benefits.

OVERVIEW OF YOUR BENEFITS

ELIGIBILITY CLASSES

For all Contributing Employers:

Eligibility Class I: Full-time members who generally work 35 or more hours per week. Coverage is for the member and the member's family.

Eligibility Class II: Part-time members who generally work between 22 and 35 hours per week. Part-time members receive benefits for themselves only. Coverage is for the member only. There is no dependent coverage.

Eligibility Class III: Part-time members who generally work between 7 and 22 hours per week. Part-time members receive benefits for themselves only. Coverage is for the member only. There is no dependent coverage.

The following is a quick reference guide that gives you an overview of your benefits. Do not rely on this guide alone. For a full explanation of each benefit, please read the rest of this SPD, as well as any information provided to you by Aetna and Cigna.

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

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.

COVERAGE	BENEFITS (IN-NETWORK ONLY)
MEDICAL	
Eligibility Class I: Family Coverage for Member, Spouse and Dependent Children **Eligibility Class II:** Coverage for Member Only **Eligibility Class III:** Coverage for Member Only	• Each individual must select an Aetna Primary Care Physician as their designated (or primary care) provider • Other than for Emergencies, services must be performed by designated Aetna Network Providers
Deductible (per calendar year) Once the family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year.	• $225 per individual/ $450 per family
Member Co-insurance Applies to all expenses unless otherwise stated.	• Covered at 85% of the Allowed Amount after deductible is met
Payment Limit (per calendar year) Certain member cost-sharing elements may not apply toward the Payment Limit. Once the family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.	• $800 per individual/ $1,600 per family (excludes deductible)
Referral Requirement	• None

COVERAGE	BENEFITS (IN-NETWORK ONLY)
PREVENTIVE CARE	
Routine Adult Physical Exams/ Immunizations One exam per calendar year for covered individuals age 19 or older.	• Covered 100% after $10 office visit co-payment
Routine Well-child Exams/ Immunizations	• Covered 100%
Routine Gynecological Care Exams Two exams per calendar year for covered individuals with female reproductive systems. Includes routine tests and related lab fees.	• Covered 100% after $10 office visit co-payment
Routine Mammograms One baseline for covered individuals with female breast tissue and lobules, between ages 35 to 39. One exam per calendar year for covered individuals with female breast tissue and lobules, age 40 or older.	• Covered 100%
Routine Digital Rectal Exams/ Prostate Specific Antigen (PSA) Tests One exam per calendar year for covered individuals with prostates, age 40 or older.	• Covered 100%
Colorectal Cancer Screenings One exam every 10 years for covered individuals age 45 or older.	• Covered 100%
Routine Hearing Exams and Hearing Aids	• Not covered

COVERAGE	BENEFITS (IN-NETWORK ONLY)
PHYSICIAN SERVICES	
Office Visits to Primary Care Physician (PCP) (includes services of an internist, general physician, family practitioner or pediatrician)	• $10 office visit co-payment
Specialist Office Visits	• $10 office visit co-payment
Allergy Testing	• $10 office visit co-payment (covered as either PCP or specialist visit)
Allergy Injections	• $10 office visit co-payment (no charge for serums if dispensed in a doctor's office)
Diagnostic Procedures If performed as part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost-sharing.	• Covered at 85% of the Allowed Amount after deductible is met
EMERGENCY MEDICAL CARE	
Urgent Care Provider	• $75 co-payment
Non-urgent Use of Urgent Care Provider	• Covered 100% after $75 co-payment
Emergency Department	• $125 co-payment (waived if admitted)
Non-emergency Services in an Emergency Department	• Not covered
Ambulance	• Covered at 85% of the Allowed Amount after deductible is met

COVERAGE	BENEFITS (IN-NETWORK ONLY)
HOSPITAL CARE	
Inpatient The member cost-sharing applies to all covered benefits incurred during your inpatient stay.	• Covered at 85% of the Allowed Amount after deductible is met
Inpatient Maternity The member cost-sharing applies to all covered benefits incurred during your inpatient stay.	• Covered at 85% of the Allowed Amount after deductible is met
Outpatient Surgery	• Covered at 85% of the Allowed Amount after deductible is met
Outpatient Hospital Expenses (excludes surgery) The member cost-sharing applies to all covered benefits incurred during your outpatient visit.	• Covered at 85% of the Allowed Amount after deductible is met
MENTAL HEALTH SERVICES	
Inpatient The member cost-sharing applies to all covered benefits incurred during your inpatient stay.	• Covered at 85% of the Allowed Amount after deductible is met
Outpatient The member cost-sharing applies to all covered benefits incurred during your outpatient visit.	• $10 co-payment

COVERAGE	BENEFITS (IN-NETWORK ONLY)
ALCOHOL/SUBSTANCE USE DISORDER SERVICES	
Inpatient The member cost-sharing applies to all covered benefits incurred during your inpatient stay.	• Covered at 85% of the Allowed Amount after deductible is met
Outpatient The member cost-sharing applies to all covered benefits incurred during your outpatient visit.	• $10 co-payment
OTHER SERVICES	
Convalescent Facility (Skilled Nursing Care) The member cost-sharing applies to all covered benefits incurred during your inpatient stay (limited to 60 days per calendar year).	• Covered at 85% of the Allowed Amount after deductible is met
Home Health Care (includes private-duty nursing) Each visit by a nurse or therapist is one visit. Each visit up to four hours by a home health care aide is one visit.	• Covered at 85% of the Allowed Amount after deductible is met
Hospice Care—Inpatient The member cost-sharing applies to all covered benefits incurred during your inpatient stay.	• Covered at 85% of the Allowed Amount after deductible is met
Hospice Care—Outpatient The member cost-sharing applies to all covered benefits incurred during your outpatient visit.	• Covered at 85% of the Allowed Amount after deductible is met

COVERAGE	BENEFITS (IN-NETWORK ONLY)
OTHER SERVICES (continued)	
Inpatient Short-term Rehabilitation Limited to 30 days per calendar year. The member cost-sharing applies to all covered benefits incurred during your inpatient stay.	• Covered at 85% of the Allowed Amount after deductible is met
Outpatient Short-term Habilitation and Rehabilitation (includes cognitive, speech, physical and occupational therapy) Limited to 20 visits per calendar year (all therapies combined).	• $10 co-payment
Spinal Manipulation Therapy	• Covered 100% after $10 co-payment
Durable Medical Equipment	• Covered at 85% of the Allowed Amount after deductible is met
Diabetic Supplies	• Covered as any other medical expense or pharmacy benefit, as applicable
Transplants Coverage is provided at an Institute of Excellence-contracted (IOE) facility only ($10,000 travel and lodging maximum)	• Covered at 85% of the Allowed Amount after deductible is met; payable as any other covered expense
Vision Care Limited to one routine eye exam and one pair of eyeglasses every two years. In lieu of eyeglasses, one order of contact lenses every two years.	• $10 co-pay for one eye exam every two years • $125 allowance once every two years for one pair of eyeglasses; in lieu of eyeglasses, one order of contact lenses

COVERAGE	BENEFITS (IN-NETWORK ONLY)
FAMILY PLANNING	
Contraceptive Drugs and Devices Not Obtainable at Pharmacy (includes coverage for contraceptive visits)	• Covered at 85% of the Allowed Amount after deductible is met; payable as any other covered expense
Pharmacy Contraceptive Drugs and Devices	• Covered as any other prescription drug expense
Fertility Services	• Covered for Eligibility Class I only • Fertility services are covered through Progyny • Call Progyny at (833) 233-0431 • See Section II.D.1 for information
Voluntary Sterilization (includes tubal ligation and vasectomy)	• The member cost-sharing is based on the type of service performed and the place of service where it is rendered

COVERAGE	BENEFITS (IN-NETWORK ONLY)
The following Dental Benefits are provided by Cigna and are subject to co-payments and limitations as described.	
DENTAL	
Eligibility Class I: Family Coverage for Member, Spouse and Dependent Children **Eligibility Class II:** Not Covered **Eligibility Class III:** Not Covered	• Each individual must select a Cigna Network Dentist as their designated (or primary care) dentist • Other than for Emergencies, services must be performed by designated Cigna Network Dentists • Co-payments and limitations may apply for some procedures (see Cigna's Dental Care Patient Charge Schedule for a list of covered procedures and applicable co-payments)
Referral Requirement	• Referrals required for some specialists

COVERAGE	BENEFITS (IN-NETWORK ONLY)
The following benefits are provided by the Benefit Fund and are subject to co-payments and limitations as described.	
PRESCRIPTION DRUGS	
Eligibility Class I: Family Coverage for Member, Spouse and Dependent Children **Eligibility Class II:** Coverage for Member Only **Eligibility Class III:** Coverage for Member Only	• Coverage of FDA-approved prescription medications for FDA-approved indications, except Plan exclusions • $10 co-payment for Preferred Drugs and $15 co-payment for Preferred Brand-name Drugs • Use Participating Pharmacies • Use *The 1199SEIU 90-Day Rx Solution* (Mandatory Maintenance Drug Access Program) for chronic conditions • Comply with the Benefit Fund's prescription drug programs, including Prior Authorization when required • Please refer to "What Is Not Covered" in Section II.C

COVERAGE	BENEFITS (IN-NETWORK ONLY)
DISABILITY AND FAMILY LEAVE	
Eligibility Class I: No Coverage **Eligibility Class II:** No Coverage **Eligibility Class III:** No Coverage	• The Benefit Fund does not provide Temporary Disability Leave Insurance or Temporary Family Leave Insurance. These benefits may be provided by your Employer. • Member must submit proof to the Benefit Fund that these benefits have been received in order to maintain their health coverage • Follow the same procedure if you are receiving workers' compensation. If you need help or advice in filing a workers' compensation claim, call the Benefit Fund at (646) 473-9200. Outside New York City, call (800) 575-7771.
LIFE INSURANCE	
Eligibility Class I: Coverage for Member Only **Eligibility Class II:** Coverage for Member Only **Eligibility Class III:** Coverage for Member Only	• **Eligibility Class I:** During your first year of service, amount is $2,000. After your first year, benefit is based on your years of service and annual earnings, up to a maximum amount of $25,000. • **Eligibility Class II:** During your first year of service, amount is $1,250. After your first year, maximum amount is $2,500. • **Eligibility Class III:** Maximum amount is $1,250

COVERAGE	BENEFITS (IN-NETWORK ONLY)
ACCIDENTAL DEATH AND DISMEMBERMENT	
Eligibility Class I: Coverage for Member Only **Eligibility Class II:** Coverage for Member Only **Eligibility Class III:** Coverage for Member Only	• For accidental death or dismemberment • Equal to, or half of, your life insurance amount, depending on the loss suffered
BURIAL	
Eligibility Class I: Coverage for Member and Spouse **Eligibility Class II:** Coverage for Member Only **Eligibility Class III:** Not Covered	• If available, a free burial plot with permanent care • Plots located in New York and New Jersey
SOCIAL SERVICES	
Eligibility Class I: Family Coverage for Member, Spouse and Dependent Children **Eligibility Class II:** Family Coverage for Member, Spouse and Dependent Children **Eligibility Class III:** Family Coverage for Member, Spouse and Dependent Children	• Wellness Member Assistance Program: www.1199SEIUBenefits.org/map

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 Temporary Disability Leave or Family Leave Benefits from Your Employer
- While Participating in Training Programs
- While on Workers' Compensation Leave
- While Taking Family and Medical Leave (FMLA)
- While Taking Uniformed Services Leave

K. Your COBRA Rights

ELIGIBILITY RESOURCE GUIDE

KEY CONTACTS

Member Services Department
(646) 473-9200 or (800) 575-7771

Call the Member Services Department to:

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

COBRA Department
(646) 473-6815 or (800) 575-7771

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.

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.

ELIGIBILITY 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 or Family Leave.
- Notify the Benefit Fund of any change that will affect your right to COBRA continuation coverage.
- Call the Benefit Fund if you want to continue your life insurance after your coverage ends.

SECTION I. A
WHO IS ELIGIBLE

YOU

You are eligible to participate in the 1199SEIU Greater New York Benefit Fund New Jersey Plan if **both** 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 described in this SPD; 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).

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).

YOUR SPOUSE

If you are enrolled in Eligibility Class I (full-time) coverage, your Spouse may be eligible if **all** of the following conditions are met:

- You and your spouse are legally married;
- You have authorized the required weekly premium deduction for spousal coverage;
- You are eligible for family coverage, based on your Eligibility 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

If you are enrolled in Eligibility Class I (full-time) coverage, 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 Eligibility 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.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

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

SECTION I. B
WHEN YOUR COVERAGE BEGINS

IF YOU ARE A NEW EMPLOYEE

You can start receiving benefits from the Benefit Fund after **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 Eligibility Class I (see Section I.D);
- You have completed and submitted the GNY-NJ Spouse and Child Coverage and Payroll Deduction Authorization Form, agreeing to pay the required weekly premium for spousal coverage by authorizing your Employer to deduct the cost of the premium from your paycheck; and
- They are eligible to receive benefits.

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), the **GNY-NJ Spouse and Child Coverage and Payroll Deduction Authorization Form** and a **Coordination of Benefits form** (to enroll your dependents).

To enroll in the Benefit Fund:

1. Get these forms from the Benefit Fund. You can access the forms:
    - In the form library on our website: www.1199SEIUBenefits.org/forms;
    - Through **MyAccount,** www.My1199Benefits.org, where you can also complete and submit the forms; or
    - By calling the Member Services Department at (646) 473-9200 or (800) 575-7771.
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, and your eligible children to be covered, and a marriage certificate if you are enrolling your spouse.
5. Follow the return instructions on each form; return them as directed *as soon as possible*. Your benefits *cannot* begin before you submit your completed forms.

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 may 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 receives a Qualified 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 documents not originally in English.

If you are adding your spouse, you must submit a completed GNY-NJ Spouse and Child Coverage and Payroll Deduction Authorization form agreeing to pay the required weekly co-premium for spousal coverage.

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 unless the notification indicates that your ex-spouse should remain the named beneficiary.

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.

SECTION I. D
HOW TO DETERMINE YOUR LEVEL OF BENEFITS

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

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

Eligibility Class I (Family Coverage)

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

Eligibility Class II (Member-only Coverage)

If you work **part time,** on average more than 22 hours but less than 35 hours per week **(generally three or four days per week),** your benefit level is generally Eligibility Class II. If you are in Eligibility Class II, only you (the member) can receive benefits. Your spouse and your children are **not eligible** to receive benefits from the Benefit Fund.

Eligibility Class III (Member-only Coverage)

If you work **part time,** on average more than seven hours but less than 22 hours per week **(generally one or two days per week),** your benefit level is generally Eligibility Class III. If you are in Eligibility Class III, only you (the member) can receive limited benefits. Your spouse and your children are **not eligible** to receive benefits from the Benefit Fund.

See pages 17–30 for an "Overview of Your Benefits."

IF YOU WORK FOR MORE THAN ONE CONTRIBUTING EMPLOYER

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

HOW YOUR HOURS WORKED IS CALCULATED TO DETERMINE YOUR ELIGIBILITY CLASS

Your Employer reports the hours for which you are paid each week (including paid sick leave, vacation, holidays and other *paid* leave) to the Benefit Fund. To determine your Eligibility Class, the Benefit Fund averages your hours over a 16-week testing period. Your Average Weekly Hours are then compared to the Eligibility Class levels described on the previous page.

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

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

SECTION I. E
YOUR ID CARDS

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

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

Call the Benefit Fund's Member Services Department at (646) 473-9200 or (800) 575-7771 if you have any problems with your ID cards, including:

- You do not receive your card(s)
- Your card(s) 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 your 1199SEIU Health Benefits ID card fraudulently, call the Fund's Fraud and Abuse Hotline at (646) 473-6148. Outside New York City, call (800) 575-7771.

For any problems with your Cigna ID card, call Cigna Member Services at (800) 244-6224 (CIGNA24).

For any problems with your Aetna ID card, call Aetna Member Services at (866) 658-2455.

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

If the Benefit Fund is the:

- **Primary payer,** your claim will be paid first by the Benefit Fund (including Aetna, CVS Caremark or Cigna) in accordance with its Schedule of Allowances or Allowed Amount and the rules set forth in this SPD.
- **Secondary payer,** it will pay the balance of your claim in accordance with its Schedule of Allowances or Allowed Amount and the rules set forth in this SPD after you have submitted a statement from the other insurer indicating what the other insurer has paid. In no event will the Benefit Fund pay more than its Schedule of Allowances or Allowed Amount.

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 Participating Providers only, **you must use that coverage first.**

The Benefit Fund may provide benefits for charges related to a deductible, co-payment or co-insurance. The Benefit Fund **will not provide** benefits for services denied by that payer solely based upon your failure to use Participating 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 dependent child does not have their own Employer-sponsored coverage or coverage through their spouse, then the birthday rule would determine the primary payer. For example, if the mother's birthday is March 11 and the father's birthday is July 10, the mother's plan would be the primary payer since the mother's birthday is earlier in the year.

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 primary plan where coverage is limited to services provided by In-network (or Participating) Providers only, **your spouse or child must use that coverage first.**

The Benefit Fund may provide benefits for charges related to a deductible, co-payment or co-insurance. The Benefit Fund **will not provide** benefits for services denied by another 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. Doing so will establish Medicare as 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 when 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 (including Aetna or Cigna) 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. Furthermore, 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* upon receiving them, up to the amount of the payments that the Benefit Fund advanced to you or on your behalf. This means that the Benefit Fund has an equitable lien by agreement on the proceeds of any verdict or settlement reached in a lawsuit that you bring against someone for causing the illness or injury, up to the amount the Benefit Fund has paid for costs arising from that person's actions. This also means the Benefit Fund has an independent right to bring a lawsuit in connection with such an injury or illness in your name and also has a right to intervene in any such action brought by you.

If you receive payments from or on behalf of the party responsible for an illness or injury, you agree that the Benefit Fund must be repaid *immediately*, up to the amount of the payments that the Benefit Fund has advanced to you or on your behalf. The Benefit Fund's right to recover its advanced benefit payments comes before you can recover any payments you may have made. You must repay the Benefit Fund regardless of whether the total amount of the recovery is less than the actual loss and even if the party does not admit responsibility, itemize the payments or identify payments as medical expenses. You cannot reduce the amount of the Benefit Fund's payments to pay for attorneys' fees, 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.

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 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 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 or Allowed Amount.

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. 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. Outside New York City, call (800) 575-7771.

WHAT WORKERS' COMPENSATION COVERS

You are covered for workers' compensation when you have an accident, injury or illness, or are ordered to quarantine, 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:

- Weekly disability payments
- Payment for lost wages (if you are unable to work for more than seven days)
- Lump-sum payments or other awards for permanent injuries
- Coverage for eligible medical expenses, drugs and appliances
- Reasonable 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.

