WE KEEP NEW YORK CITY ROLLING

ACTIVE

NEW YORK CITY SEIU LOCAL 246

WELFARE BENEFITS FUND

March 2017

Dear Member:

On behalf of the Fund Trustees, I am pleased to provide you with this Comprehensive Benefits Booklet. It describes your benefits, which are provided by the New York City SEIU Local 246 Welfare Benefits Fund ("the Welfare Fund").

This book contains thorough details of the benefits and provides you with guidelines for enrollment, eligibility, dependent coverage, and other general information concerning the Welfare Fund's procedures.

We are always striving to improve your benefits and we will continue to do so within the fiscal restraints that have been imposed upon us by the City.

I urge you to read this book carefully and become familiar with the policies and procedures necessary to insure prompt and satisfactory service. Keep it in a safe place so you can refer to it whenever needed. If you have any questions concerning these benefits or procedures described in this book, please contact the Fund office at 212.233.0616.

Sincerely,

Joseph A. Colangelo
Chairman and Administrator

NEW YORK CITY SEIU LOCAL 246
WELFARE BENEFITS FUND

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TABLE OF CONTENTS

Benefit Highlights . . . . .A

General Information. . . . . .B

Eligibility. B-1

Benefit Overpayments B-3

Designation of a Beneficiary. B-4

Coordination of Benefits B-6

Medicare Part D. B-8

COBRA B-8

90-Day Survivor Extension B-14

Creditable Coverage B-14

Privacy of Protected Health Information (HIPAA) B-14

Amendment or Termination of Benefits B-26

Third Party Reimbursement/Subrogation B-27

Appeal Procedure. B-28

Dental Benefits C

Prescription Drug Benefits. . . . . .D

Optical Benefits. . . . . E

Hearing Aid Benefit. . . . . F

Death Benefit . . . . .G

Extended Benefits . . . . .H

A Benefit Highlights

BENEFIT HIGHLIGHTS

This section of your booklet provides the highlights of benefits provided by the Fund. All of the benefits are described in detail in the appropriate sections later in the booklet.

Dental Benefits

Eligibility

Active Covered Members and their Eligible Dependents.

Description of Plan

Comprehensive Self-Insured Dental Expense Benefit

Deductible

None

Reimbursement

According to a Fee Schedule

Maximums

Non-orthodontic (age 19 and older)—$2,000 per calendar year for each Covered Member and each Eligible Dependent. Additionally, each Covered Member and each Eligible Dependent will have a separate per calendar year allowance of up to $600 for any implant or implant-related service.

Orthodontic (age 19 and older) — $1,800 lifetime maximum for each Covered Member and each Eligible Dependent (includes spouse and dependent children).

Pediatric Dental (Eligible Dependents under age 19) — No maximum, but must use a participating dental provider.

Pediatric Orthodontic (Eligible Dependents under age 19) — No maximum for medically necessary orthodontia, but must

use a participating dental provider. If the orthodontia is not medically necessary, then there is a $1,800 lifetime maximum for each Eligible Dependent under age 19.

Preferred Provider Option

Dentists who have agreed to provide covered dental procedures at no out-of-pocket expense to Covered Members and their Eligible Dependents.

Participants have the right to opt-out of the dental benefits provided by the Fund at any time by notice to the Fund Office.

Prescription Drug Benefits

Eligibility

Active Covered Members and their Eligible Dependents.

Deductibles

There is a $100 annual deductible per covered individual (Covered Members and each Eligible Dependent) for asthma drugs.

Co-Payments

Retail

There is a $10 co-payment for generic medications and a $20 co-payment per prescription for preferred brand name medications, and a 100% co-payment for non-preferred brand name medications.

For asthma medications there is a $10 co-payment for generic medications, a $25 co-payment for preferred brand name medications and a 100% co-payment for non-preferred brand name medications. As noted above, there is also a $100 deductible per Covered Member and per Eligible Dependent.

Mail Order (up to 90-day supply)

There is a $10 co-payment for generic medications and a $30 co-payment per prescription for brand name medications and a 100% co-payment for non-preferred brand name medications.

Asthma medications have a $20 co-payment for generic medications, a $50 co-payment for preferred brand name medications, and a 100% co-payment for non-preferred brand name medications.

Components

- This is a mandatory generic program
- There is a mail order requirement for chronic or maintenance medication
- Participating Pharmacies
- Self-Insured by the Welfare Fund

Optical Benefits

Eligibility

Active Covered Members and their Eligible Dependents.

Deductible

None

Maximum

- Three pairs of prescription eyeglasses per rolling 12-month period per family unit, not including Eligible Dependents under age 19.
- Up to $80 will be reimbursed per each pair of prescription eyeglasses per Covered Member and per Eligible Dependent age 19 and older, which includes frames, lenses and examination if participating providers are not used.
- Pediatric Optical (Eligible Dependents under age 19) — No maximum benefit, but must use a participating provider, and eyewear must be obtained from a participating provider's pediatric collection.

Components

- Preferred Provider list of participating optical providers
- Self-Insured by the Welfare Fund

Eyeglass Allowance for Non-participating Opticians (age 19 and older)

- Each Pair of Glasses $80
- Exam $40
- Lenses Only $40
- Frames Only $40

Participants have the right to opt-out of the optical benefits provided by the Fund at any time by notice to the Fund Office.

Hearing Aid Benefit

Eligibility

Active Covered Members and their Eligible Dependents.

Maximum Benefit

Up to $600 per Covered Member and per Eligible Dependent, once every 48 months

Death Benefit

Eligibility

Active Covered Members Only.

Maximum Benefit

$7,500

Components

Self-Insured by the Welfare Fund

Extended Benefits

Eligibility

Active Covered Members Only, who are on compensation, seriously ill, or seriously injured and cannot work.

B General Information

GENERAL INFORMATION

ELIGIBILITY

Who Is Eligible?

All employees on active pay status in a title for which contributions are payable by the City of New York or other qualified employers to the Welfare Fund.

When Do You Become Eligible for Welfare Fund Benefits?

You become a "Covered Member," eligible for the full range of benefits offered by the Welfare Fund, on your first day on payroll with New York City or other qualified employer.

When Does Your Eligibility Terminate?

All benefits terminate at the close of business, on the day of termination of employment or for which no contributions are receivable by the Welfare Fund from New York City or a participating employer on the employee's behalf.

What Happens If You Lose Eligibility and Then Reinstated?

