1199SEIU Greater New York Benefit Fund New Jersey Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: Beginning 12/01/2017
Coverage for: Eligibility Classes I, II & III
Plan Type: Taft-Hartley Trust Fund

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

Eligibility Class I members receive all of the benefits listed below for themselves and their eligible family members.

Eligibility Class II & III members receive benefits for themselves only, except for dental care, as indicated in the Limitations, Exceptions & Other Important Information column.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$225/individual or $450/family Co-pays and co-insurance do not count toward deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Office visits, pharmacy benefits and preventive care.	This plan covers all items and services even if you haven't yet met the deductible amount. But a co-payment or co-insurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$800/individual or $1,600/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Deductibles, co-payments, premiums, balance-billing charges and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Co-insurance does count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.Aetna.com or call (866) 658-2455 for a list of network providers. See www.Cigna.com or call (800) 244-6224 for a list of dental providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

The 1199SEIU Greater New York Benefit Fund New Jersey Plan considers itself a "grandfathered health plan" under the Patient Protection and Affordable Care Act.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	**Non-Participating Provider** (You will pay the most)	
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-pay/visit	Not covered	None
	Specialist visit	$10 co-pay/visit	Not covered	None
	Preventive care/ screening/ immunization	No charge through age 18. $10 co-pay/visit for age 19 and above.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Routine adult physical and immunization: One exam/12 months for age 18 and above Routine gynecological care exam: Two exams/12 months Mammogram: One baseline for ages 35 to 39. One exam/12 months for age 40 and above. Colorectal cancer screening: One exam/10 years for age 50 and above Prostate specific antigen (PSA) test: One exam/12 months for age 40 and above
If you have a test	Diagnostic test (X-ray, blood work)	15% co-insurance	Not covered	None
	Imaging (CT/PET scans, MRIs, MRAs)	15% co-insurance	Not covered	Prior approval is required. Services that are not pre-approved in accordance with the terms of the SPD will not be covered.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.1199SEIUBenefits.org	Generic drugs	$10 co-pay/retail or mail-order prescription	Provider charges	Participating Providers are pharmacies that accept Express Scripts. If you use a Non-Participating Pharmacy, you may be charged the amount the provider bills above the Fund's payment. For drugs not on the Fund's Preferred Drug List (non-preferred drugs), you must also pay the difference between the preferred and non-preferred drug price. Prior approval is required for certain medications. Certain medications are subject to clinical program management. Prescriptions for chronic conditions must be filled through *The 1199SEIU 90-Day Rx Solution*. Medications that are not pre-approved in accordance with the terms of the SPD will not be covered. For limitations, exceptions and other important information, see the SPD at www.1199SEIUBenefits.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	**Non-Participating Provider** (You will pay the most)	
If you need drugs to treat your illness or condition (continued) More information about prescription drug coverage is available at www.1199SEIUBenefits.org	Preferred brand drugs	$15 co-pay/retail or mail-order prescription	Provider charges	Participating Providers are pharmacies that accept Express Scripts. If you use a Non-Participating Pharmacy, you may be charged the amount the provider bills above the Fund's payment. For drugs not on the Fund's Preferred Drug List (non-preferred drugs), you must also pay the difference between the preferred and non-preferred drug price. Prior approval is required for certain medications. Certain medications are subject to clinical program management. Prescriptions for chronic conditions must be filled through *The 1199SEIU 90-Day Rx Solution*. Medications that are not pre-approved in accordance with the terms of the SPD will not be covered. For limitations, exceptions and other important information, see the SPD at www.1199SEIUBenefits.org.
	Non-preferred brand drugs	$15 co-pay/retail or mail-order prescription You will be charged a differential in addition to your co-pay.	Provider charges	
	Specialty drugs	$10 co-pay/generic or $15 co-pay/brand You will be charged a differential for non-preferred brand drugs.	Provider charges	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% co-insurance	Not covered	Prior approval is required for certain procedures. Procedures that are not pre-approved in accordance with the terms of the SPD will not be covered.
	Physician/ surgeon fees	15% co-insurance	Not covered	None
If you need immediate medical attention	Emergency room care	$125 co-pay if not admitted to hospital	$125 co-pay if not admitted to hospital, plus provider charges	A hospital emergency room should be used only in the case of a legitimate medical emergency, and must occur within 72 hours of an injury or the onset of a sudden and serious illness. If the condition is not an emergency, you will be responsible for all charges. If you go to a Non-Participating Hospital emergency room, you may incur additional out-of-pocket costs.
	Emergency medical transportation	15% co-insurance	Not covered	Use of emergency medical transportation in non-emergency situations is not covered.
	Urgent care	$75 co-pay/visit	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% co-insurance	Not covered	Prior approval is required for non-emergency admissions. Admissions that are not pre-approved in accordance with the terms of the SPD will not be covered.
	Physician/ surgeon fees	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health or substance abuse services	Outpatient services	$10 co-pay/visit	Not covered	None
	Inpatient services	15% co-insurance	Not covered	Prior approval is required for non-emergency admissions, partial hospitalization programs and intensive outpatient programs. Services that are not pre-approved in accordance with the terms of the SPD will not be covered.
If you are pregnant	Office visits	$10 co-pay/visit	Not covered	None
	Childbirth/delivery professional services	15% co-insurance	Not covered	None
	Childbirth/delivery facility services	15% co-insurance	Not covered	Prior approval is required for inpatient stays longer than 48 hours (natural delivery) or 96 hours (cesarean delivery). Stays exceeding the above time frames that are not pre-approved in accordance with the terms of the SPD will not be covered. Prior approval is required for hospital-grade breastfeeding equipment, which is covered as part of the durable medical equipment benefit only when medically necessary. Equipment that is not pre-approved in accordance with the terms of the SPD will not be covered. Lactation consulting is covered only when medically necessary. Cost sharing does not apply for certain preventive services. Depending on the type of services, co-payments may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	15% co-insurance	Not covered	Prior approval is required. Services that are not pre-approved in accordance with the terms of the SPD will not be covered. Coverage is limited to 60 visits/year.
	Rehabilitation services	15% co-insurance/ inpatient visit $10 co-pay/ outpatient visit	Not covered	Prior approval is required for inpatient rehabilitation. Services that are not pre-approved in accordance with the terms of the SPD will not be covered. Coverage for inpatient rehabilitation is limited to 30 days/year in a hospital for acute care. Coverage for outpatient physical/occupational/speech therapy is limited to 20 visits/discipline/year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs (continued)	Habilitation services	$10 co-pay/visit	Not covered	Prior approval is required. Services that are not pre-approved in accordance with the terms of the SPD will not be covered. Coverage is for outpatient habilitation services only. Coverage for physical/occupational/speech therapy is limited to 20 visits/discipline/year.
	Skilled nursing care	15% co-insurance	Not covered	Prior approval is required. Services that are not pre-approved in accordance with the terms of the SPD will not be covered. Services rendered in a skilled nursing facility or nursing home are covered. Coverage is limited to 60 visits/year based on medical necessity.
	Durable medical equipment	15% co-insurance	Not covered	Prior approval is required for certain items. Items that are not pre-approved in accordance with the terms of the SPD will not be covered. Annual benefit of $700/year. Excludes vehicle modifications, home modifications, exercise and bathroom equipment.
	Hospice services	15% co-insurance	Not covered	Prior approval is required for inpatient hospice services. Services that are not pre-approved in accordance with the terms of the SPD will not be covered. Coverage is limited to 210 days of hospice care/lifetime in a Medicare-certified hospice program in a hospice center, hospital, skilled nursing facility or for outpatient home services provided by an accredited hospice organization.
If your child needs dental or eye care	Children's eye exam	$10 co-pay/visit	Not covered	Coverage is for Genesis employees and their eligible family members, based on their family election. Maximum of one exam every two years.
	Children's glasses/ contact lenses	No charge	Not covered	Coverage is for Genesis employees and their eligible family members, based on their family election. Coverage is limited to $125 combined maximum for one pair of prescription glasses or one order of contact lenses every two years. Scratch-resistant and ultraviolet lens treatments are not covered.
	Children's dental check-up	No charge	Not covered	Coverage is for Eligibility Class I only, and for Genesis employees and their eligible family members, based on their family election.