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 work-related illness, accident or injury** while you are receiving Workers' Compensation Benefits, up to a maximum of 26 weeks leave within a 52-week period.

If you cannot 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 a Claim with Workers' Compensation

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. Submit proof to the Benefit Fund that you are receiving Workers' Compensation Benefits. Acceptable forms of proof include a copy of a workers' compensation check stub or a statement from your insurance carrier showing the period of coverage and amount paid. The Benefit Fund determines your eligibility for benefits based on your hours worked, which is reported by your Employer. If no hours have been reported for you, your coverage may be suspended because the Benefit Fund does not know that you are on workers' compensation.
4. Continue to send copies of all correspondence (including electronic communications) you receive in connection with your workers' compensation claim to the 1199SEIU Family of Funds' Eligibility Department. This electronic communication may be a **First Report of Injury (FROI) Form,** which indicates that your benefits have begun, or a **Supplementary Report of Injury (SROI) Form,** which indicates that your benefits have been stopped or modified. This will help the Benefit Fund keep up to date on the status of your workers' compensation claim.
5. If your workers' compensation claim is denied or disputed, notify the Benefit Fund *immediately* at (646) 473-9200. Outside New York City, call (800) 575-7771.

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 or (800) 575-7771 if:

- You do not hear from your Employer's insurance company within 21 days of filing your claim

- You are called for an examination or hearing
- Your claim is rejected or disputed
- You need help filing your claim
- You need a referral to a qualified attorney

SECTION I. I
WHEN YOUR BENEFITS STOP

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

All benefits end 30 days after the last day on which your Employer is required to make contributions to the Benefit Fund* on your behalf, unless your benefits are continued as described in Section I.D or I.J.

However, as of the last day that your Employer is required to make contributions to the Benefit Fund on your behalf if you or your spouse are covered by Medicare, 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, et al.*

If your Employer fails to remit the required weekly co-premium for spousal coverage:
In this case, your coverage may be terminated retroactive to the last day of the month that your payments were made.

If You cancel your co-premium deduction authorization:
In this case, your spousal coverage will end on the day the Fund receives the withdrawal of the authorization.

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 the Collective Bargaining Agreement between your Employer and 1199SEIU expires, and if 1199SEIU and your Employer reach an impasse in negotiations, your benefits may be terminated if your Employer fails to make required contributions on your behalf.

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

IF YOU ARE ON TEMPORARY DISABILITY LEAVE, TEMPORARY 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 Temporary Disability Leave (up to a maximum of 26 weeks leave within a 52-week period);
- The last day of your Family Medical Leave (under FMLA) and/or Temporary Family 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 leave, then there shall be no 30-day extension.

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

Upon your terminal illness or death, your spouse and covered children will continue to receive benefits:

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

If your spouse pays premiums, they must continue making premium payments to continue their coverage. 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 TEMPORARY DISABILITY LEAVE OR FAMILY LEAVE BENEFITS FROM YOUR EMPLOYER

You need to contact the Benefit Fund within 30 days of when you are not working due to a Temporary Disability Leave, Family Leave (under FMLA), Temporary Family Leave, Workers' Compensation Leave or Uniformed Services Leave. Call the Benefit Fund's Member Services Department at (646) 473-9200 (or (800) 575-7771 outside New York City) to find out which forms need to be filed with the Benefit Fund.

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

Protect Your Health Benefits

While you are receiving Temporary Disability Leave or Temporary Family Leave benefits from your Employer, you and your family are still eligible for the same Benefit Fund coverage you had before the leave.

It is important that you notify the Benefit Fund within 30 days of your illness, accident or injury. Otherwise, you may jeopardize your health benefits.

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 Temporary Disability Leave or Temporary 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 Disability Continues:
If your disability continues beyond the maximum 26-week period, your coverage through the Benefit Fund will stop immediately. See Section I.K for information on COBRA continuation coverage.

However, you may be eligible for other benefits provided by government agencies. Call the Benefit Fund at (646) 473-9200 or (800) 575-7771 for more information and advice on how to file a claim for this aid.

NOTE: The Benefit Fund **does not provide** Temporary Disability Leave insurance or Temporary Family Leave insurance.

You must continue to pay the weekly premium to maintain your Spouse's coverage while you are eligible to receive continued benefits during an employment leave.

WHILE PARTICIPATING IN TRAINING PROGRAMS

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

For information on the various programs offered by the Greater New York Education Fund, visit **www.1199SEIUBenefits.org/training** or call (212) 494-0534 or (800) 575-7771.

WHILE COVERED BY THE JOB SECURITY FUND

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

WHILE ON WORKERS' COMPENSATION LEAVE

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

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 work-related accident, injury or illness** while you are receiving Workers' Compensation Benefits, up to a maximum of 26 weeks leave within a 52-week period.

If you cannot 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).

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, child 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 a spouse, child, 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.

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

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

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

The FMLA 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 when coverage was extended solely on the basis of your FMLA Leave.

NOTE: You must continue to pay the weekly premium to maintain your Spouse's coverage if you are eligible to receive continued benefits while on Workers' Compensation or 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 of the date of discharge if the period of military service was more than 181 days; or
- Within 14 days of 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 or (800) 575-7771 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 TEMPORARY DISABILITY LEAVE OR TEMPORARY FAMILY LEAVE

You may continue to be covered by the Benefit Fund during your qualified Temporary Disability Leave or Temporary Family Leave (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. Outside New York City, call (800) 575-7771.

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

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

WHEN AND HOW LONG YOU 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 Eligibility Class;
- Your employment terminates for reasons other than gross misconduct on your part; or
- You do not return to work after an approved short-term (or Temporary) Medical, Disability or Workers' Compensation Leave (see Section I.I).

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.

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;
- 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 of 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 of 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 (see below), 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 of 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 of 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 are responsible for notifying the Benefit Fund by either calling (646) 473-6815 or (800) 575-7771 or writing to PO Box 1036, New York, NY 10108-1036, within 60 days of 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 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 coverage when you qualify, your spouse and each of your children, if eligible, have the 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 of the date your coverage ended or during any open enrollment period, you and your family can buy health coverage through the Health Insurance Marketplace, which could be a lower-cost option.** In the Marketplace, you could be eligible for a tax subsidy that lowers your monthly premiums right away, and you can see what your premiums, deductibles and out-of-pocket costs will be before you make a decision to enroll. You may also be eligible for COBRA continuation coverage. **Being eligible for COBRA does not limit your eligibility for coverage or for a tax subsidy through the Marketplace.** Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days of 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 cannot be reinstated.

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

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

If you have any questions about COBRA continuation coverage, please call the Benefit Fund at (646) 473-6815. Outside New York City, call (800) 575-7771.

Remember to notify the Benefit Fund *immediately* if any of the following occur:

- 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 of your Benefit Fund coverage ending.

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HEALTH BENEFITS RESOURCE GUIDE

KEY CONTACTS

Benefit Fund
Member Services
(646) 473-9200 or (800) 575-7771

For answers to questions about your eligibility or Prescription Drug Benefits.

Cigna
Member Services
(800) 244-6224 (CIGNA24)

For answers to questions about your Dental Benefits.

Aetna
Member Services
(866) 658-2455

For answers to questions about your Medical Benefits.

Aetna 24-Hour Health Line
(800) 556-1555

You can also visit the Fund's website at **www.1199SEIUBenefits.org** for forms, directories and other information. In addition, you can log into **MyAccount** (www.My1199Benefits.org) to access information about your eligibility and claims history, or to update your information.

BENEFIT BRIEF

- Medical Benefits provided by Aetna
- Each individual must select an Aetna Primary Care Physician as their designated (or primary care) provider
- Other than for Emergencies, services must be performed by designated Aetna Network Providers
- Referrals to specialists not required
- Individual and family deductibles may apply for some procedures
- Co-payments and limitations may apply for some procedures
- Eligibility Classes I and II have an annual restriction on out-of-pocket costs, which includes co-payments, as required by the Affordable Care Act

Eligibility Class I: Family coverage for member, spouse and dependent children

Eligibility Class II: Coverage for member only

Eligibility Class III: Coverage for member only

SECTION II. A
MEDICAL BENEFITS PROVIDED BY AETNA

1. HOW YOUR MEDICAL PLAN WORKS

ACCESSING NETWORK PROVIDERS AND BENEFITS

Before you receive services from any provider, you should ask both the provider and Aetna to confirm the provider participates in this Aetna network.

Primary Care Physician

To access benefits, you should select a Primary Care Physician (PCP) from Aetna's network of providers. Each covered family member may select their own PCP. If your covered dependent is a minor, or otherwise incapable of selecting a PCP, you should select a PCP on their behalf.

You may visit Aetna's online provider directory at www.Aetna.com to search for Network Providers in your area. You can choose a PCP based on geographic location, group practice, medical specialty, language spoken or hospital affiliation. You may also request a printed copy of the provider directory by calling the Aetna Member Services toll-free number listed on your Aetna ID card.

A PCP may be a general practitioner, family physician, internist or pediatrician. Your PCP provides routine preventive care and will treat you for illness or injury.

A PCP coordinates your medical care as appropriate, either by providing treatment or by directing you to other Network Providers for other Covered Services and Supplies. The PCP can also order lab tests and X-rays, prescribe medicines or therapies and arrange hospitalization.

Changing Your Primary Care Physician

You may change your PCP at any time on Aetna's website, www.Aetna.com, or by calling the Aetna Member Services toll-free number listed on your Aetna ID card. The change will become effective upon Aetna's receipt and approval of the request.

Out-of-Network Providers

Other than for Emergencies, benefits are *only* covered when provided by a Network Provider. If you need medical care for a non-emergent condition and there is not a Network Provider, the Fund may cover services rendered by an Out-of-Network Provider only if you first obtain Pre-certification from Aetna. If Aetna finds that these services are not available in-network and Pre-certification is granted, Aetna will pay the Out-of-Network Provider at the in-network benefit level. This means you might have to pay the difference between the provider's charges and Aetna's payment.

Specialists and Other Network Providers

You may directly access specialists and other healthcare professionals in the Network for Covered Services and Supplies under this SPD.

Telemedicine

You may access Network Providers using two-way, synchronous (i.e., real-time), interactive audiovisual technology for certain office visits, consultations, screenings, counseling and therapies. Check with your provider for more information about covered telemedicine services.

COST SHARING—WHEN YOU SHARE IN THE COST OF YOUR BENEFITS

For certain types of services and supplies, you will be responsible for any payment percentage or co-payment after you have satisfied the individual or family deductible.

The Plan will pay for covered expenses. Other than any payment percentage or co-payment, you will not have to pay any balance bills above the negotiated charge for that Covered Service or Supply as long as you use an Aetna Network Provider.

You may be billed for any deductible or non-covered expenses that you incur.

In the case of an Emergency where your care is provided by a non-Network Provider, or where certain services are provided by non-Network Providers at Network Facilities, covered expenses include charges up to the Allowed Amount.

Protections from Balance Billing

You are protected from balance billing by a medical provider if you have an Emergency Medical Condition and receive treatment for that condition from a non-Network Provider or Facility. You are also protected from balance billing for certain non-Emergency services rendered by a non-Network Provider while receiving care at a Network Hospital or ambulatory surgical center, including emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. **These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.**

UNDERSTANDING PRE-CERTIFICATION

Certain services, such as inpatient stays, outpatient surgery and certain tests and procedures require pre-certification by Aetna. **Pre-certification** is a process that helps you and your physician determine whether the services being recommended are covered expenses under the Plan. It also allows Aetna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called **discharge planning**), and to register you for specialized programs or case management when appropriate.

The Pre-certification Process

Prior to being hospitalized or receiving certain other medical services or supplies, there are certain Pre-certification procedures that must be followed.

You or a member of your family, your provider or a hospital staff member must notify Aetna to Pre-certify the admission or medical service(s) and expense(s) prior to receiving any of the services or supplies that require Pre-certification, pursuant to this SPD, in accordance with the timelines below.

Pre-certification should be secured within the time frames specified below. To obtain Pre-certification, call the Aetna Member Services toll-free number listed on your Aetna ID card unless otherwise indicated below. This call must be made:	
For a non-Emergency admission	You, your physician or the facility must call at least 14 days before the date you are scheduled to be admitted.
For a non-Emergency outpatient or intermediate care service	You or your physician must call at least 14 days before the outpatient care is provided or the treatment or procedure is scheduled.
For an Emergency admission	You, your physician or the facility must call within 48 hours, or as soon as reasonably possible, after you have been admitted.
For fertility services	Aetna does not provide Pre-certification for fertility services. For Pre-certification of covered fertility services, contact Progyny. (See Section II.D.1 for details.)
For an urgent admission	You, your physician or the facility must call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury.
For an Emergency outpatient medical condition	You or your physician must call before the outpatient care is provided; before the treatment or procedure is scheduled; or as soon as reasonably possible.

Aetna will provide a written notification to you and your physician of the Pre-certification decision. If your Pre-certified expenses are approved, the approval is good for 60 days as long as you remain enrolled in the Plan.

When you have an inpatient admission to a facility, Aetna will notify you, your physician and the facility about your Pre-certified length of stay. If your physician recommends that your stay be extended, additional days will need to be certified. You, your physician or the facility will need to call the Aetna Member Services toll-free number listed on your Aetna ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If Pre-certification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how Aetna's decision can be appealed. You or your provider may request a review of the Pre-certification decision pursuant to the Claims and Appeals sections of this SPD. (See Section II.A.6, Section VII.A and Section VII.B.)

To obtain Pre-certification, call the Aetna Member Services toll-free number listed on your Aetna ID card. Conversations with Member Services, including Pre-certifications, are never contracts.

INPATIENT AND OUTPATIENT CARE THAT REQUIRES PRE-CERTIFICATION

- Stays in a hospital
- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- Outpatient hospice care
- Stays in a residential treatment facility for mental health services or treatment of alcohol or substance use disorders
- Private-duty nursing
- Long-term habilitative or behavioral therapy

MEDICAL SERVICES THAT REQUIRE PRE-CERTIFICATION

- Ambulance transportation by fixed-wing aircraft (plane)
- Autologous chondrocyte implantation
- Cellular and genomic testing and therapy
- Chiari malformation decompression surgery
- Cochlear device and/or implantation
- Coverage at an in-network benefit level for an Out-of-Network Provider or facility unless services are emergent
- Dental implants
- Dialysis visits
- Dorsal column (lumbar) neurostimulators: trial or implantation
- Electric or motorized wheelchairs and scooters

- Endoscopic nasal balloon dilation procedures
- Fertility services (see Section II.D.1)
- Functional endoscopic sinus surgery (FESS)
- Gender reassignment surgery
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy
- Inpatient confinements (except hospice), such as:
  - Maternity and newborn stays that exceed the standard length of stay
  - Stays in a skilled nursing facility or rehabilitation facility
  - Surgical and nonsurgical stays
- Lactation counseling
- Lower limb prosthetics, such as microprocessor-controlled lower limb prosthetics
- Non-participating freestanding ambulatory surgical facility services, when referred by a Participating Provider
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint
- Osseointegrated implant
- Osteochondral allograft/knee
- Private-duty nursing
- Proton beam radiotherapy
- Reconstructive or other procedures that may be considered cosmetic, such as:
  - Blepharoplasty/canthoplasty
  - Breast reconstruction/breast enlargement
  - Breast reduction/mammoplasty
  - Excision of excessive skin due to weight loss
  - Gastroplasty/gastric bypass
  - Lipectomy or excess fat removal
  - Surgery for varicose veins, except stab phlebectomy
- Shoulder arthroplasty, including revision procedures
- Spinal procedures, such as:
  - Artificial intervertebral disc surgery (cervical spine)
  - Arthrodesis for spine deformity
  - Cervical laminoplasty
  - Cervical, lumbar and thoracic laminectomy and/or laminotomy procedures
  - Kyphectomy
  - Laminectomy with rhizotomy
  - Spinal fusion surgery
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices
- Video electroencephalograph (EEG)
- Whole exome sequencing

BEHAVIORAL HEALTH SERVICES THAT REQUIRE PRE-CERTIFICATION

Includes the treatment of alcohol and substance use disorders and mental disorders by behavioral health providers. This applies only to services covered under the Plan, including:

- Applied behavioral analysis
- Inpatient admissions
- Intensive outpatient programs (IOPs)
- Partial hospitalization programs (PHPs)
- Residential treatment center (RTC) admissions
- Transcranial magnetic stimulation (TMS)

EMERGENCY AND URGENT CARE

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the Plan's service area for:

- An Emergency Medical Condition; or
- An urgent condition.

In Case of a Medical Emergency

In the case of an Emergency Medical Condition, please follow the guidelines below:

- Seek the nearest Emergency Department or dial 911 or your local Emergency response service for medical and ambulatory assistance. If possible, call your PCP, provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the Emergency Department should contact your PCP to obtain your medical history to assist the Emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your PCP as soon as reasonably possible.
- If you seek care in an Emergency Department for a non-Emergency condition (one that does not meet the criteria mentioned in Section IX: Definitions), the Plan **will not cover** the expenses you incur.

Coverage for an Emergency Medical Condition

The Plan will pay for hospital services provided in an Emergency Department to evaluate and treat an Emergency Medical Condition.

Please contact your PCP after receiving treatment for an Emergency Medical Condition.

REMINDER

If you visit a hospital Emergency Department for a non-Emergency condition, the Plan **will not cover** your expenses. No other Plan benefits will pay for non-Emergency care in the Emergency Department.

In Case of an Urgent Condition

An **urgent condition** is a sudden illness, injury or condition that:

- Requires prompt medical attention to avoid serious deterioration of your health;
- Cannot be adequately managed without urgent care or treatment;
- Does not require the level of care provided in a hospital Emergency Department; and
- Requires immediate outpatient medical care that cannot wait for your PCP to become available.

Call your PCP if you think you need urgent care. Network Providers are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any In-network Physician or urgent care provider for an urgent care condition if you cannot reach your PCP.

If it is not feasible to contact your PCP, please do so as soon as possible after urgent care is provided. If you need help finding a Network Urgent Care Provider, you may call the Aetna Member Services toll-free number listed on your Aetna ID card, or you may access Aetna's online provider directory at www.Aetna.com.

Coverage for an Urgent Condition

The Plan will pay for the services of an urgent care provider to evaluate and treat an urgent condition.

Follow-up Care

Follow-up care is not considered an Emergency Medical Condition or urgent condition and is **not covered** as part of any Emergency or urgent care visit. Once you have been treated and discharged from Emergency or urgent care, you should contact your PCP for any necessary follow-up care.

To keep your out-of-pocket costs lower, your follow-up care should be accessed through your PCP.

NOTE: Follow-up care, which includes, but is not limited to, suture removal, cast removal and radiological tests such as X-rays, should not be provided by an Emergency Department facility.