If your benefits were terminated and you subsequently return to work, you will be considered to be a "new" employee. You will again become eligible according to the requirements set forth in the above section titled "When Do You Become Eligible For Welfare Fund Benefits?"

What Happens When You Retire?

When an active member retires, both the member and his/her spouse/domestic partner and covered dependents will be immediately covered by the New York City SEIU Local 246 Retirees Welfare Benefits Fund and subject to its rules. For the remainder of the calendar year in which the member retired, all plan utilization, while active, will be applied to the annual maximums established in the retiree plan.

What Happens If You Are Suspended?

When an active member receives a 30-day suspension without pay from his/her job pending a hearing, his/her prescription drug coverage will be extended for the 30-day period. The 30-day extension of prescription drug coverage also applies to the suspended member's covered dependents.

Who Is An Eligible Dependent?

Your Eligible Dependents are your lawful spouse or qualified domestic partner, and each child up to his/her 26th birthday and who are enrolled by you with the Fund as your dependent. At the time of enrollment, you must provide the Welfare Fund with original or certified copies (with a raised or colored seal) of documents (birth certificate, marriage certificate, domestic partnership registration, etc.) as proof of dependent status.

"Child" is defined as a Covered Member's natural child, stepchild or adopted child. Children who cannot support themselves because of a mental illness, developmental disability, intellectual disability, or physical handicap may be covered after their 26th birthday if the disability occurred before the age at which coverage would otherwise terminate, and the dependent was covered by the City at that time. Medical evidence of the disability must be submitted to the Fund at the time of enrollment.

"Qualified domestic partners" means registered domestic partners of Covered Members who have met the requirements of domestic partnership. To be eligible, Fund members must provide the same documentation required by the City to enroll domestic partners for health insurance coverage. Such documentation includes a completed "Domestic Partner Registration Certificate," and at least two documents proving the financial interdependence of the member and domestic partner (e.g. joint lease, joint bank account, etc.). Covered Members should be aware that the cost of coverage for domestic partners by the Welfare Fund may be taxable as income to the Fund member.

What Happens If There Is A Change In Your Family Status?

You must immediately notify the Fund Office of any change in your family status (marriage, divorce, separation, termination of domestic partnership, birth or adoption of a child, death of an Eligible Dependent) and of any change of address. When a change in family status has occurred you must provide the Fund Office with proof of same (i.e. original or certified copied of birth certificates, marriage certificate, judgment of divorce, separation agreement, etc.) Failure to do so could result in loss or delay of benefits.

BENEFIT OVERPAYMENTS

If an overpayment results because of a member's failure to notify the Welfare Fund of a change in family status, the Welfare Fund will suspend the Covered Member and all Eligible Dependents from using Welfare Fund benefits until such overpayment is recouped by the Welfare Fund. If a member immediately repays the Welfare Fund for an overpayment, benefits will not be suspended. If a member enters a repayment installment plan with the Welfare Fund in connection with an overpayment, benefits will not be suspended as long as the member makes timely payment of installments. If a member in a repayment installment plan defaults on any one (1) payment, the Welfare Fund will immediately suspend the Covered Member and all Eligible Dependents from benefits until the Welfare Fund is paid in full.

ANYONE INTENTIONALLY COMMITTING FRAUD FOR THE PURPOSE OF OBTAINING IMPROPER PAYMENTS WILL BE PROSECUTED TO THE FULLEST EXTENT OF THE LAW.

DESIGNATION OF A BENEFICIARY

At the time of enrollment, Covered Members must designate a beneficiary of their Welfare Fund benefits on their enrollment card.

What Happens if You Don't Designate a Beneficiary or Your Beneficiary Predeceases You?

With respect to any benefits payable to a deceased Covered Member upon their death, or with respect to death benefits payable by virtue of the death of the Covered Member where the Covered Member's designated beneficiary has predeceased the Covered Member and a successor has not been designated, or where the Covered Member has not designated a beneficiary, such benefits will be made payable to the first surviving class of the following classes of successive preference beneficiaries:

The Covered Member's:

- Surviving spouse/domestic partner;
- If no surviving spouse, to the surviving children equally;
- If no surviving children, the Covered Member's estate.

Important Reminder

You must notify the Welfare Fund immediately when you are promoted to another title, such as foreman, or a provisional title that is not represented by Local 246. It is also very important that you notify the Fund Office immediately by telephone or in writing if you are going to be taken off payroll, after you use up all of your time, due to:

- Sickness, or
- Accident, or
- Compensation injury

Remember, you lose your Welfare Fund benefits and your health insurance coverage from the day you are:

- Suspended, or
- Terminated, or
- Promoted to a non-Local 246 title

You will not be eligible for Welfare Fund benefits (i.e., prescription drug, dental, optical, or hearing aid) as of the date you come off payroll, are terminated, suspended, or promoted. Any and all bills incurred from that date, until you go back on payroll, are re-hired, reinstated or resume employment in a title Local 246 represents, will be your responsibility. You will be mailed a bill by the Welfare Fund for any charges incurred by the Welfare Fund while the fund is not receiving Welfare Fund contributions from the employer on your behalf.

Covered Members who have received a 30-day suspension pending a hearing in connection with termination will have prescription drug benefits extended by the Welfare Fund during such suspension.

The election of City (Medical/Hospital) COBRA does not enroll you in Welfare Fund COBRA. A separate Welfare Fund COBRA application is required.

You must first contact your particular Agency's Benefits Representative so you can be advised on the proper procedures to apply for COBRA, **so your health insurance benefits can continue.**

COORDINATION OF BENEFITS

What is Coordination of Benefits?

When benefits would be payable under more than one group plan, benefit payments will be coordinated so that the total benefits paid under all Group Plans will not exceed 100% of the total amounts charged. If you and your spouse are both members of the New York City SEIU Local 246 Welfare Benefits Fund and eligible for benefits, your benefit payments will also be coordinated not to exceed 100% of the total amounts charged.

How Does Coordination of Benefits Work?

If you are a Covered Member of the Fund and are eligible for benefits from another group plan:

- Submit your claim to the Fund office.
- After you have received payment from the Fund, you may submit claim for any unpaid balance to the other group plan under which you are eligible for benefits.
- You will receive any additional benefits which may be due for this claim under the second plan.
- The total amount you receive for each claim from this Fund and from any other group plan cannot exceed 100% of the total amount charged.