2. REQUIREMENTS FOR COVERAGE

To be covered by the Plan, services and supplies must meet **all** of the following requirements:

- Be included as a covered expense under this SPD;
- Not be an excluded expense under this SPD (refer to Section II.A.4a, "Medical Plan Exclusions," for a list of services and supplies that are excluded);
- Not exceed the maximums and limitations as described in this SPD;
- Be obtained in accordance with all the terms, policies and procedures as described in this SPD;

- Be provided while coverage is in effect; and
- Be Medically Necessary.

NOTE: Not every service or supply that fits the definition for Medical Necessity is covered by the Plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example, some benefits are limited to a certain number of days or visits or a dollar maximum. Refer to Section II.A.3, "What the Plan Covers," for Plan limits and maximums.

3. WHAT THE PLAN COVERS

Many preventive and routine medical expenses, as well as expenses incurred for a serious illness or injury, are covered. This section describes which expenses are covered expenses. Only expenses incurred for the services and supplies shown in this section are medical expenses covered by Aetna. Unless specified below, prescription drugs and supplements are covered by the Benefit Fund (see Section II.C). All medical expenses described in this section are covered at 85% of the Allowed Amount after the deductible, unless otherwise stated. Please see the Overview of Your Benefits section (see page 17) for information on percentage payments, co-payments or frequency limitations. Other limitations and exclusions may apply.

a. WELLNESS

Covered expenses include services and supplies provided when you are well.

Routine Physical Exams/ Immunizations

Covered expenses include services rendered by your PCP for routine physical exams. A **routine exam** is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes the following:

- Radiological services, X-rays, lab and other tests given in connection with the exam
- Immunizations for infectious diseases
- Testing for tuberculosis

Covered expenses for dependent children: An initial hospital checkup and well-child visits in accordance with the prevailing clinical standards of the American Academy of Pediatrics.

Routine Cancer Screenings

Covered expenses include routine cancer screenings as follows:

- One mammogram per calendar year for covered individuals with female breast tissue and lobules, age 40 or older

- Two Pap smears per calendar year for covered individuals with cervixes
- Two gynecological exams per calendar year for covered individuals with female reproductive systems
- One digital rectal exam and one prostate specific antigen (PSA) test per calendar year for covered individuals with prostates, age 40 or older

The following tests are covered expenses when recommended by your physician *if* you are age 45 or older:

- One fecal occult blood test per calendar year
- One sigmoidoscopy every five years for persons at average risk
- One double-contrast barium enema (DCBE) every five years for persons at average risk
- One colonoscopy every 10 years for persons at average risk for colorectal cancer

Family Planning Services

Covered expenses include certain contraceptive and family planning services, though not provided to treat an illness or injury.

Contraception Services

Other than prescriptions for contraceptive drugs and devices covered through the Fund's Prescription Drug Benefit, covered expenses include contraceptive services and supplies provided on an outpatient basis, including:

- Consultations
- Exams
- Procedures
- Other medical services and supplies

Charges incurred for contraceptive services while confined as an inpatient are **not covered.**

Other Family Planning

Covered expenses include family planning services, including:

- Voluntary sterilization
- Voluntary termination of pregnancy

The Plan **does not cover** the reversal of voluntary sterilization procedures, including related follow-up care.

Please also see Section II.A.3j, "Maternity Care."

Smoking/tobacco Cessation

Covered expenses include smoking/tobacco cessation counseling limited to eight visits per 12 months.

b. PHYSICIAN SERVICES (VISITS, SURGERY AND ANESTHESIA)

Physician Visits

Covered expenses include services provided by a physician during a visit to treat an illness or injury. The visit may be at the physician's office, in your home, in a hospital or other facility during your stay or in an outpatient facility. Covered expenses also include:

- Immunizations for infectious disease, but not if solely for your employment or travel
- Allergy testing and allergy injections
- Supplies, radiological services, X-rays and tests provided by the physician

Surgery

Covered expenses include the following services by a physician:

- Performing your surgical procedure
- Pre-operative and post-operative visits

Anesthesia

Covered expenses include the administration of anesthesia and oxygen by a physician (other than the operating physician) or a Certified Registered Nurse Anesthetist (CRNA) in connection with a covered procedure.

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 doctors and anesthesiologists that provide services in the facility may not be Participating and may charge above the Benefit Fund's allowance. In these cases, the most those providers may bill you is your in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. It also applies to certain services provided by non-Participating Providers when there is no Participating Provider at the Participating Hospital who can provide that service. **These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.**

If you receive other services at Participating Hospitals or other Participating facilities, non-Participating Providers cannot balance bill you unless you give written consent and give up your protections. You are never required to give up your protections from balance billing.

REMINDER

Certain procedures may need to be Pre-certified by Aetna. Refer to Section II.A.1, "How Your Medical Plan Works," for details about Pre-certification.

Alternatives to Physician Visits—Walk-in Clinic Visits

Covered expenses include in-network walk-in clinics for unscheduled, non-Emergency illnesses and injuries, as well as the administration of certain immunizations administered within the scope of the clinic's license.

Your Rights under the Women's Health and Cancer Rights Act of 1998

Under this Plan, coverage will be provided to a person who is receiving benefits for a Medically Necessary mastectomy and who elects breast reconstruction after the mastectomy for:

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

This coverage will be provided in consultation with the attending physician and the patient, and it will be subject to the same annual deductibles and co-insurance provisions that apply for the mastectomy.

If you have any questions about coverage of mastectomies and reconstructive surgery, please call the Aetna Member Services toll-free number listed on your Aetna ID card.

c. HOSPITAL BENEFITS

Covered services include inpatient and outpatient hospital care. This includes:

- Semi-private room and board (your Plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services and supplies provided by the outpatient department of a hospital, including the facility charge
- Services of physicians employed by the hospital
- Administration of blood and blood products

REMINDERS

- The Plan will only pay for nursing services provided by the hospital as part of its charge. The Plan **does not cover** private-duty nursing in a hospital setting.
- Hospital admissions need to be Pre-certified by Aetna. Refer to Section II.A.1, "How Your Medical Plan Works," for details about Pre-certification.
- In addition to charges made by the hospital, certain physicians and other providers may bill you separately during your stay.

Coverage for Emergency Medical Conditions

Covered expenses include hospital or physician services provided in an Emergency Department to evaluate and treat an Emergency Medical Condition.

For treatment of emergency services to be covered by the Plan, your Emergency Department visit must meet the definition of Emergency Medical Condition (see Section IX).

You are protected from balance billing by a medical provider if you have an Emergency Medical Condition and receive treatment for that condition from a non-Participating Provider or 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 Medical Condition" (see Section IX)**.**

Non-emergency Treatment Can Be Costly to You

If you use the Emergency Department for *non-Emergency treatment*, **Aetna will not pay for it, which may result in a large out-of-pocket cost to you.**

Coverage for Urgent Conditions

Covered expenses include services provided by a hospital or urgent care provider to evaluate and treat an urgent condition.

Please contact your PCP after receiving treatment of an urgent condition.

What Is Not Covered

All services and supplies provided in the following settings are **not covered services**:

- Rest homes
- Any place considered a person's main residence or providing mainly custodial or rest care
- Health resorts
- Spas
- Schools or camps

d. ALTERNATIVES TO HOSPITAL STAYS

Outpatient Surgery and Physician Surgical Services

Covered expenses include services and supplies furnished in connection with outpatient surgery made by:

- An office-based surgical facility of a physician;
- A surgery center; or
- The outpatient department of a hospital.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a surgery center or hospital; and
- The surgery is not normally performed in a physician's office.

NOTE: Benefits for surgery services performed in a physician's office are described under Section II.A.3b, "Physician Services (Visits, Surgery and Anesthesia)."

The following outpatient surgery expenses are covered:

- Services and supplies provided by the hospital or surgery center on the day of the procedure
- The operating physician's services for performing the procedure for related pre- and post-operative care, and for administration of anesthesia
- Services of another physician for related post-operative care and administration of anesthesia; this **does not include** a local anesthetic

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

- A stay in a hospital
- Facility charges for office-based surgery
- The services of a physician or other healthcare provider who renders technical assistance to the operating physician

Birthing Center

Covered expenses include services and supplies provided by a birthing center related to your care in a birthing center for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery or 96 hours after a cesarean delivery.

Home Health Care

Covered expenses include unlimited home visits by a private-duty nurse, therapist or home health aide.

Hospice Care

Covered expenses include by the following furnished to you for hospice care when given as part of a hospice care program:

Facility Expenses

The following services and supplies provided by a hospital, hospice or skilled nursing facility:

- Room and board, as well as other services and supplies, furnished during a stay for pain control and other acute and chronic symptom management
- Services and supplies furnished to you on an outpatient basis

Outpatient Hospice Expenses

The following services and supplies provided by a hospice care agency:

- Part-time or intermittent nursing care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) for up to eight hours a day
- Part-time or intermittent home health aide services for your care, up to eight hours a day
- Medical and social services under the direction of a physician. These include, but are not limited to:
  - Assessment of your social, emotional and medical needs and your home and family situation
  - Identification of available community resources
  - Assistance provided to you to obtain resources to meet your assessed needs
- Physical and occupational therapy
- Consultation or case management services by a physician
- Medical supplies
- Prescription drugs
- Dietary counseling
- Psychological counseling

Covered expenses include services and supplies provided by the providers listed below if they are not an employee of a hospice care agency and such agency retains responsibility for your care:

- A physician for a consultation or case management services
- A physical or occupational therapist
- A home health care agency for:
  - Physical and occupational therapy
  - Part-time or intermittent home health aide services for your care, up to eight hours a day
  - Medical supplies
  - Psychological counseling
  - Dietary counseling

What Is Not Covered

Unless otherwise specified above, **not covered** 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 (see Section V)
- Funeral arrangements
- Homemaker or caretaker services. These are services that are not solely related to your care. These include, but are not limited to, sitter or companion services for either you or family members, transportation or maintenance of

your residence.

- Pastoral counseling
- Respite care. This is care received during a period of time when your family or usual caretaker cannot attend to your needs.

REMINDER

Refer to the Overview of Your Benefits section (see page 17) for hospice care maximums and member cost-sharing.

e. AMBULANCE SERVICE

Covered services include emergency transportation when your condition is unstable and requires medical supervision and rapid transport. These emergency Ambulance services are limited to transportation by a licensed ambulance:

- To the first facility to provide emergency services
- From one facility to another if the first can't provide the emergency services you need

Covered services also include non-emergency transportation when an Ambulance is the only safe way to transport you. These non-emergency Ambulance services are limited to transportation by a licensed ambulance:

- To the nearest facility able to treat your condition
- From a facility to your home by ground ambulance

The following are not covered services:

- Ambulance services for non-emergency transportation
- Ambulance services for routine transportation to receive outpatient or inpatient services

Pre-certification is required for Ambulance transportation by fixed-wing aircraft (plane).

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

Unless specified above, **not covered** under this benefit are charges incurred to transport you:

- By any form of transportation other than a professional ambulance service
- If an ambulance service is not required for your physical condition
- If the type of ambulance service provided is not required for your physical condition

f. OBESITY TREATMENT

Covered expenses include services provided by a physician, licensed or certified dietitian, nutritionist or hospital for the non-surgical treatment of obesity for the following outpatient weight-management services:

- An initial medical history and physical exam
- Diagnostic tests given or ordered during the first exam

Morbid Obesity Surgical Expenses

Covered expenses include services provided by a hospital or a physician for the surgical treatment of morbid obesity of a covered person. **Morbid obesity** means having a Body Mass Index ("BMI") that is greater than 40 kilograms per meter squared or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

Coverage includes the following expenses as long as they are incurred within a two-year period:

- One morbid obesity surgical procedure, including complications directly related to the surgery
- Pre-surgical visits
- Related outpatient services
- One follow-up visit

This two-year period begins with the date of the first morbid obesity surgical procedure, unless a multistage procedure is planned.

Complications, other than those directly related to the surgery, will be covered under the Plan's covered medical expenses, subject to Plan limitations and maximums.

What Is Not Covered

Unless otherwise specified, charges incurred for the following are **not covered**:

- Weight-control services, including surgical procedures, medical treatments, weight-control/weight-loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications (see Section V for related benefits)
- Exercise programs or equipment
- Other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, except as described in this SPD
- Services which are covered to any extent under any other part of this Plan

g. DIAGNOSTIC (LAB AND RADIOLOGY) AND PRE-OPERATIVE TESTING

Diagnostic Complex Imaging Expenses

The Plan covers services provided on an outpatient basis by a physician, hospital or licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

- CAT scans
- Magnetic resonance imaging (MRI)
- Positron emission tomography (PET) scans

Complex imaging expenses for pre-operative testing will be payable under this benefit.

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include radiological services other than diagnostic complex imaging, lab services and pathology and other tests provided to diagnose an illness or injury. The services must be provided by a physician, hospital or licensed radiological facility or lab.

REMINDER

Refer to the Overview of Your Benefits section for details about any deductible, payment percentage and maximum that may apply to outpatient diagnostic testing and lab and radiological services.

Outpatient Pre-operative Testing

Prior to a scheduled covered surgery, covered expenses include tests performed by a hospital, surgery center, physician or licensed diagnostic laboratory, provided the surgery is a covered service and the tests are:

- Related to your surgery, and the surgery takes place in a hospital or surgery center;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a hospital; and
- Not repeated in or by the hospital or surgery center where the surgery will be performed.

Test results should appear in your medical record kept by the hospital or surgery center where the surgery will be performed.

What Is Not Covered

Unless specified above, **not covered** under this benefit are diagnostic complex imaging expenses if your tests indicate that surgery should not be performed because of your physical condition. The Plan will pay for the tests; however, surgery will not be covered.

h. DURABLE MEDICAL AND SURGICAL EQUIPMENT

Covered expenses include the purchase, rental or repair of durable medical equipment (DME) as described below:

The initial purchase of DME is covered if:

- Long-term care is planned; and
- The equipment cannot be rented or is likely to cost less as a purchase than as a rental.

Repair of purchased DME: Maintenance and repairs needed due to misuse or abuse are **not covered.**

Replacement of purchased DME is covered if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The Plan limits coverage to one item of equipment for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered DME includes those items covered by Medicare unless excluded in Section II.A.4a, "Medical Plan Exclusions." Aetna reserves the right to limit payment up to the most cost-efficient and least restrictive level of service or item that can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

i. EXPERIMENTAL OR INVESTIGATIONAL TREATMENT

Covered services include drugs, devices, treatments or procedures from a Provider under an "approved clinical trial" only when you have **cancer or a terminal illness** and both of the following conditions are met:

- Standard therapies have not been effective or are not appropriate.
- We determine you may benefit from the treatment.

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (FDA) has approved the drug, device, treatment or procedure to be investigated or has granted it investigational new drug (IND) or Group C/treatment-IND status, when this is required.
- The clinical trial has been approved by an institutional review board that will oversee it.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and it conforms to standards of the NCI or other applicable federal organization.
- It takes place at an NCI-designated cancer center or at more than one institution.

- You are treated in accordance with the procedures of that study.

What Is Not Covered

The following are not covered services:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)

j. MATERNITY CARE

Covered expenses include services provided by a physician for pregnancy and childbirth services and supplies at the same level as any illness or injury. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, covered expenses include a hospital stay for:

- A minimum of 48 hours after a vaginal delivery;
- A minimum of 96 hours after a cesarean section; or
- A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier.

If the mother is discharged earlier, the Plan will pay for one post-delivery home visit by a healthcare provider.

Covered expenses for a birthing center are described under Section II.A.3d, "Alternatives to Hospital Stays."

Additional Covered Expenses

Covered expenses also include the following:

- Circumcisions
- Treatment of miscarriages
- Theses specific breastfeeding services and supplies if Medically Necessary, covered at 100% of charges with no deductible:
  - Electric breast pump (one every 36 months)
  - Lactation counseling (six visits every 12 months, after which specialist visit co-payments apply)

Your Rights under the Newborns' and Mothers' Health Protection Act of 1996

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain Pre-certification for any days of confinement that exceed 48 hours (or 96 hours). For information on Pre-certification, call the Aetna Member Services toll-free number listed on your Aetna ID card.

NOTE: Newborn children will not be covered, including for charges in connection with childbirth, unless eligible and enrolled.

Covered expenses for fertility services are described under Section II.D.1.

k. PROSTHETIC DEVICES

Covered expenses include internal and external prosthetic devices and special appliances if the device or appliance improves or restores a body part function that has been lost or damaged by illness, injury or congenital defect. Covered expenses also include instruction and incidental supplies needed to use a covered prosthetic device.

The Plan **will not cover** expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes or other devices to support the feet, unless required for the treatment of or to prevent complications from diabetes or if the orthopedic shoe is an integral part of a covered leg brace
- Foot orthotics
- Trusses, corsets and other support items
- Any item listed in Section II.A.4a, "Medical Plan Exclusions"

l. SHORT-TERM REHABILITATION THERAPY SERVICES

Covered expenses include short-term rehabilitation therapy services when prescribed by a physician, as described below. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A hospital, skilled nursing facility or hospice facility;
- A home health care agency; or
- A physician.

The following short-term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation

Cardiac and pulmonary rehabilitation benefits are available as part of an inpatient hospital stay.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy

Benefits for these services are limited to a combined total of 20 visits per calendar year. See Section II.A.3q for Habilitation Therapies for autism or developmental delay. Inpatient Rehabilitation services will be paid as part of your hospital benefits (see Section II.A.3c).

A "visit" consists of no more than one hour of therapy. Covered expenses include two therapy visits of no more than one hour in a 24-hour period.

m. RECONSTRUCTIVE OR COSMETIC SURGERY AND SUPPLIES

Covered expenses include reconstructive services and supplies provided by a physician, hospital or surgery center including:

- Surgery needed to improve a significant functional impairment of a body part
- Surgery to correct the result of an accidental injury that occurred when the member was eligible under this Plan, including subsequent related or staged surgery, provided that the reconstructive surgery occurs no more than two calendar years after the original injury; for a covered child, the time period for coverage may be extended through age 18
- Surgery to correct the result of an injury that occurred during a covered surgical procedure, provided that the reconstructive surgery occurs no more than two calendar years after the original injury

  NOTE: Injuries that occur as a result of a medical (i.e., non-surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.
- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when:
  - The defect results in severe facial disfigurement; or

- The defect results in significant functional impairment and the surgery is needed to improve function

Reconstructive Breast Surgery

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast, and physical therapy to treat complications of a mastectomy, including lymphedema.

NOTE: A benefit maximum may apply to reconstructive or cosmetic surgery services. Please refer to the Overview of Your Benefits section.

n. SPECIALIZED CARE

Chemotherapy

Covered expenses include chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a hospital stay is otherwise Medically Necessary based on your health status.