If your spouse has a claim and is eligible for benefits under another group plan, your spouse must submit a claim to his or her plan first.

- After the claim is paid by your spouse's plan, a claim for the unpaid balance may be submitted to this Fund along with an explanation of benefits received from the other plan.
- Any additional benefits which may be due under the Fund's plan for this claim will be paid by this Fund.
- The total amount paid for each claim from any group plan under which your spouse is eligible and from this Fund cannot exceed 100% of the total amount charged.

If a claim is submitted for a child when one parent is a Covered Member of the Fund and the other parent is a covered member of another plan:

- Submit this claim to the plan of the parent whose birthday (month and day only) occurs first in the calendar year.
- After the claim has been paid by the first plan, it may be submitted to the second plan along with an explanation of benefits received from the first plan. You need to be aware and follow claim submission time limits for both plans.
- The payment you receive for each claim from both plans cannot exceed 100% of the total amount charged.
- If the claim is submitted for a child whose parents are divorced when one parent is a Covered Member of the Fund and the other parent is a covered member of another plan:

  If the parent with custody has not remarried:
  - Submit the claim to the plan that covers the parent with custody first.
  - After the claim has been paid by the first plan then it may be submitted to the second plan along with an explanation of benefits from the first plan.

  If the parent with custody has remarried:
  - Submit the claim to the plan that covers the parent with custody first.
  - Submit the claim to the plan that covers the stepparent second.
  - Submit the claim to the plan that covers the parent without custody last.
  - If there is a court order that establishes financial responsibility for the medical, dental, or other health care expenses of the child, submit the claim to the plan that covers the parent with the court-ordered responsibility first. A copy of such court order must be submitted with your claim.

MEDICARE PART D

As an active employee, if you purchase a private Medicare prescription drug plan, its benefits will be SECONDARY to the coverage provided by the Fund. These benefits will only take effect AFTER you have fully utilized the Fund's benefits.

COBRA

Continuation of Coverage (Self-Pay) as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA)

What Is COBRA?

COBRA continuation coverage is a continuation of Fund coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Fund because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Fund, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

What is a Qualifying Event?

If you are a member, you will become a qualified beneficiary if you will lose your coverage under the Fund because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a member, you will become a qualified beneficiary if you will lose your coverage under the Fund because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare Part D; or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Fund because any of the following qualifying events happens:

1. The parent-member dies;
2. The parent-member's hours of employment are reduced;
3. The parent-member's employment ends for any reason other than his or her gross misconduct;
4. The parent-member becomes enrolled in Medicare Part D;
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Fund as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the City of New York ("Employer"), and that bankruptcy results in the loss of coverage of any employee covered under the Fund, the employee is a qualified beneficiary with respect to the bankruptcy. The employee's spouse, surviving spouse, and dependent children also will be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Fund.

Election Period

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, you must notify the Fund Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse, a dependent child's losing eligibility for coverage as a dependent child, or enrollment in Medicare Part D), you must notify the Fund Administrator. The Fund requires you to notify the Fund Administrator within 60 days after the qualifying event occurs. You must send this notice to the Fund Administrator. In the event of death, a copy of the death certificate must be provided. In the event of enrollment in Medicare, you must send a copy of the Medicare card. In the event of divorce, you must send a copy of the divorce judgment. In the event of legal separation, you must send a copy of the Court Order of Separation.

Once the Fund Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event or on the date that Fund coverage would otherwise have been lost, if later.

Continuation Period

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare Part D, a divorce or legal

separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

1. Disability Extension of 18-month Period of Continuation Coverage

   If you or anyone in your family covered under the Fund is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, and you notify the Fund Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Fund Administrator is notified of the Social Security Administration's determination by sending a copy of the Determination letter within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Fund Administrator

2. Second Qualifying Event Extension of 18-month Period of Continuation Coverage

   If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare Part D, or gets divorced or legally separated. The extension is also available to a child when that child

stops being eligible under the Fund as a dependent child. In all of these cases, you must make sure that the Fund Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Fund Administrator. In the event of death, a copy of the death certificate must be provided. In the event of enrollment in Medicare, you must send a copy of the Medicare card. In the event of divorce, you must send a copy of the divorce judgment. In the event of legal separation, you must send a copy of the Court Order of Separation.

Termination of Coverage

The continued coverage will cease on the first of the following dates:

1. The date the Plan terminates;
2. The date a required premium is due and unpaid after any applicable grace period;
3. The date you and/or your Dependent(s) become insured under another group health plan. Contact the Fund Administrator for additional information when you and/or your Dependents become insured under another group plan;
4. The date the applicable period of continuation is exhausted; or
5. The first day of the month that begins 30 days after you or your Dependent(s) receive a final determination from Social Security that you or your Dependent(s) are no longer disabled, in situations where the Qualifying Event was termination of employment or reduction in hours, and where COBRA coverage was being continued for an additional 11 months.

How are COBRA Rates Determined?

The law permits the Fund to charge any person who elects to continue coverage 102% of the full cost to the Plan. If the cost changes, the Fund will revise the charge you are required to pay, but not more than once every 12 months. In addition, if the benefits change for active employees your coverage will change as well.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Fund Administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website. For more information about the Marketplace, visit www.HealthCare.gov

Keep Your Fund Informed of Address Changes

In order to protect your family's rights, you should keep the Fund Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Administrator.

90-DAY SURVIVOR EXTENSION

Upon the death of a member, Fund benefits will be extended to the member's spouse or domestic partner and Eligible Dependent children for 90 days.

CREDITABLE COVERAGE

If you need to show a new health plan how long you were covered under this Fund, you may request a written statement from the Fund office certifying the length of your coverage.

PRIVACY OF PROTECTED HEALTH INFORMATION

UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY CT ("HIPAA") PRIVACY NOTICE

Section 1: Purpose of This Notice and Effective Date

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is required by law:

The New York City Local 246 SEIU Welfare Benefits Fund ("the Fund") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Fund's uses and disclosures of Protected Health Information (PHI);
2. Your rights to privacy with respect to your PHI;
3. The Fund's duties with respect to your PHI;
4. Your right to file a complaint with the Fund and with the Secretary of the United States Department of Health and Human Services (HHS); and
5. The person or office you should contact for further information about the Fund's privacy practices.

Section 2:
Your Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all individually identifiable health information related to an individual's past, present, or future physical or mental health conditions or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

When the Fund May Disclose Your PHI

Under the law, the Fund may disclose your PHI without your consent or authorization or without giving you the opportunity to agree or object, in the following cases:

- ***At your request.*** If you request it, the Fund is required to give you access to certain of your PHI in order to allow you to inspect and/or copy it.
- ***When required by applicable law.***
- ***As required by HHS***. The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations.
- ***Public health purposes.*** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

- ***Domestic violence or abuse situations***. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect, or domestic violence. In such cases, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
- ***Health oversight activities.*** To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against healthcare providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
- ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or court-ordered discovery request.
- ***Law enforcement health purposes***. When required for law enforcement purposes (for example, to report certain types of wounds).
- ***Law enforcement emergency purposes.*** For certain law enforcement purposes, including: identifying or locating a suspect, fugitive, material witness or missing person, and disclosing information about an individual who is or is suspected to be a victim of a crime.
- ***Determining cause of death and organ donation***. When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We also may disclose PHI for cadaveric organ, eye, or tissue donation purposes.
- ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.
- ***Research***. For research, subject to certain conditions.

- ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- ***Workers' Compensation programs.*** When authorized by and to the extent necessary to comply with Workers' Compensation or other similar programs established by law.
- ***For treatment, payment or health care operations***. The Fund and its business associates will use PHI in order to carry out treatment, payment, or healthcare operations.

  Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

  For example, the Fund may disclose to a treating orthodontist the name of your treating dentist so the orthodontist may ask for your dental x-rays from the treating dentist.

  Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations).

  For example, the Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund. If we contract with third parties to help us with payment operations, such as a physician who reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."

Health care operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. We will not use or disclose your personal health information that is genetic information for underwriting purposes.

For example the Fund may use information about your claims to refer into a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

- ***Disclosure to the Fund's Trustees.*** The Fund also will disclose PHI to the Fund Sponsor, the Board of Trustees of the Fund, for purposes related to treatment, payment, and health care operations, and has amended the Summary Plan Description to permit this use and disclosure as required by federal law. For example, the Fund may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.

  In addition, the Fund may disclose "summary health information" to the Board of Trustees for obtaining premium bids or modifying, amending or terminating the Fund's group health plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor such as the Board of Trustees has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with federal privacy rules.

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

When the Disclosure of Your PHI Requires Your Written Authorization

Although the Fund does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Fund will use or disclose psychotherapy notes about you. However, the Fund may use and disclose such notes when needed by the Fund to defend itself against litigation filed by you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Although the Fund does not routinely sell PHI or use it for marketing purposes, it must obtain your written authorization before it may sell your PHI or use it for marketing purposes.

When You Can Object and Prevent the Fund from Using or Disclosing PHI

The Fund will disclose to your spouse/domestic partner the portion of your PHI that is directly relevant to your spouse or domestic partner's involvement with your care or payment for that care unless you notify the Fund's Privacy Official in writing (contact information next page) that you object to our sharing that information with your spouse or domestic partner. In an emergency or if you become incapacitated, the Fund may also disclose your PHI to other family members, relatives, or close friends under certain circumstances as permitted in the Fund's procedures, unless you have previously notified the Fund's Privacy Official in writing that you do not want your information shared under those circumstances.

If you want the Fund to routinely disclose your PHI to persons other than your spouse or domestic partner (e.g., your children), then you must complete an authorization form designating that person as authorized to receive your PHI. Authorization forms are available from the Privacy Official at the Fund office.

Other Uses or Disclosures

The Fund may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Section 3: Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures

You may request the Fund to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Fund, however, is not required to agree to your request except if the use or disclosure is for purposes of carrying out payment or health care operations, is not otherwise required by law, and the PHI pertains solely to a healthcare item or service that has been paid for in full by you or somebody other than the Fund.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to:

Privacy Official
Joseph Colangelo, President
SEIU Local 246
217 Broadway, Suite 501
New York, NY 10007-2909

You May Request Confidential Communications

The Fund will accommodate your reasonable request to receive communications of PHI confidentially by alternative means or solely at alternative locations (e.g. mailing information somewhere other than your home address) where the request includes a statement that disclosure using the Fund's regular communications procedures could endanger you. You or your personal representative will be required to complete a form to request confidential communications of your PHI. Make such requests to the Fund's Privacy Official.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," defined below, for as long as the Fund maintains the PHI. The Fund must provide the requested information within 30 days if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. A reasonable fee may be charged. Requests for access to PHI should be made to the Fund's Privacy Official. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights, and a description of how you may complain to Fund and HHS.

Designated Record Set includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for a health Fund or other information used in whole or in part by or for the covered entity to make

decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. See the Fund's Right to Amend Policy (available on request from the Fund's Privacy Official) for a list of exceptions.

The Fund has 60 days after receiving your request to act on it. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline. If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

You should make your request to amend PHI to the Fund's Privacy Official. You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund also will provide you with an accounting of certain disclosures by the Fund of your PHI made after April 14, 2003. We do not have to provide you with an accounting of disclosures related to treatment, payment for treatment, or health care operations, or disclosures made to you or authorized by you in writing.

The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which

the accounting will be provided. If you request more than one accounting within a 12-month period, the Fund will charge a reasonable, cost-based fee for each subsequent accounting.

Your Personal Representative

You may exercise your rights through a personal representative. Except as provided below in connection with parents of unemancipated minor children, your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority includes a power of attorney for health care purposes, notarized by a notary public, a court order of appointment of the person as the conservator or guardian of the individual, or an individual who is the parent of a minor child.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 4: The Fund's Duties

Maintaining Your Privacy

The Fund is required by law to maintain the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information, and follow the terms of this Notice that is currently in effect. Furthermore, we are required to notify you if your protected health information has been breached.

This Notice is effective September 23, 2013, and the Fund is required to comply with the terms of this notice. However, the Fund reserves the right to change its privacy practices and this Notice, and to apply the changes to any PHI received or

maintained by the Fund prior to that date. If a privacy practice is materially changed, a revised version of this Notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI.

The Notice will be provided via mail to all named participants. Any other person, including dependents of named participants, may receive a copy upon request.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Fund's policies on:

- The uses or disclosures of your PHI,
- Your individual rights,
- The duties of the Fund, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the United States Department of Health and Human Services, pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

Section 5: Your Right to File a Complaint

If you believe that your privacy rights have been violated, you may file a written complaint with the Fund in care of the Fund's Privacy Official. The Fund will not retaliate against you for filing a complaint. You may also file a complaint with:

Office for Civil Rights
U.S. Department of Health & Human Services
Jacob Javits Federal Building
26 Federal Plaza, Suite 3312
New York, NY 10278

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Official.