Radiation Therapy

Covered expenses include the treatment of illness by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy

Covered expenses include infusion therapy provided on an outpatient basis by:

- A freestanding facility;
- The outpatient department of a hospital; or
- A physician in their office or in your home.

Celluar and Gene Therapy

The Plan covers cellular therapies and gene therapies approved by the FDA, provided they are Medically Necessary to treat your disease and are received at a certified hospital or certified outpatient facility.

Blood Transfusions and Blood Processing

Covered expenses include Medically Necessary administration (collection and storage), blood processing and other processing and fees related to: pre-operative autologous blood donations; intraoperative autotransfusion and cell saver devices; transfusion of blood/blood products; certain blood-derived clotting factors; and therapeutic phlebotomy.

Dialysis

Charges are covered for hemodialysis and related services administered to patients with end-stage renal disease in a hospital-based or freestanding hemodialysis center as hospital outpatient miscellaneous expenses.

This includes:

- Hemodialysis center charges for Medically Necessary services
- Hemodialysis equipment and supplies

See Section I.F for information on when Medicare is the primary payer of these benefits.

Enteral Nutrition

Covered expenses include devices, supplies and nutritional formulas related to the provision of nutritional requirements through a tube into the stomach or small intestine.

o. SPINAL MANIPULATION TREATMENT

Covered expenses include manipulative (adjustive) treatment or other physical treatment made by a physician on an outpatient basis for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

p. TRANSPLANT SERVICES

Covered expenses include services provided during an organ transplant occurrence. **Organ** means solid organ, stem cell, bone marrow and tissue.

The network level of benefits is paid only for a treatment (and related drug prescriptions) received at a facility designated by the Plan as an Institute of Excellence (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

Covered transplant expenses are typically incurred during the four phases of transplant care. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

REMINDER

To help ensure coverage, all transplant procedures need to be Pre-certified by Aetna. Refer to Section II.A.1, "How Your Medical Plan Works," for details about Pre-certification.

What Is Not Covered

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

- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within one calendar year for an existing illness
- Harvesting and/or storage of organs without the expectation of immediate transplantation for an existing illness
- Home infusion therapy after the transplant occurrence

- Services and supplies furnished by a non-IOE facility
- Services and supplies furnished to a donor when the recipient is not covered under this Plan
- Services that are covered under any other part of this Plan

q. BEHAVIORAL HEALTH CARE

Covered expenses include the treatment of alcohol and substance use disorders and mental disorders by behavioral health providers.

NOTE: Not all types of services are covered. For example, educational services and certain types of therapies are **not covered.** See Section II.A.4a, "Medical Plan Exclusions," and the Overview of Your Benefits section for more information.

Treatment of Mental Disorders

Covered expenses include the treatment of other mental disorders by behavioral health providers. In addition to meeting all other conditions for coverage, the treatment must meet **all** of the following criteria:

- There is a written treatment plan prescribed and supervised by a behavioral health provider;
- The plan includes follow-up treatment; and
- The plan is for a condition that can favorably be changed.

Benefits are payable for services provided in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office for the treatment of mental disorders as follows:

Outpatient Care

Outpatient visits are covered expenses. **Note:** Outpatient physical/occupational/speech therapy for medical conditions associated with autism or developmental delay is also covered.

Inpatient Treatment

Covered expenses include room and board at the semi-private room rate and other services and supplies provided during your stay in a hospital, psychiatric hospital or residential treatment facility appropriately licensed by the State Department of Health or its equivalent. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

PHP and IOP Treatment

Covered expenses include treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility.

The Plan covers Partial Hospitalization Program (PHP) services (more than four hours, but less than 24 hours a day) provided in either a facility or program for the intermediate short-term or a medically directed intensive treatment. Partial hospitalization will only be covered if you would need

inpatient care were you not admitted to this type of facility.

The Plan also covers Intensive Outpatient Program (IOP) services provided by an appropriately licensed or credentialed practitioner.

Note: Custodial care charges for intermediate care rendered at a facility are not covered by the Fund. If you receive behavioral health services at a residential treatment center, only services that qualify as the covered services listed above will be covered.

Habilitative and Behavioral Therapy

The Plan covers long-term physical, occupational and speech therapy treatment for conditions associated with autism or developmental delay. You must obtain Pre-certification for long-term Habilitation Therapies to determine whether the services being recommended are covered expenses under the Plan.

REMINDER

Inpatient care must be Pre-certified by Aetna. Refer to Section II.A.1, "How Your Medical Plan Works," for details about Pre-certification.

Treatment for Alcohol and Substance Use Disorder

Covered expenses include the treatment of alcohol and substance use disorder by behavioral health providers. In addition to meeting all other conditions for coverage, the treatment must meet **all** of the following criteria:

- There is a program of therapy prescribed and supervised by a behavioral health provider; and
- The program of therapy includes either:
  - A follow-up program directed by a behavioral health provider on at least a monthly basis; or
  - Meetings at least twice a month with an organization devoted to the treatment of alcohol and substance use disorder.

Inpatient Treatment

The Plan covers room and board at the semi-private room rate, as well as other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility appropriately licensed by the State Department of Health or its equivalent.

Coverage includes:

- Treatment in a hospital for the medical complications of alcohol and substance use disorder; **medical complications** include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis
- Treatment in a hospital when the hospital does not have a separate treatment facility section

PHP and IOP Treatment

The Plan covers outpatient treatment of alcohol and substance use disorder.

The Plan covers Partial Hospitalization Program (PHP) services (more than four hours, but less than 24 hours a day) provided in a facility or program for the intermediate short-term, or medically directed intensive treatment of alcohol or substance use disorder. Partial hospitalization will only be covered if you would need inpatient care were you not admitted to this type of facility.

The Plan also covers Intensive Outpatient Program (IOP) services provided by an appropriately licensed or credentialed practitioner.

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.

REMINDER

Inpatient care must be Pre-certified by Aetna. Refer to Section II.A.1, "How Your Medical Plan Works," for details about Pre-certification.

r. ORAL AND MAXILLOFACIAL TREATMENT (MOUTH, JAWS AND TEETH)

Covered expenses include services and supplies provided by a physician, dentist or hospital for non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Covered expenses also include services and supplies for surgical treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles and nerves) needed to:

- Treat a fracture, dislocation or wound
- Cut out cysts, tumors or other diseased tissues
- Cut into gums and tissues of the mouth; this is only covered when **not done** in connection with the removal, replacement or repair of teeth
- Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement

s. VISION CARE

Covered expenses include:

- A $10 co-payment for one eye exam every two calendar years;
- $125 allowance once every two years for one pair of eyeglasses; in lieu of eyeglasses, one order of contact lenses

4. WHAT IS NOT COVERED

Please also see general exclusions in Section VII.D.

MEDICAL PLAN EXCLUSIONS

Not every medical service or supply is covered by the Plan, even if prescribed, recommended or approved by your physician. Charges made for the following are **not covered:**

- Acupuncture, acupressure and acupuncture therapy
- Allergy: Specific non-standard allergy services and supplies, including, but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's test), treatment of non-specific candida sensitivity and urine autoinjections
- Artificial organs: Any device intended to perform the function of a body organ
- Behavioral health services
- Blood, blood plasma, synthetic blood and blood derivatives or substitutes; blood, blood products and related services are supplied to your provider free of charge
- Charges in excess of the benefit, day, dollar, supply or visit limits as described in this SPD
- Charges for a service or supply furnished by a Network Provider in excess of the negotiated charge
- Charges submitted for services by an unlicensed hospital, physician or other provider, or services not within the scope of the provider's license
- Charges submitted for services that are not rendered or rendered to a person not eligible for coverage under the Plan
- Educational services:
  - Services or supplies related to education, training/retraining services or testing, including: educational therapies, special education, remedial education, job training or job hardening programs and Habilitation Therapies provided in educational settings
  - Evaluation or treatment of learning disabilities; minimal brain dysfunction; developmental, learning and communication disorders; behavioral disorders (including pervasive developmental disorders); or training or cognitive rehabilitation, other than the habilitative and rehabilitative services described in Section II.A.3, "What the Plan Covers."
  - Services, treatment and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills

- Health exam required or requested:
  - By a third party, including tests, examinations and treatments required to obtain or maintain employment or which an Employer or employee is required to provide under a labor agreement
  - By law or for the purposes of securing insurance or professional or other licenses
  - To travel; attend a school, camp or sporting event; or participate in a sport or other recreational activity
  - For any special medical reports not directly related to treatment, except when provided as part of a Covered Service
- Exercise programs, exercise equipment, membership in health or fitness clubs, training, advice or coaching and recreational therapy or other forms of activity or activity enhancement
- Experimental or Investigational drugs, devices, treatments or procedures, except as described in this SPD
- Facility charges for care services or supplies provided in:
  - Rest homes
  - Assisted living facilities
  - Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care
  - Health resorts
  - Spas or sanitariums
  - Infirmaries at schools, colleges or camps
- Food items, including infant formulas, nutritional supplements, vitamins (including prescription vitamins), medical foods and other nutritional items (except enteral nutrition), even if it is the sole source of nutrition
- Foot care: Except as specifically covered for diabetics, any services, supplies or devices to improve comfort or appearance of toes, feet or ankles, including:
  - Treatment of calluses, bunions, toenails, hammer-toes, sublimations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Shoes (including orthopedic shoes), orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury
- Growth/height: Treatments, devices, drugs, services or supplies to increase or decrease height or alter the rate of growth, including surgical

procedures, devices to stimulate growth and growth hormones

- Hearing:
  - Hearing exams given during a stay in a hospital or other facility
  - Tests, appliances and devices for the improvement of hearing, including hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss, or devices that simulate speech
- Home and mobility: Additions or alternations to a home, vehicle, workplace or other environment and any related equipment or device, including:
  - Home births: Services and supplies related to births occurring in the home or in a place not licensed to perform deliveries
  - Home uterine activity monitoring
- Infertility services:
  - Procedures, services and supplies to reverse voluntary sterilization
  - Aetna does not cover infertility treatments and fertility services; see Section II.D.1 for coverage information
- Miscellaneous charges for services or supplies, including:
  - Annual or other charges to be in a physician's practice
  - Charges to have preferred access to a physician's services, such as boutique or concierge physician practices
  - Cancelled or missed appointment charges or charges to complete claim forms
  - Charges the recipient has no legal obligation to pay or charges that would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law), including:
    - Care in charitable institutions
    - Care for conditions related to current or previous military service
    - Care while in the custody of a governmental authority
    - Any care a public hospital or other facility is required to provide
    - Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws
- Non-emergency charges incurred outside of the United States, if:
  - You traveled to such location to obtain supplies, even if otherwise covered under this SPD

- Such supplies are unavailable or illegal in the United States
- The purchase of such supplies outside the United States is considered illegal

- Non-medically Necessary services, including, but not limited to, those treatments, services, prescription drugs and supplies which are not Medically Necessary, as determined by Aetna, for the diagnosis and treatment of illness, injury, restoration of physiological functions or covered preventive services; this applies even if they are prescribed, recommended or approved by your physician
- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Payment for that portion of the charge for which Medicare or another party is the primary payer
- Personal comfort and convenience items: Services or supplies primarily for your convenience and personal comfort, or that of a third party, including telephone, television or Internet; barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; travel, transportation or living expenses; and rest cures, recreational or diversional therapy
- Private-duty nursing during your stay in a hospital and outpatient private-duty nursing services, except as specifically described in the Home Health Care provision in Section II.A.3, "What the Plan Covers" and in the Overview of Your Benefits section
- Services and supplies provided in connection with treatment or care that is not covered under the Plan
- Services and supplies provided by an Out-of-Network Provider
- Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued as described in Section I.K
- Services of a resident physician or intern rendered in that capacity
- Services provided by a spouse, domestic partner, parent, child, stepchild, sibling, in-law or any household member
- Services provided where there is no evidence of pathology, dysfunction or disease, except as specifically provided in connection with covered routine care and cancer screenings
- Services that are not covered under this SPD
- Sexual dysfunction/enhancement: Treatments, services or supplies to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgeries, implants, devices or preparations to correct or enhance erectile function or enhance sensitivity
- Sex therapy, sex counseling or advisory services

- Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine, including manipulation of the spine treatment, except as specifically described in this SPD
- Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:
  - Drugs or preparations to enhance strength, performance or endurance
  - Treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance-enhancing drugs or preparations
- Therapies and tests:
  - Aromatherapy
  - Biofeedback and bioenergetic therapy
  - Carbon dioxide therapy
  - Chelation therapy (except for heavy metal poisoning)
  - Computer-aided tomography (CAT) scanning of the entire body
  - Educational therapy
  - Gastric irrigation
  - Hair analysis
  - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds
  - Hypnosis and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery
  - Lovaas therapy
  - Massage therapy
  - Megavitamin therapy
  - Primal therapy
  - Psychodrama therapy
  - Purging
  - Recreational therapy
  - Rolfing
  - Sensory or auditory integration therapy
  - Sleep therapy
  - Thermograms and thermography
- Transplant services obtained from a facility that is not designated as an Institute of Excellence-contracted (IOE) facility for the transplant being performed

- Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services, except as described in this SPD
- Unauthorized services, including any service obtained by or on behalf of a covered person without Pre-certification by Aetna when required; this exclusion does not apply in a medical Emergency or in an urgent care situation
- Vision-related services and supplies:
  - Acuity tests
  - Anti-reflective coatings
  - Duplicate or spare eyeglasses, lenses or frames
  - Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
  - Replacement of lenses or frames that are lost, stolen or broken
  - Services to treat errors of refraction
  - Special supplies, such as non-prescription sunglasses and subnormal vision aids
  - Special vision procedures, such as orthoptics, vision therapy or vision training
  - Tinting of eyeglass lenses
  - Vision services or supplies that do not meet professionally accepted standards
- Weight: Treatments, drugs, services and supplies intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, except as described in this SPD and the Preferred Drug List (PDL)
- Work-related: Illnesses or injuries related to employment or self-employment, including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your Employer, workers' compensation or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational," regardless of cause.

5. GENERAL PROVISIONS

TYPE OF COVERAGE

Only non-occupational accidental injuries and non-occupational illnesses are covered. The Plan covers services

and supplies only while you are covered under the Plan.

PHYSICAL EXAMINATIONS

Aetna will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

ADDITIONAL PROVISIONS

The following additional provisions apply to your coverage:

- This SPD applies to coverage only and does not restrict your ability to receive healthcare services that are not, or might not be, covered.
- If you are connected to more than one Employer or you are both a member and a dependent, you are subject to the same conditions and limitations as a member with one Employer.
- In the event of a misstatement of any fact affecting your coverage under the Plan, the true facts will be used to determine the coverage in force.
- This SPD describes the main features of the Plan. If you have any questions about the terms of the Plan or about the proper payment of benefits, contact Aetna or the Benefit Fund.

6. CLAIMS AND APPEAL PROCESS FOR MEDICAL BENEFITS

All claims should be promptly submitted to Aetna in writing. When care is provided by a Network Provider, the Network Provider will file the claims. The deadline for filing a claim is 12 months after the date of service. If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Benefits will be paid as soon as the necessary proof to support the claim is received.

If your claim or your Request for Benefits is denied, Aetna and the Benefit Fund provide for two levels of appeal. The notice of an Adverse Benefit Determination will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call the Aetna Member Services toll-free number listed on your Aetna ID card.

CLAIM DETERMINATIONS

Urgent Care Claims

Aetna will make notification of an urgent care claim determination as soon as possible but not more than 72 hours after the claim is made.

If more information is needed to make an urgent care claim determination, Aetna will notify the claimant within 24 hours of receipt of the claim. The claimant has 48 hours after receiving such notice to provide Aetna with the additional

information. Aetna will notify the claimant within 48 hours of the earlier:

- The receipt of the additional information; or
- The end of the 48-hour period given to the physician to provide Aetna with the information.

If the claimant fails to follow Plan procedures for filing a claim, Aetna will notify the claimant within 24 hours following the failure to comply.

Pre-service Claims

Aetna will make notification of a pre-service claim determination as soon as possible but not later than 15 calendar days after the pre-service claim is made. Aetna may determine that due to matters beyond its control, an extension of this 15-calendar-day-claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 15-calendar-day period. If this extension is needed because Aetna needs additional information from you to make a claim determination, the notice of the extension shall specifically describe the required information. You will have 45 calendar days from the date of the notice to provide Aetna with the required information.

Post-service Claims

Aetna will make notification of a post-service claim determination as soon as possible but not later than 30 calendar days after the post-service claim is made. Aetna may determine that due to matters beyond its control, an extension of this 30-calendar-day claim determination period is required. Such an extension, of not longer than 15 additional calendar days, will be allowed if Aetna notifies you within the first 30-calendar-day period. If this extension is needed because Aetna needs additional information from you to make a claim determination, the notice of the extension shall specifically describe the required information. You will have 45 calendar days from the date of the notice to provide Aetna with the required information.

Concurrent Care Claim Extension

Following a request for a concurrent care claim extension, Aetna will notify you of the claim determination for Emergency or urgent care as soon as possible but not later than 24 hours, with respect to Emergency or urgent care, provided the request is received at least 24 hours prior to the expiration of the approved course of treatment, and 15 calendar days with respect to all other care, following a request for a concurrent care claim extension.

Concurrent Care Claim Reduction or Termination

Aetna will notify you of the concurrent care claim determination to reduce or terminate a previously approved course of treatment with enough time for you to file an appeal.

COMPLAINTS

If you are dissatisfied with the service you receive from Aetna or want to complain about a provider, you must write to Aetna Member Services within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents you think are relevant to the matter. Aetna will review the information and provide you with a written response within 30 calendar days of receipt of the complaint, unless additional information is needed and it cannot be obtained within this period. The notice of the decision will tell you what you need to do to seek an additional review.

APPEAL PROCEDURE

You may submit an appeal if Aetna gives notice of an Adverse Benefit Determination.

You have 180 calendar days following receipt of the notice of an Adverse Benefit Determination to request your level one appeal. Your appeal may be submitted verbally or in writing and should include:

- Your name;
- Your Employer's name;
- A copy of Aetna's notice of an Adverse Benefit Determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

The notice of an Adverse Benefit Determination will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call the Aetna Member Services toll-free number listed on your Aetna ID card.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing verbal or written consent to Aetna.

Level One Appeal

If Aetna gives notice of an Adverse Benefit Determination, you or your authorized representative has the right to file a level one appeal. A level one appeal shall be provided by Aetna or company personnel not involved in making the Adverse Benefit Determination.