Section 7: Conclusion

PHI use and disclosure by the Fund is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this Notice and the regulations.

AMENDMENT OR TERMINATION OF BENEFITS

The benefits provided by the Welfare Fund may, from time to time, be changed, modified, augmented, or discontinued by the Board of Trustees. The Board of Trustees adopts rules and regulations for the payment of benefits and all provisions of this booklet are subject to such rules and regulations and to the Trust indenture, which established the Fund and governs its operations.

Your coverage and your dependent's coverage will stop on the earliest of the following dates:

- When the Fund is terminated
- When you are no longer eligible
- When there is a non-payment of the direct pay premiums
- When the City of New York or the quasi-public Agency, Authority, Board or Corporation ceases to make contributions on your behalf to the Fund
- Your dependents' coverage will terminate for the above reasons and also when they are no longer your Eligible Dependents.

Active member benefits under this plan have been made available by the Trustees and are always subject to modification or termination in the exercise of the prudent discretion of the Trustees. No person acquires a vested right to such benefits either before or after his or her retirement. The Trustees may expand, modify, or cancel the benefits for members, change eligibility requirements or the amount of the premiums, and otherwise exercise their prudent discretion at any time without legal right or recourse by an active member or any other person.

THIRD-PARTY REIMBURSEMENT/ SUBROGATION

If a covered member or eligible dependent is injured through the acts or omissions of a third party, the Fund shall be entitled — to the extent it pays out benefits — to reimbursement from the covered member or eligible dependent from any recovery obtained. Alternatively, the Fund shall be subrogated, unless otherwise prohibited by law, to all rights of recovery that the covered member or eligible dependent may have against such third party arising out of its acts or omissions that caused the injury. Subrogation means that the Fund becomes substituted in the injured person's place to pursue a claim for recovery against the third party. Fund benefits will be provided only on the condition that the covered member or eligible dependent agrees in writing:

1. To reimburse the Fund, to the extent of benefits paid by it, out of any money recovered from such third party, whether by judgment, settlement, or otherwise;
2. To provide the Fund with an assignment of proceeds to the extent of benefits paid out by the Fund on the claim and to cooperate and assist the Fund on seeking recovery. The Assignment will be filed with the person whose act caused the injuries, his or her agent, the court and/or the provider of services; and
3. To take all reasonable steps to affect recovery from the responsible third party and to do nothing after the injury to prejudice the Fund's right to reimbursement or subrogation, and to execute and deliver to the Fund Office all necessary documents as the Fund may require to facilitate enforcement of the Fund's rights and not to prejudice such rights.

APPEAL PROCEDURE

You or your authorized representative may appeal the denial of a claim by:

1. A written appeal to the Board of Trustees that must be received by the Fund's office no later than 60 days after your receipt of the denial.
2. You may submit additional information and comments in writing that support your appeal.
3. Please attach a copy of the denial letter.

The Trustees will act on the appeal within a reasonable period of time and render their decision in writing, which shall be final and conclusive and binding on all persons.

Dental
Benefits

DENTAL BENEFITS

The Welfare Fund provides Comprehensive Dental Expense Benefits. This benefit is self-insured and is administered by a Third Party Dental Administrator. Comprehensive Dental Expense Benefits are provided for you and your Eligible Dependents.

Who Is Eligible?

All Covered Members and Eligible Dependents are entitled to this benefit.

How Do Comprehensive Dental Expense Benefits Work?

Comprehensive Dental Expense Benefits provide a scheduled reimbursement for expenses you have incurred for preventive, basic and major non-orthodontic dental services with no deductible requirement. Benefits are also provided for orthodontic services up to plan maximums.

Schedule of Benefits

Your Comprehensive Dental Expense Benefits program pays a set amount for covered expenses that you may incur for preventive, basic, and major dental services up to a maximum benefit of $2,000 per calendar year for each covered member and eligible dependent age 19 and older. Additionally, each covered member and eligible dependent will have a separate allowance per calendar year of up to $600 maximum for any implant or implant-related service. For the latest fee schedule, please contact the Fund Office.

For Pediatric Dental Services (Eligible Dependents under age 19), preventive and basic dental services are covered with no cap on services; however, a participating dental provider must be used.

General Information

1. Pre-authorization is required for a procedure exceeding $300. Claims for pre-authorization must be submitted to the Welfare Fund's Third Party Dental Administrator, along with the necessary x-rays. A pre-authorization is required for verification of the treatment plan as well as being informed of your potential out of pocket expenses.
2. The maximum allowance per calendar year is $2,000 per covered member and Eligible Dependents age 19 and older for preventive, basic, and major dental services. Additionally, each covered member and eligible dependent will have a separate allowance per calendar year of up to $600 maximum for any implant or implant-related service. Any amount over the plan maximum is the member's responsibility. Please be aware of the services your dentist plans to perform as well as his/her total fee.
3. If your spouse has other dental coverage, that is his/her "primary coverage," please submit his/her claims to that plan first. When you receive the explanation of benefits ("EOB"), submit it to the Fund's Third Party Dental Administrator for coordination of benefits. "Primary coverage" for eligible dependent children will be determined by the parent whose birthday comes first in the calendar year.
4. When filling out the top portion of the dental claim form, please remember to either assign payment to yourself or your dentist. This is only necessary when being treated by an out of network dentist.
5. Remember, do not sign the bottom of a dental claim form until all services are completed.
6. Do not leave signed and pre-dated dental claim forms with your dentist.
7. Covered Members and their Eligible Dependents have the right to opt-out of the dental benefits by giving notice to the Fund Office.

Orthodontic Benefit

How Does The Orthodontic Benefit Work?

If you use an in-network provider, there is no out-of-pocket cost to you for covered services. If you use an out-of-network provider, please contact the Fund Office for current information.

Who is Eligible for the Orthodontic Benefit?

Covered Members and their Eligible Dependents.

What are Covered Orthodontic Expenses?

- The initial work-up
- The insertion of the initial appliance
- 20 consecutive visits

What is the Lifetime Maximum Benefit?

There is a $1,800 lifetime maximum for each covered member and eligible dependent age 19 and older.

For pediatric orthodontia (for Eligible Dependents under age 19), there is no cap for medically necessary orthodontia when a participating provider is used. If the orthodontia is not medically necessary or if a non-participating provider is used, then there is a $1,800 lifetime maximum for each eligible dependent under age 19.

Pre-Authorization

What Is Pre-authorization?

When a dentist charges for any individual procedure that will amount to $300 or more, dental services must be pre-authorized by the Fund's dental consultant before treatment is provided. X-rays must be included with treatment plans submitted for pre-authorization. Pre-authorization by the Fund's Third Party Dental Administrator is limited to the approval of the course of treatment proposed. It does

not include approval of payment for services not covered under the dental plan, nor is it a determination of the patient's eligibility or of the amount to be paid under the Fund's dental schedule.

The covered member's or eligible dependent's dentist is required to submit x-rays and a treatment plan to the Fund's Third Party Dental Administrator no later than 30 days after the initial examination. A claim submitted for pre-authorization will be returned to the dentist indicating the pre-authorization decision. Your dentist should contact you upon his/her receipt of the EOB from the Fund's Third Party Dental Administrator.

The dentist may proceed to provide dental services as soon as the treatment plan has been authorized by the Fund. The Fund reserves the right to modify or deny payment of a procedure amounting to $300 or more that have not been pre-authorized by the Fund before the beginning of treatment.

Submitting a Claim

How Do You Submit A Claim?

Claim forms are available at the Fund Office and on the Local 246 website, www.nyclocal246.org. The forms themselves provide instructions concerning proper filing. When you have a claim, you should promptly submit the completed claim form. Claims submitted more than one year after completion of dental services will be denied.

It may become necessary to require additional proof or information concerning a particular claim, and therefore, the Fund reserves the right to require such proof or information, including but not limited to any or all of the following:

- A dental chart showing the dental condition and/or work done before the treatment for which a claim is made.
- X-rays, lab or hospital reports.

- Cast molds or other evidence of the dental condition or treatment.
- Post-treatment examination of the patient, at the Fund's expense, by a dentist it selects.

Alternate Benefit Provision

What Is An Alternate Benefit Provision?

When more than one dental course of treatment would provide suitable treatment, your benefits will be based on the treatment determined by the Fund's Third Party Dental Administrator to be best suited to your condition by accepted standards of dental practice. If two courses of treatment would both provide satisfactory results according to accepted standards of dental practice and one is less expensive than the other, the Plan will reimburse, within plan benefit limits, for the less expensive treatment.

Participating Provider Organization (PPO)

What is the Participating Provider Organization?

Participating Providers are dental care providers who have agreed to provide covered dental procedures at no out-of-pocket expense to Fund members and their Eligible Dependents. Payment for services rendered will be sent directly to a participating provider. These participating providers are credentialed by a credentials verification organization to ensure that they are properly licensed and qualified to provide dental care.

The Fund does not recommend the services of any particular provider. We have selected participants in the dental care panel because they have agreed to accept the Fund's fee schedule as

payment in full for covered services. We have sought out providers who have treated Fund members in the past. However, you must not rely solely on our selection. Please visit any potential office before having work done to ensure that you will be comfortable at that office. Also, before making an appointment, verify that the dentist is still a Participating Provider Organization.

Please remember that Fund members and their dependents are still subject to annual and lifetime coverage limits as specified in the dental plan description. The only time you will have to make a payment is for procedures not covered, for procedures performed after you have reached the plan maximum, or for broken appointments.

If, for any reason you encounter any problems or irregularities with the services provided by a participating dentist, please contact the Fund Office.

Contact the Fund Office if you are charged for any covered service. Do not pay any such charge.

A listing of all the PPOs is available on the Local 246 website.

Exclusions and Limitations

The following services are not reimbursed or covered by the Fund:

1. Services rendered for injuries or conditions that are compensable under Worker's' Compensation or Employer's Liability Laws; services that are provided by any Federal or State or local government agency, or are provided without cost to Covered Members and/or Eligible Dependents.
2. Services rendered or items furnished for any conditions, disease, ailment, or injury occurring while the covered member and/or eligible dependent is on active duty during military service, or for services or items provided under the

laws of the United States of America, or of any state of the United States, or of any foreign country, or of any political subdivision of any of the foregoing.

3. Surgical procedures to correct congenital or developmental malformations, and procedures, appliances or restorations for cosmetic purposes or to increase vertical dimension, treat temporomandibular joint dysfunction, restore occlusion or restore tooth structure lost by attrition.
4. Dental services rendered prior to the date the person became eligible for such services under this plan, or after the date on which coverage ends.
5. Analgesics (such as nitrous oxide) or other euphoric or prescription drugs.
6. Periodontal splinting and/or crown and bridgework used in conjunction with periodontal splinting, including multiple abutments.
7. Procedures primarily for the purpose of plaque control (except prophylaxis), oral hygiene or dietary instructions.
8. Sealants and bases, cosmetic bonding, or procedures of an experimental nature.
9. Replacement of lost or stolen appliances.
10. Any services or items which are determined by the plan's Third Party Dental Administrator not to be a necessary service or item in connection with the condition, disease or injury for which the Covered Member is being treated.
11. Services or items rendered by a family member, or treatment covered or provided under terms of a benefit plan issued by another insurance company, benefit plan or dental facility.

Coverage is subject to the following limitations:

Diagnostic and Palliative

1. Examinations will be provided only once in a six (6) month period. Complete mouth radiograph series will be provided only once in a three (3) year period, unless special need is shown. Supplementary bitewing radiographs are provided upon request, but no more than once every six (6) months.
2. Palliative treatment is not covered when rendered on the same day as other treatment.

Preventive and Periodontal

1. Prophylaxis and scalings will be provided twice in any 12-month period.

Restorative and Prosthetic

1. Benefits are allowed for one restoration per tooth, regardless of the number of restoration combinations actually placed.
2. Reconstruction: Replacement of inlays, onlays, crowns and bridges will be made only after five years have elapsed following insertion under this or any other prior program.
3. Replacement will be made of an existing denture only if it is unsatisfactory and cannot be made satisfactory. Services that are necessary to make such appliances satisfactory will be provided in accordance with the contract. Prosthodontic appliances, including abutment crowns, will be replaced only after five years have elapsed following any prior provision of such appliances under any prior dental plan.
4. If, in the provision of Prosthodontic Services, the covered member and the dentist decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the plan will cover only the standard procedure and the covered member is responsible for any difference in cost.