- **Urgent Care Claims (may include concurrent care claim reduction or termination):** Aetna shall issue a decision within 36 hours of receipt of the request for a level one appeal.
- **Pre-service Claims (may include concurrent care claim reduction or termination):** Aetna shall issue a decision within 15 calendar days of receipt of the request for a level one appeal.
- **Post-service Claims:** Aetna shall issue a decision within 30 calendar days of receipt of the request for a level one appeal.

You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim.

A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided, free of charge, upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all comments, documents, records and other information relevant to the claim.

Level Two Appeal

If Aetna upholds an Adverse Benefit Determination at the first level of appeal (a level one appeal), you or your authorized representative has the right to file a level two appeal.

- **Urgent Care Claims (may include concurrent care claim reduction or termination):** Aetna shall issue a decision within 36 hours of receipt of the request for a level two appeal. An appeal of an urgent care claim shall be provided by Aetna or company personnel not involved in making the Adverse Benefit Determination. The appeal must be submitted within 60 calendar days following receipt of the notice of a level one appeal.
- **Pre-service Claims (may include concurrent care claim reduction or termination):** The Benefit Fund shall issue a decision within 15 calendar days of receipt of the request for a level two appeal.
- **Post-service Claims:** The Benefit Fund shall issue a decision within 30 calendar days of receipt of the request for a level two appeal.

The decision shall be made at the Appeals Committee of the Board of Trustees ("Appeals Commitee") meeting following the Plan's receipt of a request for review plus 30 days (unless special circumstances require an extension to the next scheduled meeting), and the claimant will be notified in writing. If your appeal is denied by the Appeals Committee, you have the right to file a civil action under the Employee Retirement Income Security Act of 1974 ("ERISA") only in a federal court in New York City.

An appeal of a pre-service claim or a post-service claim must be submitted within 60 calendar days following receipt of the notice of a level one appeal. Send your appeal request to Aetna, and Aetna will forward your appeal request and any additional information you have provided, along with the level one appeal file, to the Benefit Fund.

Exhaustion of Process

You must exhaust the applicable level one and level two processes of the appeal procedure before you start a lawsuit. No lawsuits may be filed by you, your spouse or your children, or by providers as an assignee, after

three years from the date of service, or, where there is no service, after three years from the date of the initial denial.

SECTION II. B
DENTAL BENEFITS PROVIDED BY CIGNA

BENEFIT BRIEF

- Dental Benefits provided by Cigna
- Each individual must select a Cigna Network Dentist as their designated (or primary care) dentist
- Other than for Emergencies, services must be performed by designated Cigna Network Dentists
- Referrals required for some specialists
- Co-payments and limitations may apply for some procedures (see Cigna's Dental Care Patient Charge Schedule (provided to you by Cigna) for a list of covered procedures and applicable co-payments)
- No annual maximum

Eligibility Class I: Family coverage for member, spouse and dependent children

Eligibility Class II: Not covered

Eligibility Class III: Not covered

1. WHAT THE PLAN COVERS

COVERED DENTAL SERVICES

Covered Dental Service means a dental service that:

- Is performed by, or under the direction of, the designated Participating Dental Facility or upon referral by the Participating Dentist to an approved specialist and authorized by Cigna;
- Is essential for the necessary care of the teeth and supporting structure (gums); and
- Starts and is completed while the person is insured.

You, your spouse and your children are covered for the following based upon co-payments and maximums described in your Dental Care Patient Charge Schedule provided to you by Cigna.

Diagnostic/preventive: Typical services include:

- Four oral evaluations per year and X-rays needed to diagnose a specific injury or disease

- Panoramic (complete set of) X-rays once every three years
- Prophylaxis (cleaning) twice per year
- Fluoride treatment twice per year for children up to age 19

Some services may be subject to a co-payment.

Restorations: Fillings subject to co-payments.

Crown, bridgework and prosthetics: Typical services include inlays, onlays, crowns, pontics or dentures and their repair or relining. Services provided once every five years subject to co-payments, except for repair and relining of dentures once every 36 months.

Endodontics: Root canal treatment subject to co-payments.

Periodontics: Treatment of supporting tissues (gums and bones) of the teeth. Typical services include gingivectomy, bone replacement grafts and scaling and root planning. Subject to co-payments and annual and tooth limitations.

Oral surgery: Typical services include extraction and removal of impacted teeth, other surgical procedures and post-operative care. Subject to co-payments.

Orthodontics: Typical services include orthodontic treatment plan and records, interceptive orthodontic treatment, comprehensive orthodontic treatment and retention (post-treatment stabilization). Treatment covered every 24 months for children and adults. Co-payments for adults payable over the 24-month period. Atypical cases or cases beyond 24 months require an additional payment by the patient.

General anesthesia/intravenous (IV) sedation: General anesthesia is covered when performed by an oral surgeon when Clinically Necessary for covered procedures. IV sedation is covered when performed by a periodontist or oral surgeon when Clinically Necessary for covered procedures. Plan limitation for this benefit is one hour per appointment, and co-payments are based upon time intervals. There is no coverage for general anesthesia or IV sedation when used for the purpose of anxiety control or patient management.

Emergency services: Emergency Dental Treatment means diagnostic and palliative procedures administered in the case of: (1) a dental Emergency that involves acute pain; or (2) a dental condition that requires immediate treatment.

GETTING YOUR BENEFITS

If you have any questions or concerns regarding your dental office, your eligibility, your Dental Benefits under the Plan, your Cigna ID card, specialty referrals, Emergencies, Covered Services, location of dental offices or other matters, call Cigna Member Services at (800) 244-6224.

CHOOSING YOUR DENTIST

You and your dependents should select a dental office when you become covered for Dental Benefits. If you do not do this, you must advise Cigna of your dental office selection prior to receiving treatment. The Dental Benefits under the Plan are available only at your dental office, except in the case of an Emergency or when Cigna authorizes a payment for Out-of-Network Benefits.

If for any reason your selected dental office cannot provide your dental care, or if your Network General Dentist terminates from the network, Cigna will let you know and will arrange a transfer to another dental office.

To obtain a list of dental offices near you, visit www.Cigna.com or call Cigna's Dental Office Locator at (800) 244-6224. Both are available 24 hours a day, 7 days a week. If you would like to have the list faxed to you, provide your fax number, including your area code. You may always obtain a current dental office directory by calling Cigna Member Services.

For Covered Services at your dental office, you will be responsible for the fees listed in your Dental Care Patient Charge Schedule, provided to you by Cigna. For services listed in your Dental Care Patient Charge Schedule at any other dental office, you may be charged Usual Fees. For non-Covered Services, you are responsible for paying Usual Fees. If, on a temporary basis, there is no Network General Dentist in your service area, Cigna will let you know if you may obtain Covered Services from a non-Network Dentist. You will pay the non-Network Dentist the applicable Patient Charge for Covered Services. Cigna will pay the non-Network Dentist the difference, if any, between their Usual Fee and the applicable Patient Charge.

EMERGENCY DENTAL CARE

An Emergency is a dental condition of recent onset and severity, which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain or eliminate acute infection. You should contact your Network General Dentist if you have an Emergency in your service area.

Emergency Care Away from Home

If you have an Emergency while you are out of your service area or you are unable to contact your Network General Dentist, you may receive Emergency Covered Services from any General Dentist. Routine restorative procedures or definitive treatments (e.g., root canal) are not considered Emergency care. You should return to your Network General Dentist for these procedures. For Emergency Covered Services, you will be responsible for the Patient Charges listed in your Dental Care Patient Charge Schedule. Cigna will reimburse you the difference, if any,

between the dentist's Usual Fee for Emergency Covered Services and your Patient Charge, up to a total of $50 per incident. To receive reimbursement, send appropriate reports and X-rays to Cigna at the address listed on the back of your Cigna ID card.

Emergency Care after Hours

There is an additional charge for Emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable charges.

OTHER PATIENT CHARGES

Network General Dentists are typically reimbursed by Cigna through fixed monthly payments and supplemental payments for certain procedures. Network General Dentists are also compensated by the fees you pay, as set out in your Dental Care Patient Charge Schedule. There are no deductibles and no annual dollar limits for services covered by your Dental Plan. Your Network General Dentist should tell you about Patient Charges for Covered Services, the amount you must pay for non-Covered Services and the dental office's payment policies.

Patient Charges and limitations are subject to change. You will be responsible for the Patient Charges listed in your Dental Care Patient Charge Schedule that is in effect on the date a procedure is started.

SPECIALTY REFERRALS

When specialized dental care services are required, a Participating Dentist must initiate the referral process.

Covered specialists include:

- Pediatric dentists (dentistry for children up to age 7)
- Endodontics (root canal treatment)
- Periodontics (treatment of gums and bones)
- Oral surgeons (complex extractions and other surgical procedures)
- Orthodontics (tooth movement)

There is no coverage for prosthodontics or other specialists not listed above.

2. WHAT IS NOT COVERED

Covered Dental Services **do not include** or, where applicable, no payment will be made for, any:

- Completion of crown and bridge, dentures or root canal treatment already in progress on the effective date of your Cigna coverage
- Complex rehabilitation involving six or more "units" of crown and/or bridge in the same treatment plan
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance)
- Crowns or bridges used solely for splinting

- General anesthesia, sedation and nitrous oxide, unless specifically listed in your Dental Care Patient Charge Schedule; when listed in your Dental Care Patient Charge Schedule, general anesthesia and IV sedation are covered when Clinically Necessary and provided in conjunction with Covered Dental Services performed by an oral surgeon or periodontist
- Hospitalization, including any associated incremental charges for dental services performed in a hospital
- Orthodontic services related to incremental costs associated with optional/elective materials, including, but not limited to:
  - Ceramic, clear lingual brackets or other cosmetic appliances
  - Orthognathic surgery and associated incremental costs
  - Appliances to guide minor tooth movement or to correct harmful habits
  - Services that are not typically included in orthodontic treatment
  - Services in progress at the time you enrolled in the Plan
- Prescription drugs
- Procedures, appliances or restorations, if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact); (2) diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ), unless TMJ therapy is specially listed in your Dental Care Patient Charge Schedule; or (3) restore teeth that have been damaged by attrition, abrasion, erosion and/or abfraction
- Procedures or appliances for minor tooth guidance, or to control harmful habits
- Procedures or services associated with the placement or prosthodontic restoration of a dental implant
- Replacement of fixed and/or removal of prosthodontic or orthodontic appliances that have been lost, stolen or damaged due to patient abuse, misuse or neglect
- Resin-bonded retainers and associated pontics
- Services provided by a non-Network Dentist without Cigna's Prior Authorization (except for Emergencies)
- Surgical removal of an impacted wisdom tooth if the tooth is not diseased or if the removal is only for orthodontic reasons

No payment will be made for expenses incurred or services received:

- Due to injuries that are intentionally self-inflicted

- For clinical lab services, pharmacy services or X-ray or imaging services, if referred by a practitioner who has a financial relationship (or whose immediate family member has a financial relationship) with the provider of those services
- For care, treatments or surgeries not prescribed as necessary by a dentist
- For charges made by a hospital
- For, or in connection with, injuries arising out of, or in the course of, any employment for wage or profit
- For, or in connection with, an illness which is covered under any workers' compensation or similar law
- For, or in connection with, unnecessary or Experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society
- For treatments or services that are not Clinically Necessary
- That are provided or paid for by a federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid
- That are required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war
- To the extent that benefits are paid or payable for those expenses or services under any group medical plan, no-fault insurance policy or an uninsured motorist policy
- To the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received
- When charges would not have been made if the person had no insurance
- Which the person would not be legally required to pay

3. CIGNA'S APPEAL PROCESS FOR DENTAL BENEFITS

If your claim or your Request for Benefits is denied, Cigna provides for two levels of appeal. Each notice of benefit or appeal determination will be provided in writing and, if it is a denial, will include the rationale for the denial, a reference to the specific plan provision on which the denial is based and the next step in the appeal process.

If you have a concern regarding a person, a service, the quality of care or your benefits, you can write to Cigna or call Cigna Member Services and speak to a Cigna representative. The toll-free number and address appear on the back of your Cigna ID card.

Cigna will attempt to resolve the matter in your initial contact. If Cigna needs more time to review or investigate a complaint about: (1) a denial of, or failure to pay for, a referral; or (2) a determination as to whether a benefit is covered under

the Plan, it will either get back to you on the same day it receives your complaint or use the appeal procedure described in this section.

Concerns regarding the quality of care, choice of or access to providers or provider network adequacy will be forwarded to Cigna's Quality Management Staff for review. Cigna will provide written acknowledgment of your concern within 15 calendar days, with appropriate resolution information to follow in a timely manner.

APPEAL PROCEDURE

Cigna has a two-step appeal procedure to review any dispute you may have with Cigna's decision, action or determination. To initiate an appeal, you must submit a request for an appeal, in writing, within 365 calendar days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable (or choose not) to write, you may ask to register your appeal or ask for information about utilization review decisions by calling the Cigna Member Services toll-free number listed on your Cigna ID card or on the explanation of benefits or claim form, from Monday through Friday, during regular business hours. If calling after hours, follow the recorded instructions if you wish to leave a message.

Cigna will acknowledge your appeal in writing upon receipt. Acknowledgments will include the name, address and telephone number of the person designated to respond to your appeal, and they will indicate what additional information, if any, must be provided. If no decision is made within the applicable time frames described below regarding your appeal of an adverse utilization review determination, the adverse determination will be deemed to be reversed.

Level One Appeal

You or your authorized representative must submit your level one appeal in writing or by telephone. Written appeal requests should be sent to the address listed on the explanation of benefits or claim form. To submit an appeal over the phone, call the Cigna Member Services toll-free number listed on your Cigna ID card.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Clinical Necessity or clinical appropriateness will be considered by a healthcare professional of the same or similar specialty as the care under consideration, as determined by Cigna's dentist reviewer. Cigna will respond, in writing, with a decision within 30 calendar days of receiving an appeal (or within 15 calendar days of receiving an appeal of an adverse utilization review determination). This notification will include the reasons for the decision, including clinical rationale, if applicable, as well as additional appeal rights, if any.

If more time or information is needed in the case of a utilization review determination, Cigna will notify you, in writing, to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. You are not obligated to grant Cigna an extension or to provide the requested information. If you remain dissatisfied with the level one appeal utilization review determination by Cigna, you have the right to request an external appeal, as well as a level two appeal. You may request an external appeal application from the New York State Department of Financial Services by:

- Calling its toll-free number at (800) 400-8882;
- Visiting its website at www.dfs.ny.gov/complaints/file_external_appeal; or
- Visiting the New York State Department of Health's website at www.health.ny.gov.

Level Two Appeal

If you are dissatisfied with Cigna's level one appeal decision, you or your authorized representative may request a second review. To start a level two appeal, follow the same process required for a level one appeal. Most requests for a second review will be conducted by the Cigna Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving Clinical Necessity or clinical appropriateness, the Appeals Committee will consult with at least one healthcare professional of the same or similar specialty as the care under consideration, as determined by Cigna's dentist reviewer. You may present your situation to the Appeals Committee in person or via conference call.

For level two appeals, Cigna will acknowledge, in writing, that it has received your request and will schedule an Appeals Committee review. The Appeals Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, Cigna will notify you, in writing, to request an extension of up to 15 calendar days and to specify any additional information needed by the Appeals Committee to complete the review. You are not obligated to grant the Appeals Committee an extension or to provide the requested information. You will be notified, in writing, of the Appeals Committee's decision within five business days of the Appeals Committee meeting and within the Appeals Committee review time frames mentioned if the Appeals Committee does not approve the requested coverage.

EXTERNAL APPEAL

Your Right to an External Appeal

Under certain circumstances, you have the right to an external appeal of a denial of coverage. Specifically, if Cigna

has denied coverage on the basis that the service is not Clinically Necessary, or is an Experimental or Investigational Treatment, you or your authorized representative may appeal that decision to a certified External Appeal Agent, an independent entity certified by the State to conduct such appeals.

Your Right to Appeal a Determination That a Service Is Not Clinically Necessary

If Cigna has denied coverage on the basis that the service is not Clinically Necessary, you may appeal to a certified External Appeal Agent if you satisfy the following criteria:

- The service, procedure or treatment must otherwise be a Covered Dental Service under this Plan; and
- You must have received a final adverse utilization review determination through the first level of the Plan's internal appeal process (level one appeal), and Cigna must have upheld the denial; or
- You and Cigna must agree, in writing, to waive any internal appeal.

Your Right to Appeal a Determination That a Service Is Experimental or Investigational

If Cigna has denied coverage on the basis that the service is an Experimental or Investigational Treatment, you must satisfy the following criteria:

- The service, procedure or treatment must otherwise be a Covered Dental Service under this Plan; and
- You must have received a final adverse utilization review determination through the first level of the Plan's internal appeal process (level one appeal), and Cigna must have upheld the denial; or
- You and Cigna must agree, in writing, to waive any internal appeal.

External Appeal Procedure

If, through the first level of Cigna's internal appeal process (level one appeal), you have received a final adverse utilization review determination upholding a denial of coverage on the basis that the service is not Clinically Necessary, or is an Experimental or Investigational Treatment, you have 45 calendar days from receipt of such notice to file a written request for an external appeal. If you and Cigna have agreed, in writing, to waive any internal appeal, you have 45 calendar days from receipt of such waiver to file a written request for an external appeal. Cigna will provide an external appeal application with the final adverse utilization review determination issued through the first level of Cigna's internal appeal process (level one appeal) or its written waiver of an internal appeal.

You will lose your right to an external appeal if you do not file an application for an external appeal within 45 calendar days from your receipt of the final adverse utilization review determination from the first level of Cigna's internal appeal process

(level one appeal), regardless of whether you choose to pursue a second-level internal appeal (level two appeal) with Cigna.

The External Appeal Program is a voluntary program.

You may request an external appeal application from the New York State Department of Financial Services by:

- Calling its toll-free number at (800) 400-8882;
- Visiting its website at www.dfs.ny.gov/complaints/file_external_appeal; or
- Calling the Cigna Member Services toll-free number listed on your Cigna ID card.

Submit the completed application to the New York State Department of Financial Services at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which Cigna based its denial, the External Appeal Agent will share this information with Cigna in order for it to exercise its right to reconsider its decision. If Cigna chooses to exercise this right, Cigna will have three business days to amend or confirm its decision.

In general, the External Appeal Agent must make a decision within 30 calendar days of receipt of your completed application. The External Appeal Agent may request additional information from you, your dentist or Cigna. If the External Appeal Agent requests additional information, the Agent will have five additional business days to make its decision.

The External Appeal Agent must notify you, in writing, of its decision within two business days.

If the External Appeal Agent overturns Cigna's decision that a service is not Clinically Necessary or approves coverage of an Experimental or Investigational Treatment, Cigna will provide coverage subject to the other terms and conditions of this document. The External Appeal Agent's decision is binding on both you and Cigna. The External Appeal Agent's decision is admissible in any court proceeding.