Prescription Drug Benefits

D

PRESCRIPTION DRUG BENEFITS

Who is Eligible?

All Covered Members and their Eligible Dependents.

What is the Benefit?

This is a self-insured benefit provided by the Fund through its prescription benefit manager ("PBM"). Every covered member is issued a prescription drug card that will certify their and their Eligible Dependents' eligibility at participating pharmacies.

Participating Pharmacy Program

The following co-pays apply for drugs (except asthma drugs; see "Asthma Drugs" section below) purchased at a participating retail pharmacy:

- $10 for generic
- $20 for brand name with no generic substitution available (also known as "preferred brand name")
- 100% co-payment for non-preferred brand-name

No deductible for covered drugs (there is a deductible for asthma drugs; see "Asthma Drugs" section below). The following co-pays apply for drugs (except Asthma Drugs; see "Asthma Drugs" section below) purchased from the PBM's mail order pharmacy (up to a 90-day supply):

- $10 for generic
- $30 for preferred brand
- 100% co-payment for non-preferred brand name

Should you insist on receiving a brand name medication when a generic equivalent is available, you will be required to pay the difference between the cost of the brand name medication and the generic equivalent, plus the $20 co-payment. As this can

be very costly to you, we suggest that you thoroughly discuss generic medications with your physician.

Certain types of medications are subject to a Step Therapy Program. Contact the PBM to determine which medications are affected.

The drugs requiring Fund payment must be prescribed by a doctor, dentist, or physician licensed in the state in which the treatment is given and dispensed under the Rx number of a licensed pharmacist.

This benefit covers:

- Prescriptions that require compounding.
- Prescriptions that require legend drugs (drugs that by law cannot be dispensed by a pharmacy without a prescription).

Asthma Drugs

There is a $100 annual deductible per each covered individual (covered member and each eligible dependent) for all asthma drugs.

The Fund covers all asthma drugs previously covered by the NYC PICA program, with the following deductibles and co-payments:

The following co-pays apply for asthma drugs purchased at a participating retail pharmacy:

- $10 for generic
- $25 for preferred brand name
- 100% co-payment for non-preferred brand name

The following co-pays apply for asthma drugs purchased from the PBMs mail order pharmacy (up to 90-day supply):

- $20 for generic
- $50 for preferred brand name
- 100% co-payment for non-preferred brand name

Those individuals who begin taking Psychotropic and Asthma ("P&A") drugs on or after July 15, 2005, will be required to participate in a Step Therapy Program. The program is designed for individuals who take prescription drugs regularly to treat an ongoing medical condition, such as asthma. The program will help reduce the cost for these expensive medications by requiring the use of generic drugs before brand name drugs. Additional information will be provided regarding this program.

What is Not Covered by this Benefit?

- Prescriptions other than for maintenance medications may not exceed a 30-day supply
- One refill may be authorized by the doctor
- Drugs that may be purchased without a prescription are not covered (even if prescribed and dispensed in the manner outlined above)
- Allergens, antigens and other prescription drugs purchased from a laboratory or physician directly are not covered
- Insulin or prescription with specified dosage — no injectables or companion implements
- Injectables are not covered
- Drugs for a course of treatment where injectable medication for the same medical condition could otherwise be prescribed and/or is available are not covered
- Growth hormones
- Dietary supplements
- Fertility drugs
- Charges for the administration or injection of any drug
- Prescriptions that an eligible person is entitled to receive without charge from any Workers' Compensation case
- Drugs labeled "caution — limited by Federal Law to investigational use" or experimental drugs even though a charge is made to the individual

- Immunization agents, biological sera, blood or blood plasma
- Medication that is to be taken or administered to an individual, in whole or in part, while he/she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, similar institution that operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Minoxidal topical solution
- The use of Retin A as a treatment for photo aging (wrinkles)
- Drugs containing nicotine or other smoking deterrent medications
- Medications for erectile dysfunction
- Experimental drugs and drugs being used for off-label uses
- Immunosuppressants
- Medications for cosmetic purposes
- New drugs that arrive on the market unless first approved by the Trustees
- Medications otherwise covered by your City health plan

For a complete list of excluded medications, please contact the Fund Office.

Can I Choose a Non-Participating Pharmacy?

If a non-participating pharmacy is used, you will be reimbursed based on the contract rate the Fund would have been charged had you used a participating pharmacy, minus your co-payment and/or deductible. In order to file your claim for reimbursement, contact the Fund office at 212.233.0616 to obtain a prescription reimbursement form.

Please make sure your submission includes the name of the drug, the date it was issued, the Rx number, the dosage, the name of the pharmacy, the cost of the drug, the Covered Member's name, social security number and dependent information is necessary.

How Do You Obtain Chronic or Maintenance Medication?

If you are on chronic or maintenance medication, you should obtain your medication directly from the Fund's PBM. Have your doctor send your prescription electronically directly to the Fund's PBM. To verify the co-payment required, please call the Fund's PBM. The Fund's PBM will then send the prescribed medication to you.

Using the mail order program enables you to obtain 90-day supplies of your medication. You may receive three refills for a maintenance medication. After, you must obtain a new prescription from your physician.

The Fund will cover your initial 30-day prescription for maintenance medication and up to one refill at a retail pharmacy. Thereafter, all refills must be obtained through the Fund's mail order program.

If you require maintenance medication, please remember that in order to save money for yourself and the Fund, use the mail order program when ordering maintenance prescription drugs for 90 days. Also, remember to enclose your co-pay and your original prescription in the envelope when ordering so you can receive prompt service from the Fund's Pharmacy Benefit Manager.

How Do I Enroll For This Benefit?

All eligible members are enrolled by the Fund Administrator. The Fund's PBM is then notified to issue a prescription drug I.D. card. If you wish to add a dependent through marriage, birth or adoption, please notify the Fund office immediately so a new card can be issued and your dependents will be covered for this benefit.

What Happens When I Retire?

When an active member retires, both the member and his/her covered dependents will be immediately covered by the New York City SEIU Local 246 Retirees Welfare Benefits Fund and subject to its rules. Please note that the benefits under this Plan differ from the benefits offered under the Retirees Welfare Benefits Fund (i.e. prescription drugs, orthodontics), so please carefully review both Plans and call the Fund Office with any questions. For the remainder of the calendar year in which the member retired, all prescription drug plan utilization, while active, will be applied to the annual maximum established in the retiree plan.