Cigna will charge you a fee for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. Cigna will also waive the fee if it determines that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

Your Responsibilities

It is your responsibility to initiate the external appeal process by filing a completed application with the New

York State Department of Financial Services. If the adverse utilization review determination was initiated after healthcare services were provided, your dentist may file an external appeal by completing and submitting the "New York State External Appeal Application for Healthcare Providers to Request an External Appeal of a Retrospective Final Adverse Determination," which will require your signed acknowledgment of the provider's request and consent to release your medical records.

Under New York State law, your completed request for appeal must be filed within 45 calendar days of either the date upon which you receive written notification from Cigna that it has upheld a first-level denial of coverage or the date upon which you receive a written waiver of any internal appeal. Cigna has no authority to grant an extension of this deadline.

The 45-calendar-day time frame for requesting an external appeal begins upon receipt of the final adverse utilization review determination of the first-level internal appeal (level one appeal), regardless of whether or not a second-level internal appeal (level two appeal) is requested. Note that by choosing to request a second-level internal appeal, the time may expire for the insured to request an external appeal.

COMPLAINTS/APPEALS TO THE STATE OF NEW YORK

At any time in the grievance/appeal process, you may contact the New York State Department of Health (for medically related issues) at the following addresses and telephone numbers to register your complaint:

New York City Office
90 Church Street, 14th Floor
New York, NY 10007-2919
(212) 417-5550

Counties served: Bronx, Kings, New York, Queens and Richmond

Central Islip Office
Court House Corporate Center
320 Carlton Avenue, Suite 500, 5th Floor
Central Islip, NY 11722
(631) 851-4300

Counties served: Nassau and Suffolk

New Rochelle Office
145 Huguenot Street, 6th Floor
New Rochelle, NY 10801-5291
(914) 654-7000

Counties served: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester

At any time in the grievance/appeal process, you may contact the New York State Department of Financial Services (for billing- or contract-related issues). To register a complaint, call the Consumer Hotline at (800) 342-3736. For more information on external appeals, call (800) 400-8882.

New York City Office
One State Street
New York, NY 10004-1511

Garden City Office
1399 Franklin Avenue, Suite 203
Garden City, NY 11530

Albany Office
One Commerce Plaza
Albany, NY 12257

Buffalo Office
535 Washington Street, Suite 305
Buffalo, NY 14203

Oneonta Office
28 Hill Street, Room 210
Oneonta, NY 13820

Syracuse Office
333 East Washington Street
Syracuse, NY 13202

RELEVANT INFORMATION

Relevant information is any document, record or other information, which:

- Was relied upon in making the utilization review determination;
- Was submitted, considered or generated in the course of making the utilization review determination, without regard to whether such document, record or other information was relied upon in making the utilization review determination;
- Demonstrates compliance with the administrative processes and safeguards required by federal law in making the utilization review determination; and
- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit, or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the utilization review determination.

LEGAL ACTION

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the appeal procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two appeal process prior to bringing legal action.

SECTION II. C
PRESCRIPTION DRUGS

BENEFIT BRIEF

Prescription Drugs

- Coverage of FDA-approved prescription medications listed on the formulary for FDA-approved indications
- $10 co-pay for Tier 1 formulary drugs and $15 co-pay for Tier 2 formulary drugs
- For Tier 3 drugs, you can be billed the difference between the Benefit Fund's allowance and whatever the pharmacy charges, which could result in a significant cost to you
- 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 visit **www.1199SEIUBenefits.org/gny-nj-prescription** or call the Benefit Fund at (646) 473-9200 or (800) 575-7771

Eligibility Class I: Family coverage for member, spouse and dependent children

Eligibility Class II: Coverage for member only

Eligibility Class III: Coverage for member only

WHAT IS COVERED

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 and are proven to be safe and effective in the clinical trial process;
- 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 Tier 1 and Tier 2 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 is a $10 co-pay for Tier 1 drugs (Preferred Generic Drugs) and a $15 co-pay for a Tier 2 drugs (Preferred Brand Drugs) when you comply with the Benefit Fund's prescription drug programs:

- *The 1199SEIU 90-Day Rx Solution*
- Prior Authorization for certain medications
- Quantity and day supply limitations
- 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 visit **www.1199SEIUBenefits.org/gny-nj-prescription** or call the Benefit Fund at (646) 473-9200 or (800) 575-7771**.**

PREFERRED DRUGS

We use a **formulary** developed by our Pharmacy Benefit Manager ("PBM"), **CVS Caremark**. A formulary is a list of drugs that are available through the Plan. (The formulary is similar to what you might know as our Preferred Drug List.)

The formulary places covered US Food and Drug Administration–approved drugs into categories based on their clinical effectiveness, safety and cost. It is designed to control costs for you and the Plan. Covered prescription drugs are divided into three tiers:

- Tier 1 (Preferred Generic Drugs)
- Tier 2 (Preferred Brand Drugs)
- Tier 3 (Non-Preferred Brand Drugs)

All Participating Providers have access to a copy of the formulary. It should be used when prescription medication is required.

Your doctor must prescribe a Tier 1 or Tier 2 drug to treat your condition. If there is no Tier 1 or Tier 2 therapeutic option, you may seek approval of a Tier 3 or non-formulary drug. If the Benefit Fund determines that a Tier 3 or non-formulary drug **is medically necessary**, the Benefit Fund may approve coverage of your prescription with no out-of-pocket costs to you beyond your co-pay. However, if the Benefit Fund **does not approve coverage**, you may be billed the difference between the Benefit Fund's allowance—which may be $0—and whatever the pharmacy charges, which could result in a significant cost to you.

If you would like a list of the CVS Caremark 1199SEIU formulary, please visit **www.1199SEIUBenefits.org/pdl** or call the Benefit Fund at (646) 473-9200.

PRESCRIPTION DRUG PROGRAMS

PRIOR AUTHORIZATION FOR CERTAIN MEDICATIONS

You must get Prior Authorization before benefits can be provided for prescriptions filled with certain medications. The formulary will be updated periodically to reflect which drugs require Prior Authorization.

If your doctor prescribes any of those drugs, call the Benefit Fund's Pharmacy Benefit Manager at (833) 250-3237 (or (855) 299-3262 for Specialty Drugs) for 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.

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.

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 list of drugs included in this program. Specialty care drugs are available only through mail-delivery service.

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. Outside New York City, call (800) 575-7771. If you think someone is fraudulently using your card, call the Benefit Fund's Fraud and Abuse Hotline at (646) 473-6148 or (800) 575-7771, or visit our website at **www.1199SEIUBenefits.org.**

USE A PARTICIPATING PHARMACY

For a list of Participating Pharmacies visit **www.1199SEIUBenefits.org/pharmacies** or call the Benefit Fund's Member Services Department at (646) 473-9200 or (800) 575-7771.

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

1. Pay for your prescription when it is filled.
2. Submit for reimbursement.
    a. Online: Members registered on the Fund's Pharmacy Benefit Manager online portal/website are encouraged to upload their prescription receipts and complete the direct prescription claim reimbursement process online. To learn more about the Fund's Pharmacy Benefit Manger and register for its online portal, visit **www.1199SEIUBenefits.org/gny-nj-prescription**.
    b. By mail: Visit **www.1199SEIUBenefits.org/gny-nj-prescription** to download the Prescription Drug Reimbursement Form (Direct Claim Form), or call the Benefit Fund's Member Services Department at (646) 473-9200 or (800) 575-7771 to ask for the form. Submit the completed form and your itemized paid receipt(s) for your prescription 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 can be filled at a *90-Day Rx Solution* pharmacy in your neighborhood or you can use the PBM's Mail-order Pharmacy, which will deliver your medication to your home address.

If you are already 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 the medication works for you.

Call the Benefit Fund at (646) 473-9200 or (800) 575-7771, or visit our website at **www.1199SEIUBenefits.org /90-day-rx,** 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 or deductibles that your spouse may incur, up to the Benefit Fund's Schedule of Allowances.

Although your spouse's name will appear on your 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, except for diabetic supplies
- Experimental and unproven 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 home test kits, except for limited FDA-approved COVID-19 tests using your Pharmacy Benefit
- 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.

SECTION II. D
ADDITIONAL HEALTH BENEFITS

1. FERTILITY SERVICES PROVIDED BY PROGYNY

WHAT IS COVERED

Coverage for you and your spouse and/or adult dependent begins after you have been enrolled as Eligibility Class I for at least 18 months. In order to be eligible for these benefits, the covered person must have an Infertility diagnosis (as defined in Section IX: Definitions). Eligibility Classes II and III are not eligible for this benefit.

The Plan's fertility program is administered by Progyny. Fertility benefits must be provided by a Progyny in-network provider. **No benefits will be provided outside of this network.** Progyny Rx is the fertility medication provider.

Benefits are payable for the diagnosis and treatment of Infertility, subject to a **lifetime maximum of two "Smart Cycles"** per family. Smart Cycles are Progyny's benefit "currency" and are used to customize your new lifetime benefit. (See full definition in Section IX: Definitions.) Each Smart Cycle is designed to cover treatment bundles, which include individual services, tests and medications. The following are parts of the Smart Cycle; please contact Progyny for current equivalencies.

- IVF fresh cycle
- IVF freeze, all cycle
- Frozen embryo transfer (FET)
- Frozen oocyte transfer (FOT)
- Pre-transfer embryology services
- Intrauterine insemination (IUI)
- Timed intercourse
- Donor sperm
- Donor oocyte cohort
- Donor embryo

If you are undergoing or seeking to begin fertility treatment, you must contact Progyny (toll free) at (833) 233-0431 for Pre-certification. Representatives are available Monday through Friday from 9:00 am to 9:00 pm.

WHAT IS NOT COVERED

- Home ovulation prediction kits
- Services and supplies furnished by an out-of-network provider
- Services and supplies not listed as covered in the Progyny Member Guide
- Charges associated with a gestational carrier program for any non-covered individual acting as the carrier, including but not limited to fees for laboratory tests
- Treatments considered experimental by the American Society of Reproductive Medicine

- Women with natural menopause

2. DOULA SERVICES

If you or your covered spouse/adult dependent are the pregnant person, this additional health benefit applies: an allowance for a total of eight prenatal and postnatal Doula visits and Doula support during labor and delivery.

SECTION III – DISABILITY AND FAMILY LEAVE BENEFITS

Temporary Disability Leave insurance and Temporary Family Leave insurance may be provided through your Employer to replace a part of your lost wages, but these are not benefits provided by the Benefit Fund.

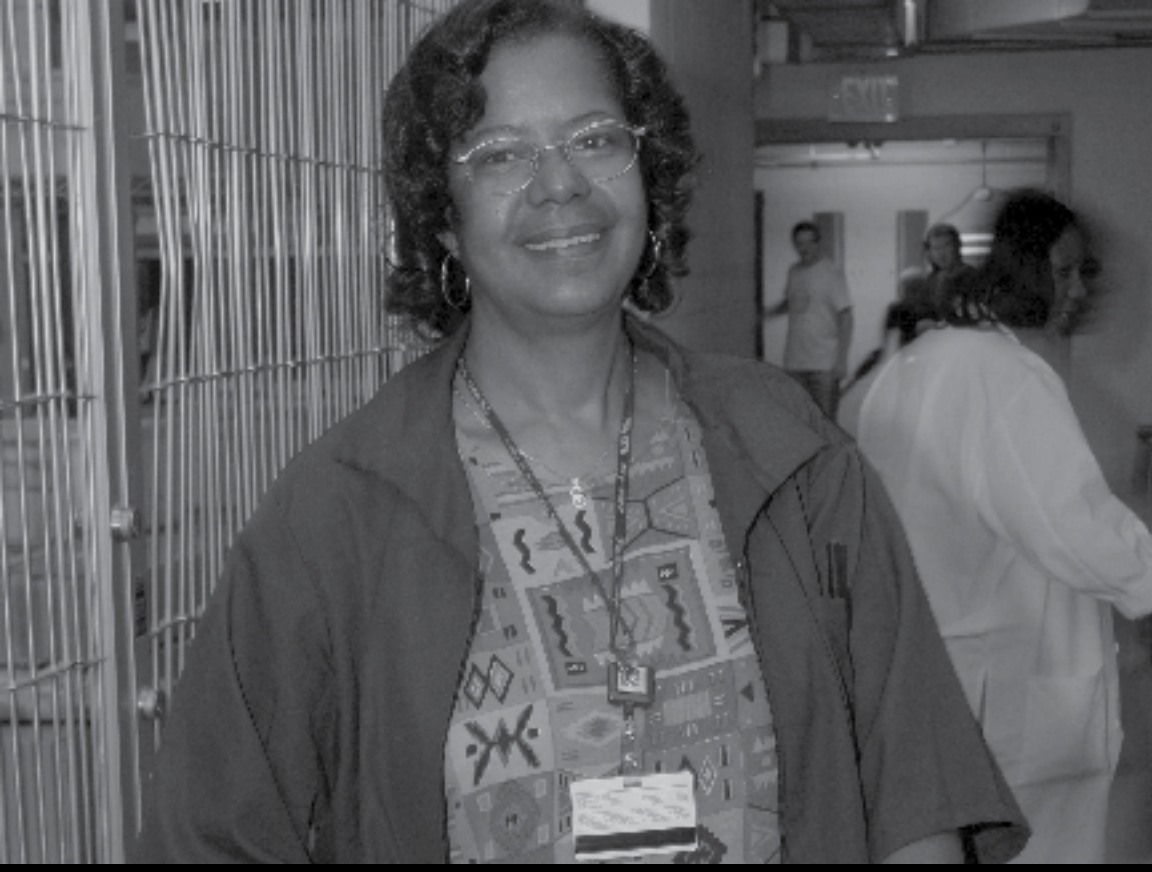
You must notify the Benefit Fund when you apply for Temporary Disability Leave or Temporary Family Leave benefits through your Employer. You must submit copies of your benefit payment stubs to the 1199SEIU Family of Funds' Eligibility Department as proof of your continued Leave.

Your health coverage through the Benefit Fund will continue while you are receiving Temporary Disability Leave or Temporary Family Leave benefits (see Section I.I).

Follow the same procedure if you are receiving workers' compensation. If you need help or advice in filing a workers' compensation claim, call the Benefit Fund at (646) 473-9200. Outside New York City, call (800) 575-7771.

WHEN YOU RETURN TO WORK

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



SECTION IV – LIFE INSURANCE BENEFITS

A. Life Insurance Eligibility

B. Life Insurance Benefit

C. Accidental Death and Dismemberment

D. Burial

LIFE INSURANCE BENEFITS RESOURCE GUIDE

KEY CONTACT

Member Services Department
(646) 473-9200 or (800) 575-7771

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

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.

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

SECTION IV. A
LIFE INSURANCE ELIGIBILITY

WHO IS COVERED

If you are in Eligibility Class I, Eligibility Class II or Eligibility Class III, your spouse is **not eligible** for Life Insurance Benefits or Accidental Death and Dismemberment Benefits, and your children are **not eligible** for any benefits in Section IV.

Once you are enrolled in the Benefit Fund and eligible for benefits, you are covered for Life Insurance Benefits. Your benefits end in accordance with Section I.I.

If you are in Eligibility Class I, **you and your spouse** are eligible for the Burial Benefit (if available). Your children are **not covered** for these benefits.

If you are in Eligibility Class II, **only you** are eligible for the Burial Benefit (if available). Your spouse and children are **not covered** for these benefits.

If you are in Eligibility Class III, you are **not eligible** for the Burial Benefit. Your spouse and children are **not covered** for these 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 of your active Benefit Fund coverage ending.

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 do so, choose one of the following methods:

1. Visit **www.My1199Benefits.org** and log into **MyAccount**. Once logged in, go to "My Information" and click on "Beneficiaries." You can complete and submit the form and required documentation electronically through **MyAccount**.
2. Visit **www.1199SEIUBenefits.org/forms** to download the **Enrollment Change Form**. Complete the form, then return it and all required documentation to the Benefit Fund Member Eligibility department at the address listed on the form.
3. Call the Benefit Fund's Member Services department at (646) 473-9200 (or (800) 575-7771 outside NYC) and ask for an Enrollment Change Form. Once

received, complete the form and return it and all required documentation to the Benefit Fund Member Eligibility department at the address listed on the form.

The change of beneficiary will not be effective until the completed Enrollment Change Form is received by the Benefit Fund.

NOTE: If you have designated your Spouse as your beneficiary and you later get divorced, your divorce will automatically revoke that designation upon notification of your divorce to the Fund, unless the notification indicates that your ex-Spouse should remain the named beneficiary. If you do not have a designated beneficiary following your divorce, after your death, your Life Insurance Benefit will be paid as if there is no beneficiary (see "If There Is No Beneficiary" below).

HOW YOUR BENEFICIARY APPLIES FOR BENEFITS

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

1. Notify the Benefit Fund's Member Services Department.
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 siblings, 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 may, 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 Eligibility Class, years of service and earnings
- First year maximum amount of $2,000
- Death from any cause

Eligibility Class I: Coverage for member only

Eligibility Class II: Coverage for member only

Eligibility Class III: Coverage for member only

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

Your life insurance amount is **$2,000 during the first year** you are covered by the Benefit Fund.

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

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

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

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

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

Eligibility Class I: Coverage for member only

Eligibility Class II: Coverage for member only

Eligibility Class III: Coverage for member only

Once you're enrolled in the Benefit Fund and eligible for benefits, you—only you, not your Spouse or children—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 of the date of your accident or injury; and
- Occurs while you are employed and covered by the Benefit Fund.

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 the following:

- 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 use disorder

SECTION IV. D
BURIAL

BENEFIT BRIEF
Burial • If available, a free burial plot with permanent care **Eligibility Class I:** Coverage for member & spouse **Eligibility Class II:** Coverage for member only **Eligibility Class III:** Not covered

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

If you are in Eligibility Class II, **only you** are covered for a free non-sectarian burial plot with permanent care, if available.

If you are in Eligibility Class III, **neither you nor your Spouse are covered** for this benefit.

Plots are located in New York and New Jersey.

To receive information on a burial plot, call the Benefit Fund at (646) 473-9200. Outside New York City, call (800) 575-7771.

SECTION V – SOCIAL SERVICES

BENEFIT BRIEF

Wellness Member Assistance Program

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

Eligibility Class I: Family coverage

Eligibility Class II: Family coverage

Eligibility Class III: Family coverage

WELLNESS MEMBER ASSISTANCE PROGRAM

The Benefit Fund's Wellness 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 members. They can work with you to try to get you information about 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 use disorders
- 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
- Weight reduction and weight management provided by a participating program (co-payments may apply)

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

Visit **www.1199SEIUBenefits.org/map** to learn more about specific programs and find support. You may also call the Wellness Member Assistance Program at (646) 473-6900 or (800) 575-7771 for additional information, to speak to a social worker or to get a referral to a provider and clinical resources.

SECTION VI – RETIREE HEALTH BENEFITS

The Benefit Fund does not provide Retiree Health Benefits.

NOTE FOR 1115 GOLD CARD MEMBERS: If you were a member of a bargaining unit formerly represented by 1115 SEIU; were hired prior to March 1, 1985; were active as of January 1, 2002; and retired with at least 20 years of service, you may be eligible for certain retiree health benefits. Please contact the Fund for additional information.

SECTION VII – GETTING YOUR BENEFITS

A. Getting Your Healthcare Benefits

B. Your Rights Are Protected—
Appeal Procedure

C. When Benefits May Be
Suspended, Withheld or Denied

D. What Is Not Covered

E. Additional Provisions

KEY CONTACTS

Benefit Fund
Member Services Department
(646) 473-9200 or (800) 575-7771

Call the Member Services Department you:

- Need a claim form
- Have questions about completing your claim form
- Have questions about what is not covered by the Benefit Fund
- Have questions about the processing of your claim

Benefit Fund
Appeals Department Hotline
(646) 473-8951

Call the Benefit Fund's Appeals Hotline if you need information on appealing your prescription or eligibility claims.

Aetna
Member Services
(866) 658-2455

Call Aetna if you need information on appealing your medical claims.

Cigna
Member Services
(800) 244-6224 (Cigna24)

Call Cigna if you need information on appealing your dental claims.

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 an Out-of-Network Provider with Aetna or Cigna, any disputes regarding payment for services 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 Network Provider, payment disputes shall be handled exclusively under the terms set forth in your participation agreement and provider manual.

Please see Section II for descriptions of Aetna's and Cigna's claims procedures.

FILING A TIMELY CLAIM WITH THE BENEFIT FUND

- Disability claims must be filed with your Employer's disability carrier within 30 days of the start of your disability.
- Prescription 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 either 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.

IF YOU RECEIVE AN OVERPAYMENT FROM THE BENEFIT FUND

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the overpaid funds belong to the Benefit Fund, and you agree to hold that money in trust for the Benefit Fund and to reimburse the Benefit Fund within 30 days of receiving the overpayment. The Plan has the right to reduce by the amount of the overpayment any future benefit payment made to or on behalf of a participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. This right does not affect any other right of recovery the Plan may have with respect to overpayments.

SECTION VII. B
YOUR RIGHTS ARE PROTECTED—APPEAL PROCEDURE

Please see Section II for descriptions of Aetna's and Cigna's appeal procedures.

For the Benefit Fund:

If your claim or your Request for Benefits is denied by the Benefit Fund, the Plan provides for two levels of appeal, as described in this section.

FIRST-LEVEL APPEAL—ADMINISTRATIVE REVIEW OF ADVERSE DECISION

For Appeals Related to Prescription Claims:

Prescription appeals should be submitted within 180 days to the Fund's Pharmacy Benefit Manager.

For Appeals Related to Eligibility:

If your claim or Request for Benefits is totally or partially denied, you may request an Administrative Review of such denial within 180 days of 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.

Requests for a prescription claim appeal or an eligibility appeal should be sent to:

1199SEIU Greater New York
Benefit Fund New Jersey Plan
Claim Appeals
PO Box 646
New York, NY 10108-0646

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 appeal levels have been exhausted 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, or, where there is no service, after three years from the date of the initial denial. All lawsuits must be filed in a federal court in New York City.

SECOND-LEVEL APPEAL—PRESCRIPTION, NON-URGENT AETNA CLAIMS AND ELIGIBILITY APPEALS

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 Board of Trustees Appeals Committee. Such a request must be filed within 60 days of receipt of the denial notice. Your request for a review must be in writing, unless your claim involves urgent care, in which case the request may be made orally.

Requests for an appeal to the Board of Trustees Appeals Committee should be sent to:

1199SEIU Greater New York
Benefit Fund New Jersey Plan
Claim Appeals
PO Box 646
New York, NY 10108-0646

Urgent Care Situations for Prescription Drugs

In urgent care situations regarding the Prior Authorization of prescription drugs, the Benefit Fund's decision upon Administrative Review (first-level) 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 the Fund has determined that your claim for benefits is an expense resulting from an illness, accident or injury caused by the conduct of a third party, it is **not covered.** Please see Section I.G. for a description of your appeal procedure.

WHAT YOU ARE ENTITLED TO

In connection with your right to appeal, you:

- Are entitled to submit written comments, documents, records or any other material 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 does not work for that person
- Are entitled to authorize a representative to appeal on your behalf

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.

TIME FRAMES FOR ADMINISTRATIVE REVIEW AND APPEAL

Please see Section II for descriptions of Aetna's and Cigna's administrative review and appeal procedures.

For the Benefit Fund:

After each appeal request (i.e., the Administrative Review (first-level appeal), and the appeal to the Board of Trustees Appeals Committee (second-level appeal)), 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.

For Administrative Review requests (first-level appeals), 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 by Aetna, Cigna and the Fund's Pharmacy Benefit Manager in sufficient time to help ensure that the total period for completing both the Administrative Review and the appeal to the Board of Trustees Appeals Committee (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 second-level appeals (i.e., appeals of first-level, Administrative Review decisions), the Appeals Committee's appeal decision 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 TEMPORARY DISABILITY LEAVE OR TEMPORARY FAMILY LEAVE BENEFIT CLAIMS

The Benefit Fund has no involvement in determining whether you are granted Temporary Disability Leave or Temporary Family Leave benefits. To appeal a denial of Temporary Disability Leave or Temporary Family Leave benefits, you must send a timely request for review, in writing, to your Employer's disability carrier or the applicable state agency. Please provide copies of the benefit determinations to the Benefit Fund to protect your healthcare benefit coverage.

SECTION VII. C
WHEN BENEFITS MAY BE SUSPENDED, WITHHELD OR DENIED

It is important that you provide the Benefit Fund with all the information, documents or other material it needs to process your claim for benefits.

The Benefit Fund may be unable to process your claim if you, your spouse or your children:

- Do not repay the Benefit Fund for benefits that you were not entitled to receive;
- Do not sign an agreement (or comply with such an agreement) to repay the Benefit Fund in the case of legal claim against a third party;
- Do not sign the "Assignment of Benefits" authorization when you want your benefits paid directly to your provider; or
- Do not allow the disclosure of medical information, medical records or other documents and information when requested by the Benefit Fund.

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 Benefit Fund, or was not repaid to the Benefit Fund, as required in Section I.G.

BENEFIT FUND'S RIGHT TO CONFIRM CLAIMS

Before paying any benefits, the Benefit Fund may require that:

- You, your spouse or your children be examined by a doctor or dentist selected by the Benefit Fund as often as required during the period of the claim; or
- An autopsy be performed to determine the cause of death, except where prohibited by law.

SECTION VII. D
WHAT IS NOT COVERED

In addition to the various exclusions and limitations set forth elsewhere in this SPD pertaining to those benefits provided by Aetna or Cigna, 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 certain infertility treatment or fertility preservation services, cryosterilization and reversal of voluntary 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 or inpatient charges for intermediate care
- 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 in excess of the Benefit Fund's Schedule of Allowances or Allowed Amount
- 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 costs or other legal costs
- Charges related to programs for smoking cessation, weight reduction, weight management, stress management and other similar programs that are not provided by a licensed practitioner or Participating Program
- Charges related to an illness, accident or injury that was the result of your committing a criminal act (except as a victim of domestic abuse) or was deliberately self-inflicted (except where attributable to a mental health 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. For claims not involving the receipt of services, no legal action may be brought against the Benefit Fund or the Trustees after three years from the date of the Benefit Fund's initial denial.

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 Benefit 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. No benefit shall 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 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 charge a reasonable fee 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 aforementioned 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 in this section. 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.

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 the Benefit Fund maintains about you, as well as 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/HIPAA.** Anyone may request an additional copy by calling the Benefit Fund at (646) 473-9200. Outside New York City, call (800) 575-7771.

FIDUCIARY RESPONSIBILITY

In addition to creating rights for Benefit Fund participants, ERISA imposes duties on fiduciaries, the people responsible for operating the Benefit Fund.

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 be able to 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 such cases, 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 Plan Administrator's control.

- If you have a claim for benefits that is entirely or partially denied or ignored and if you believe the decision against you is arbitrary and capricious or violates ERISA, 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 disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you have the right to file a suit under ERISA only in a federal court in New York City.
- If the Benefit Fund's fiduciaries misuse the Benefit Fund's money, or if you are discriminated against for asserting your rights, you may get help from the U.S. Department of Labor or exercise your 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 and Aetna has not rejected that assignment, the provider will have no greater rights than you have, and they 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 of the date of service or pre-service authorization denial, whichever is earlier; and
- After the administrative appeal has been completed, in accordance with Section VII.B.

NOTE: No other rights conferred under the terms of this Plan or ERISA may be transferred or assigned. You cannot assign your right to appeal an Adverse Benefit Determination but you can authorize a representative to appeal on your behalf (see Section VII.B). Furthermore, you cannot assign your

benefits if Aetna notifies you, in writing, that the assignment will not be accepted.

QUESTIONS?

If you have any questions about:

- Your Benefit Fund, call the Fund at (646) 473-9200 or (800) 575-7771.
- Your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest U.S. Department of Labor's Employee Benefits Security Administration office, which you can find online, www.DOL.gov/Agencies/EBSA/About-EBSA/About-Us/Regional-Offices, 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 Employee Benefits Security Administration Publications Hotline 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;
- 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
- Make all factual determinations required to administer, apply, construe and interpret the Plan (and all related Plan documents).

Without limiting the generality of the preceding statements in this section, the Plan Administrator shall, specifically, have the ultimate discretionary authority to:

(i) Determine whether any individual is eligible for any benefits under the Plan;

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

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

(iv) Interpret all of the terms used in the Plan;

(v) Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;

(vi) Decide questions, including legal or factual questions, relating to the eligibility for, or calculation and payment of, benefits under the Plan;

(vii) Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other related Plan documents;

(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 Board of Trustees Appeals Committee with respect to any matter arising under the Plan and any other Plan documents shall be final and binding on all parties. In addition, the Plan Administrator may bring a court action to enforce the terms of the Plan or to recover benefit overpayments.

SECTION VIII. D
INFORMATION ON THE PLAN

NAME OF THE PLAN

The 1199SEIU Greater New York Benefit Fund New Jersey Plan

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 request a copy of any Collective Bargaining Agreement by writing to the Plan Administrator at PO Box 2661, New York, NY 10108-2661, or you may examine a copy at the Benefit Fund office.

You can find out if a particular Employer contributes to the Benefit Fund by writing to the Plan Administrator. The Employer's address 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 Plan Administrator consists of the Board of Trustees and its duly authorized designees and subordinates, including, but not limited to, the Executive Director, the Board of Trustees Appeals Committee and other senior employees.

For this Plan, Aetna and Cigna are third-party administrators of the 1199SEIU Greater New York Benefit Fund. If you have any questions, please call the Benefit Fund's Member Services Department at (646) 473-9200. Outside New York City, call (800) 575-7771.

The Trustees may be contacted at:

1199SEIU Greater New York
Benefit Fund New Jersey Plan
c/o Executive Director
498 Seventh Avenue, 10th Floor
New York, NY 10018
Phone: (646) 473-9200
Outside New York City: (800) 575-7771

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:

1199SEIU Greater New York
Benefit Fund New Jersey Plan
c/o Executive Director
498 Seventh Avenue, 10th Floor
New York, NY 10018
Phone: (646) 473-9200
Outside New York City: (800) 575-7771

The Benefit Fund's Counsel may be contacted at:

1199SEIU Greater New York
Benefit Fund New Jersey Plan
General Counsel's Office
498 Seventh Avenue, 10th Floor
New York, NY 10018
Phone: (646) 473-9200
Outside New York City: (800) 575-7771

IDENTIFICATION NUMBER

Employer Identification Number:
13-6125570

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; examples include 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; examples include 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 in person or by mail, fax or email:

Compliance Coordinator
498 Seventh Avenue
New York, NY 10018

(646) 473-6600 (phone)
(646) 473-8959 (fax)
PrivacyOfficer@1199Funds.org (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. Such complaints can be filed electronically through the Office for Civil Rights Complaint Portal, https://ocrportal.hhs.gov/ocr; by mail, U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201; or by phone, (800) 368-1019 or (800) 537-7697 (TDD).

Complaint forms are available at www.HHS.gov/ocr/complaints.

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:

UNION TRUSTEES	
Yvonne Armstrong Senior Executive Vice President 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018	Allan Sherman Assistant Division Director 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018
Joseph Chinea Vice President 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018	Milly Silva Secretary-Treasurer 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018
Daniel Ratner Trustee 1199SEIU United Healthcare Workers East 498 Seventh Avenue New York, NY 10018	Daine Williams Executive Vice President 1199SEIU United Healthcare Workers East 100 Duffy Avenue Hicksville, NY 11801

EMPLOYER TRUSTEES	
Michael Balboni Executive Director Greater New York Health Care Facilities Association 519 8th Avenue, 16th Floor New York, NY 10018	Howard A. Sukoff President Creative Management 1202 Tillinghast Turn Scotch Plains, NJ 07076
William Pascocello Greater New York Health Care Facilities Association 519 8th Avenue, 16th Floor New York, NY 10018	Doug Wissmann Director of Finance Hillside Manor Rehabilitation and Extended Care Center 182-15 Hillside Avenue Jamaica Estates, NY 11432
Robin Rosen Labor Attorney Greater New York Health Care Facilities Association 519 8th Avenue, 16th Floor New York, NY 10018	

NOTE: These lists are current as of the date of this SPD and do not include Alternate Trustees.

SECTION IX – DEFINITIONS

DEFINITIONS

Accident
A sudden, unexpected and unforeseen identifiable occurrence or event producing, at the time, objective symptoms of a bodily injury. The accident must occur while the person is covered under this Plan. The occurrence or event must be definite as to time and place. It must not be due to, or contributed to, an illness or disease of any kind.

Accidental Death and Dismemberment
A Plan-sponsored Amalgamated Life Insurance Company policy providing for payments to a beneficiary designated by the employee under the circumstances described in Section IV.C and in the Certificate of Coverage (a discrete policy).

Administrative Review
The procedure to appeal a claim that the Plan 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.

Aetna
The Aetna Life Insurance Company, an affiliate or a third-party vendor under contract with Aetna, that provides Medical Benefits in your state as described in this SPD.

Affordable Care Act
The Patient Protection and Affordable Care Act, as amended from time to time.

Allowed Amount
For purposes of the Plan, the term "Allowed Amount" refers to the payment amount set forth in the Provider's contract with the Fund, the Fund's carriers or the Fund's network for the service provided.

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, a surgical center, an ambulatory care center or in the operating room at a doctor's office.

Annual Rate of Pay
52 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.

Average Weekly Hours
The weekly average of your hours reported to the Benefit Fund by your Employer. Sixteen weeks are averaged to determine your Eligibility Class.

Behavioral Health Provider/Practitioner
An individual professional that is properly licensed or certified to provide diagnostic and/or therapeutic services for mental disorders and substance use disorder under the laws of the jurisdiction where the individual practices.

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.

Birthing Center
A freestanding facility that meets **all** of the following requirements:

- Meets licensing standards
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care
- Is directed by at least one physician who is a specialist in obstetrics and gynecology
- Has a physician or certified nurse midwife present at all births and during the immediate postpartum period
- Provides full-time skilled nursing services directed by a registered nurse or certified nurse midwife during labor, delivery and the immediate postpartum period
- Has a written agreement with a hospital in the area for Emergency transfer of a patient or a child; written procedures for such a transfer must be displayed and the staff must be aware of them

Body Mass Index
A degree of obesity that is calculated by dividing your weight in kilograms by your height in meters squared.

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 that 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 Plan, as described in Section I.A.

Cigna
The Cigna Health organization that provides Dental Benefits in your state as described in this SPD.

Claim Form
One of the Plan forms that must be completed to request any of the benefits provided by the Plan.

Clinically Necessary
For Dental Benefits to be considered Clinically Necessary, the treatment or service must be reasonable and appropriate, and it must meet **all** of the following requirements:

- Be consistent with the symptoms, diagnosis or treatment of the condition present
- Conform to commonly accepted standards throughout the dental field
- Not be used primarily for the convenience of the member or provider of care
- Not exceed the scope, duration or intensity of the level of care needed to provide safe and appropriate treatment

For Medical Benefits, see Medically Necessary.

COBRA Continuation Coverage or COBRA Coverage
Coverage provided to a member or eligible dependent(s) for a temporary period under certain circumstances. The member or eligible dependent must pay for this coverage. See Section I.K for details.

Concurrent Review
Administrative 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 SPD.
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 information.

Co-pay, Co-payment or Co-insurance
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, which may be changed by the 1199SEIU Greater New York Benefit Fund New Jersey Plan from time to time. The co-payment amount you owe your Network General Dentist for any dental procedure is listed in your Cigna Dental Care Patient Charge Schedule. The co-payment amount you owe for medical and hospital services is listed in Aetna's Schedule of Benefits and this SPD's Overview of Benefits section.

Cosmetic Surgery
Includes any procedure for which 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 Benefits
Eligible health services that meet the requirements for coverage under the terms of this Plan, including:

1. They are Medically Necessary.
2. You received Pre-certification, if required.

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
See Allowed Amount.

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 it could be provided by persons without professional skills or training. Examples of this include, but are not limited to, assistance with walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changing dressings of non-infected wounds, post-operative or chronic conditions, preparation of special diets and supervision of medication that can be self-administered by the member.

Day Care Treatment
A partial confinement treatment program to provide treatment for you during the day. The hospital, psychiatric hospital or residential treatment facility does not make a room charge for day care treatment. Such treatment must be available for at least four hours, but not more than 12 hours in any 24-hour period.

Deductible
The part of your covered expenses you pay before the Plan starts to pay benefits. Additional information regarding deductibles and deductible amounts can be found in Aetna's Schedule of Benefits, Cigna's Dental Care Patient Charge Schedule and the Overview of Your Benefits section in this SPD.

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 Plan, as described in Section I.A.

Detoxification
The process by which an alcohol- or drug-intoxicated person, or an alcohol- or drug-dependent person, is medically managed through the period of time necessary to eliminate the:

- Intoxicating alcohol or drug;
- Alcohol- or drug-dependent factors; or
- Alcohol in combination with drugs.

This can be done by metabolic or other means determined by a physician or a nurse practitioner working within the scope of their license. The process must keep the physiological risk to the patient at a minimum. And if it takes place in a facility, the facility must meet any and all applicable licensing standards established by the jurisdiction in which it is located.