Is Generic Substitution Required?

Yes. If a brand name medication has a generic substitution available, the Fund will cover the cost of the generic medication only.

Waivers of the generic substitution requirement will only be provided subject to a request by a physician. All physician requests for generic waivers must be submitted directly to the Fund's PBM for review. If a waiver is granted, you will be responsible for paying the brand name co-pay, plus the cost difference between the generic and the brand.

E

Optical Benefits

OPTICAL BENEFITS

Who is Eligible?

Covered Members and their Eligible Dependents.

What Does This Benefit Provide?

This benefit is designed to provide prescription eyeglasses to Covered Members and their Eligible Dependents who require them, up to three pair of prescription glasses per rolling 12-month period, per family. This includes examinations, selected frames, and selected lenses. However, Eligible Dependents under age 19 are not included in this limit. Every eligible dependent under age 19 is entitled to a voucher that covers an eye examination and corrective lenses, which must be used at a participating optical provider.

You are responsible for any costs over and above those covered by the Fund's optical plan.

Are There Participating Optical Providers?

Yes, the Trustees of the Fund have made special arrangements with certain service providers so that a covered member may obtain these services at no out-of-pocket expense according to the plan provisions. Also, Eligible Dependents under age 19 must use a participating optical provider in order to take advantage of the no-cost benefit.

Do You Have to Use a Participating Provider?

If you are age 19 or older, you may go to any legally qualified optical provider. You will be reimbursed up to $80 for the total cost of the exam, frames, and lenses upon the return of paid bills/receipts to the Fund Office. For examinations only, the maximum reimbursement will be $40. However, Eligible Dependents under age 19 must use a participating optical provider in order to take advantage of the no-cost benefit.

Eyeglass Allowance For Non-participating Opticians (age 19 and older)

- Exam, frames and lenses. . $80
- Exam Only. $40
- Lenses Only. $40
- Frames Only $40

How Do You Use The Optical Benefit?

Participating Provider Program

- Please contact the Fund office for a list of participating providers. Then simply visit a facility on the Fund's list of participating providers and advise the provider that you are a member of the Fund. The participating provider will then bill the Fund for all covered services.

Direct Reimbursement (age 19 and older)

- Direct reimbursement can only be used if you utilize a non-participating provider. You are required to pay the full cost of the service at the optician and submit to the Fund for payment. Reimbursement is made in accordance with the fee schedule or the actual charge, whichever is less.
- To receive reimbursement, attach an original itemized receipt marked "paid" and a copy of the prescription and mail same to the Fund office.
- Claims must be submitted for payment no later than 90 days from the date of service.

Covered Members and their Eligible Dependents have the right to opt-out of the optical benefits by giving notice to the Fund Office.

F

Hearing Aid Benefit

HEARING AID BENEFIT

Who Is Eligible?

The Hearing Aid benefit is provided for Covered Members and their Eligible Dependents.

How Does the Hearing Aid Benefit Work?

The Fund reimburses expenses for the purchase, repair, and maintenance of a hearing aid(s) up to a total maximum benefit of $600 once every 48 months for all Covered Members and their Eligible Dependents.

What Expenses Are Covered?

Covered expenses under your Hearing Aid benefit include:

- Cost and installation of hearing aid appliances prescribed by a physician or otologist.
- Hearing analysis, tests, or evaluations performed by a physician, otologist, or audiologist, if not covered by your health insurance provider.
- Your claim must be submitted to the Fund Office within 90 days of the date you receive services by a physician, otologist, or audiologist, in order for your claim to be covered under this Hearing Aid benefit.

What Is Not Covered?

Hearing Aid benefit will not be paid for:

- Expenses not recommended or approved by a physician, otologist, or audiologist
- Expenses for which benefits are payable under any Workers' Compensation Law
- Benefits payable under Medicare or any other governmental plan or any other health insurance plan
- Non-durable equipment, such as batteries

- Special procedures or training such as lip reading courses, schooling or institutional expenses
- Medical or surgical treatment of the ear or ears
- Charges for services or supplies that are covered in whole or in part under any other benefit plan

G

Death Benefit

DEATH BENEFIT

Who Is Covered Under This Benefit?

This is a self-insured benefit payable in the event of the death of the covered member only.

How Does The Benefit Work?

In the event of your death from any cause — on the job or off — while you are a covered member of the Fund the benefit will be paid to your designated beneficiary upon submission to the Fund Office of proof in the form of a stamped, certified death certificate issued by the appropriate government agency.

How Much Is The Benefit?

The death benefit is $7,500.

How Do You Designate A Beneficiary?

You may name anyone you wish as your beneficiary and you may change your beneficiary at any time by filling out and signing a beneficiary card provided by the Fund Office.

Please Note: If the designated beneficiary has predeceased the member and a successor has not been designated, or where the member has not designated a beneficiary, such benefits will be made payable to the first surviving class of the following classes of successive preference beneficiaries:

The Covered Member's:

1. Surviving spouse/domestic partner;
2. If no surviving spouse, to the surviving children equally; or
3. If no surviving children, the Covered Member's estate.

Extended Benefits

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EXTENDED BENEFITS

For Covered Members Who Are Seriously Ill Or Injured And Can Not Work

Who Is Eligible?
Active Covered Members only.

What Is The Benefit?
Members who get hurt on the job and go out on Workers' Compensation, are seriously ill or seriously injured for an extensive period of time and cannot work, and who go off payroll, as long as the Welfare Fund is notified and valid medical documentation is provided which is satisfactory to and approved by the Welfare Fund Trustees, will be able to have their Welfare Fund benefits extended for up to 90 days from the last date they are officially still on payroll. Drugs covered by Workers' Compensation are not covered by the Welfare Fund.

This benefit can be utilized up to two times for an active Covered Member, and they must be separate, unrelated occurrences each time.

For Covered Members Suspended from Their Jobs

Who Is Eligible?
Active Covered Members and Eligible Dependents.

What Is The Benefit?
Covered Members who are suspended from their job will have their prescription drug benefits and the prescription drug benefits of their Eligible Dependent extended by the Fund for the first 30 days of the suspension.

90-Day Survivor Extension

The Eligible Dependents of a deceased Covered Member will continue to be covered for welfare fund benefits for a period of 90 days from the date of the member's death.

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