Directory
A listing of all Network Providers. Information is also available through Cigna's online dental directory at www.Cigna.com/hcpdirectory/ and through Aetna's online provider directory at www.Aetna.com. When using these provider directories, you may need to make sure the providers participate in this specific Plan.

Disabled
The condition of being temporarily unable to work due to an accident, injury or illness.

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

Doula
Birth/postpartum doulas with certification from an organization approved by the Plan Administrator.

Durable Medical and Surgical Equipment
Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an illness or injury;
- Suited for use in the home;
- Not normally of use to people who do not have an illness or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical and surgical equipment **does not include** equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over-bed tables, elevators, communication aids, vision aids and telephone alert systems.

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.

Effective Treatment of a Mental Disorder
This is a program that is:

- Prescribed and supervised by a physician; and
- For a mental disorder that can be favorably changed.

Eligibility Class
One of the three wage-earning levels used by the Benefit Fund to determine the level of benefits to which a member and/or eligible dependents are entitled.

Eligible
Status of having met the criteria adopted by the Trustees of the Benefit Fund to determine your enrollment, plan of benefits and Eligibility Class.

Emergency Admission
An admission to a hospital or treatment facility ordered by a physician within 24 hours after you receive emergency services.

Emergency Care
Services provided in connection with an Emergency Medical Condition, including screening and examination services provided to a member or their eligible dependent who requests medical treatment to determine if an Emergency Medical Condition exists, as well as such further medical examination and treatment as may be required for stabilization. Emergency care may also include post-stabilization

services provided in connection with the emergency services visit. Emergency Care includes healthcare procedures, treatments or services, including psychiatric stabilization and medical detoxification from drugs or alcohol, that are provided for an Emergency Medical Condition.

Emergency Medical Condition
A severe medical condition that:

- Comes on suddenly;
- Needs immediate medical care; and
- Leads a person with average knowledge of health and medicine to believe that, without immediate medical care, it could result in:
  - Danger to life or health;
  - Loss of a bodily function;
  - Loss of function to a body part or organ; or
  - Danger to the health of an unborn baby.

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 the Life Insurance Beneficiary Selection Form and Coordination of Benefits forms.

Enteral Nutrition
The provision of nutritional requirements through a tube into the stomach or small intestine.

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 or Investigational
A drug, device, procedure or treatment that is found to be experimental or investigational because of any of the following:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved
- The needed approval by the FDA has not been given for marketing
- A national medical or dental society or regulatory agency has stated, in writing, that it is experimental or investigational or suitable mainly for research purposes

- It is the subject of a Phase I or Phase II clinical trial, or it is the subject of the experimental or research arm of a Phase III clinical trial; these terms have the meanings given by regulations and other official actions and publications of the FDA and HHS
- Written protocols or a written consent form used by a facility provider state that it is Experimental or Investigational

Family
Your spouse and your children who are eligible to receive benefits from the Plan, as described in Section I.A.

FDA (Food and Drug Administration)
The U.S. Department of Health and Human Services agency responsible for ensuring the safety and effectiveness of all food, drugs, biologics, vaccines and medical devices.

Fiduciary
Each of the Trustees and others responsible for directing the administration of the Benefit Fund and their responsibilities under the law.

Full Time
The number of hours worked in a normal regular workweek, as set forth in the applicable Union contract. Overtime is **not included.**

Fund or Trust Fund
The 1199SEIU Greater New York Benefit Fund New Jersey Plan, whose principal office is at 498 Seventh Avenue in New York City.

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.

Habilitation Therapies
Physical, occupational, cognitive or speech therapy services that help a developmentally delayed or disabled person learn, keep or improve skills and functional abilities they may not be developing normally.

Health Benefits ID Card
The card issued by the Benefit Fund or network with which the Benefit Fund has a contract. The card serves as identification to assist you in getting covered benefits.

Health Professional
A person who is licensed, certified or otherwise authorized by law to provide healthcare services to the public. For example: physicians, nurses and physical therapists.

Home Health Care Agency
An agency that meets **all** of the following requirements:

- Mainly provides skilled nursing and other therapeutic services
- Is associated with a professional group (of at least one physician and one registered nurse) that makes policy
- Has full-time supervision by a physician or a registered nurse
- Keeps complete medical records on each person
- Has an administrator
- Meets licensing standards

Home Health Care Plan
A plan that provides for continued care and treatment after discharge from a hospital. The care and treatment must be:

- For the same or related condition that required the hospital stay;
- Prescribed, in writing, by the attending physician within seven days from the hospital discharge; and
- An alternative to a hospital stay.

Hospice Care
Care given to a terminally ill person by or under arrangements with a hospice care agency. The care must be part of a hospice care program and provided by a hospice facility. The care is designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure.

Hospice Care Program
This is a written plan of hospice care that meets **all** of the following requirements:

- Is established and reviewed from time to time by a physician attending to the person and by appropriate personnel of a hospice care agency
- Is designed to provide palliative and supportive care to terminally ill persons, as well as supportive care to their families
- Includes an assessment of the person's medical and social needs and a description of the care to be given to meet those needs

Hospice Facility
A facility, or distinct part of one, that meets **all** of the following requirements:

- Mainly provides inpatient hospice care to terminally ill persons
- Charges patients for its services
- Meets any licensing or certification standards established by the jurisdiction where it is located
- Keeps a complete medical record on each patient
- Provides an ongoing quality assurance program, including reviews by physicians other than those who own or direct the facility
- Is run by a staff of physicians (at least one staff physician must be on call at all times)

- Provides 24-hour nursing services under the direction of a registered nurse
- Has a full-time administrator

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 bylaws 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
- 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, the chronically ill, convalescents or people with an alcohol or substance use disorder;
- A facility providing custodial, psychiatric or rehabilitative care; or
- An educational facility

In no event does hospital include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital or facility primarily for rehabilitative or custodial services.

Hospitalization
When necessary and continuous confinement as an inpatient in a hospital is required and a charge for room and board is made.

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

Infertility
A disease, condition or status characterized by any of the following:

- The inability to achieve a successful pregnancy after 12 months of regular, unprotected sexual intercourse or, for a female who is 35 years of age or older, after six months of regular, unprotected sexual intercourse.
- The need for medical intervention in order to achieve a successful

pregnancy based on either partner's reproductive organs or known etiology suggestive of impaired reproductive ability

- The need for medical intervention to preserve fertility where planned medical treatment results in iatrogenic infertility

Injury
An accidental bodily injury that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable, unforeseeable consequences of a voluntary act by a person. An act or event must be definite as to time and place.

Institutes of Excellence™ (IOE) Facility
A facility designated by Aetna in the provider directory as an Institute of Excellence network provider for specific services or procedures.

Intensive Outpatient Program (IOP)
Services must be Medically Necessary and delivered by an appropriately licensed or credentialed practitioner. Services are designed to address a mental disorder or substance use disorder and may include:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services, such as medication monitoring

Care is delivered according to accepted medical practice for the condition.

Jaw Joint Disorder
This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint;
- A myofacial pain dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Leave
A job-protected leave of absence from your place of employment. Types of leave include but are not limited to: Temporary Disability Leave, Temporary Family Leave and Uniformed Services Leave.

Legal Separation
A marital status whereby spouses, while remaining legally married, have chosen to live separate lives physically and economically, as determined in the sole discretion of the Trustees, and as evidenced by, but not limited to, such circumstances as the following: living separate and apart from each other; maintaining separate legal residences and/or separate finances; having custody arrangements for children; or formally dividing joint legal property, assets and responsibilities.

Legally Separated
See Legal Separation.

Level of Benefit
The Eligibility Classification (Eligibility Class I, Eligibility Class II or Eligibility Class III) used to determine the specific package of benefits for which you, your covered spouse and your covered children are entitled.

Lien Acknowledgment
A form that describes and acknowledges the Benefit Fund's right to recover up to the amount it has paid or will pay for expenses relating to any claims which you or your beneficiary may have against any person or entity responsible for an illness, 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
A Plan-sponsored Amalgamated Life Insurance Company policy 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 (a discrete policy).

LPN
A licensed practical or vocational nurse.

Mail-order Pharmacy
A pharmacy through which prescription drugs are legally dispensed by mail or other carrier.

Maternity Care
Includes prenatal and postnatal care, as well as care required by childbirth and miscarriages.

Maximum Out-of-Pocket Limit
The maximum out-of-pocket limit is the most a covered person will pay per year in co-payments, payment percentage and deductible, if any, for covered services.

Medically Necessary or Medical Necessity
Healthcare services that a provider exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
- Not primarily for the convenience of the patient, physician or other healthcare provider; and

- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Consistent with the standards set forth in policy issues involving clinical judgment

For Dental Benefits, see Clinically Necessary.

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 Disorder
A mental disorder, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association, is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation or behavior that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities.

Mental Health Benefits
Services for mental disorders typically treated by psychiatrists, psychologists or other licensed therapists using psychotherapy and/or psychotropic drugs.

Morbid Obesity
A body mass index that is greater than 40 kilograms per meter squared, or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea or diabetes.

Negotiated Charge
The amount a Network Provider has agreed to accept for providing any covered benefits under this Plan. Aetna may also receive or pay additional amounts from or to third parties under price guarantees.

Network Dentist/Network General Dentist
A licensed dentist who has signed an agreement with Cigna under which they agree to provide general dentistry or specialty care services to you. The term, as well as the term "Participating Dentist," includes both Network General Dentists and Network Specialty Dentists.

Network Provider
See Participating Provider.

Network Service or Supply
A healthcare service or supply that is:

- Furnished by a Network Provider; or
- Furnished or arranged by your Primary Care Physician (PCP).

Network Specialty Dentist
A licensed dentist who has signed an agreement with Cigna under which they agree to provide specialized dental care services upon payment authorization by Cigna Health.

Newly Organized
Those employees in a bargaining unit when 1199SEIU United Healthcare Workers East concludes a Union contract, which, for the first time, requires payment to the Greater New York Benefit Fund New Jersey Plan 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.

Night Care Treatment
A partial confinement treatment program provided when you need to be confined during the night. A room charge is made by the hospital, psychiatric hospital or residential treatment facility. Such treatment must be available at least:

- Eight hours in a row a night; and
- Five nights a week.

Non-occupational Illness
An illness that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an illness that does.

An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that illness under such law.

Non-occupational Injury
An accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury that does.

Non-participating Provider
See Out-of-Network Provider.

Non-specialist
A physician who is not a specialist.

Non-urgent Admission
An inpatient admission that is not an Emergency admission or an urgent admission.

Occupational Injury or Occupational Illness
An injury or illness that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment, whether or not on a full-time basis; or
- Results in any way from an injury or illness that does.

Occurrence
A period of disease or injury. An occurrence ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment, services or supplies for a disease or injury; and
- Neither takes any medication nor has any medication prescribed for a disease or injury.

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.

Out-of-Network Provider
A healthcare provider who has not contracted with Aetna to furnish medical services or supplies, or Cigna to furnish dental services, at a negotiated charge. Also known as a Non-participating Provider.

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 that is less than the number of hours stipulated in the applicable Union contract for full-time employees performing the same work.

Partial Confinement Treatment
A plan of medical, psychiatric, nursing, counseling or therapeutic services to treat alcohol or substance use disorder or mental disorders. The Plan must meet **all** of the following requirements:

- It is carried out in a hospital, psychiatric hospital or residential treatment facility on less than a full-time inpatient basis
- It is in accord with accepted medical practice for the person's condition
- It does not require full-time confinement
- It is supervised by a psychiatric physician who weekly reviews and evaluates its effect

Day care treatment and night care treatment are considered partial confinement treatment.

Partial Hospitalization Treatment
Services must be Medically Necessary and provided by a behavioral health provider with the appropriate license or credentials. Services are designed to address a mental disorder or substance use disorder and may include the following:

- Group, individual, family or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services, such as medication monitoring

Care is delivered according to accepted medical practice for the person's condition.

Participating Dental Facility
An approved dental care facility for the provision of ordinary and customary dental care, with such care to be provided at predetermined fees negotiated by Cigna.

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 physician, board-certified or board-eligible specialist, 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 provide covered services to members and dependents.

Patient Charge Schedule
The list provided by Cigna of Covered Services and amounts payable by you.

Payment Limit
The limit on the amount of co-payments and co-insurance an individual or family pays in a calendar year.

Payment Percentage
The percentage of covered expenses that the Plan pays and the percentage of covered expenses that you pay. The percentage that the Plan pays is referred to as the "Plan Payment Percentage," and varies by the type of expense. Please refer to Aetna's Schedule of Benefits for specific information on Payment Percentage amounts.

Permanently Disabled
The condition of being unable to engage in any gainful employment due to a disability 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 retail pharmacies, mail order pharmacies and specialty pharmacy network pharmacies.

Physician
A duly licensed member of a medical profession who meets **all** of the following requirements:

- Has an MD or DO degree
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where they practice
- Provides medical services that are within the scope of their license or certificate

This also includes a health professional who:

- Under applicable insurance law, is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if an illness or injury is caused, to any extent, by alcohol or substance use disorder or a mental disorder; and
- Is a physician that is not you or related to you.

Plan
The benefits and the rules and regulations pertaining to the 1199SEIU Greater New York Benefit Fund New Jersey Plan 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.

Pre-certification or Pre-certify
A requirement that Aetna, Cigna or the Benefit Fund (depending on the service) be contacted before certain services, such as hospitalization or outpatient surgery, are provided, or before prescription drugs are prescribed, to determine whether the services being recommended or the drugs being prescribed are considered covered expenses under the Plan. It is not a guarantee that benefits will be payable. This review process evaluates the Medical Necessity and appropriateness of a proposed service or care. This includes, but is not limited to, all non-Emergency hospital admissions and surgical procedures, admissions for mental health services or alcohol/substance use disorder, admissions for physical rehabilitation, certain home care or outpatient services or treatment, certain prescription drugs and some dental claims. Pre-certification **does not include** eligibility determination or review of a Non-participating Provider's charges.

Preferred Brand-name Drugs
Brand-name drugs included in the Benefit Fund's Preferred Drug List.

Preferred Drugs
Generic alternatives to brand-name drugs.

Prescriber
Any provider acting within the scope of their license who has the legal authority to write an order for outpatient prescription drugs.

Prescription
A written order for the dispensing of a prescription drug by a prescriber. If it is a verbal order, it must promptly be put in writing by the Participating Pharmacy.

Prescription Drug
An FDA-approved drug or biological that can only be dispensed by prescription.

Primary Care Physician (PCP)
A physician who:

- Aetna's directory lists as a PCP;
- Is selected by a person from the list of PCPs in the directory;
- Supervises, coordinates and provides initial care and basic medical services to a person as a family care physician, an internist or a pediatrician; and
- Is shown on Aetna's records as your PCP.

Prior Authorization
See Pre-certification or Pre-certify.

Provider
A physician, other health professional, hospital, skilled nursing facility, home health care agency or other entity or person licensed or certified under applicable state and federal law to provide healthcare services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Psychiatric Hospital
An institution specifically licensed or certified as a psychiatric hospital by applicable state and federal laws to provide a program for the diagnosis, evaluation and treatment of alcohol and/or substance use disorder, mental disorders or mental illnesses.

Psychiatric Physician
This is a physician who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcohol and substance use disorders or mental disorders.

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 Physician or Primary Care Dentist to direct you to a Network Provider for Medically Necessary services or supplies covered under the Plan.

Rehabilitation Facility
A facility, or a distinct part of a facility, that 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
The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by illness or injury.

Residential Treatment Facility (mental disorders)

An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for mental health residential treatment programs. It is credentialed by Aetna or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Residential Treatment Programs treating mental disorders:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

Residential Treatment Facility (substance use disorder)

An institution specifically licensed as a residential treatment facility by applicable state and federal laws to provide for substance use disorder residential treatment programs. It is credentialed by Aetna or accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following for Chemical Dependence Residential Treatment Programs:

- A behavioral health provider or an appropriately state-certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a physician who is an addiction specialist
- It is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility or otherwise licensed institution)

In addition to the above requirements, an institution must meet the following for Chemical Dependence Detoxification Programs within a residential setting:

- An RN must be onsite 24 hours per day for 7 days a week within a residential setting
- Residential care must be provided under the direct supervision of a physician

Retail Pharmacy
A pharmacy that dispenses outpatient prescription drugs at retail prices.

Retrospective Review
Administrative 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.

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. If there are no such rooms, Aetna will figure out the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area
The geographic area, as determined by Aetna for medical services or Cigna for dental care services, in which Network Providers for this Plan are located.

Skilled Nursing Facility
A facility specifically licensed as a skilled nursing facility by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation hospitals, as well as portions of a rehabilitation hospital and a hospital designated for skilled or rehabilitation services.

A Skilled Nursing Facility does *not* include institutions that provide only:

- Minimal care,
- Custodial care services,
- Ambulatory care or
- Part-time care services.

It also does *not* include institutions that primarily provide for the care and treatment of mental disorders or substance use disorders.

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
- The services are not custodial

Smart Cycle
Progyny's benefit currency. Progyny bundles all services necessary for a treatment cycle into this unit of currency versus a dollar maximum. Everything needed for a comprehensive fertility treatment is contained within the Smart Cycle, including all necessary diagnostic testing and the latest technology (such as PGT-A, ICSI, etc.). Each treatment or service is valued as a portion of a Smart Cycle. Individuals can utilize their Smart Cycles for whichever treatments they and their physician determine to be necessary until they exhaust their Smart Cycle balance.

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 that include typically high-cost drugs that require special handling, special storage or monitoring, and may include things such as oral, topical, inhaled and injected routes of administration.

Specialty Care Pharmacy
A licensed, registered pharmacy that has signed an agreement with the Benefit Fund's Pharmacy Benefit Manager to fill prescriptions for specialty care drugs.

Spouse
The person to whom a member is legally married and who is eligible for benefits from the Plan, as described in Section I.A.

Stay
A full-time inpatient confinement for which a room and board charge is made.

Substance Use Disorder
A physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association. 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 or Surgical Procedures
The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as cutting, abrading, suturing, destruction, ablation, removal, lasering, introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy), correction of fracture, reduction of dislocation, application of plaster casts, injection into a joint or injection of sclerosing solution, or otherwise physically changing body tissues and organs.

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
- Is equipped and has trained staff to handle Emergency Medical Conditions

If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Terminal Illness
A medical prognosis that you are not likely to live more than 12 months.

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.

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 Care Facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an Urgent Condition.

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
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available

Usual Fee
The customary fee that an individual dentist most frequently charges for a given dental service.

Walk-in Clinic
Walk-in clinics are freestanding healthcare facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-Emergency illnesses and injuries and for the administration of certain immunizations. It is not an alternative for Emergency Department services or the ongoing care provided by a physician. Neither an Emergency Department nor the outpatient department of a hospital shall be considered a walk-in clinic.

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.

NOTES

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