Excluded Services and Other Covered Services:

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

- Acupuncture
- Cosmetic surgery
- Habilitation services to the extent coverage is available from any other sources
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight-loss programs

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

- Abortion services
- Bariatric surgery (subject to prior approval)
- Care provided in a skilled nursing facility or nursing home: Coverage limited to 60 visits/year
- Chiropractic care
- Dental care (adult): Eligibility Class I and Genesis employees who elect family coverage
- Private-duty nursing (subject to prior approval)
- Routine eye care (adult): Genesis employees who elect family coverage; One eye exam every two years ($10 co-pay); One pair of glasses or one order of contact lenses every two years ($125 combined maximum)
- Routine foot care: Coverage limited to certain underlying medical conditions

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

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

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet Minimum Value Standards? Yes.

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

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

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

About these Coverage Examples:

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

Peg is Having a Baby

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

The plan's overall deductible	$200
Specialist co-payment	$10
Hospital (facility) co-insurance	85%
Other co-insurance	0%

This EXAMPLE event includes services like:

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

In this example, Peg would pay*:

Cost Sharing	
Deductibles	$200
Co-payments	$70
Co-insurance	$800
What Isn't Covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,080**

*Note: These numbers assume Peg is in Eligibility Class I. Eligibility Class II is covered for prenatal vitamins but is not covered for most prescriptions.

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	$200
Specialist co-payment	$10
Hospital (facility) co-insurance	85%
Other co-insurance	0%

This EXAMPLE event includes services like:

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

In this example, Joe would pay*:

Cost Sharing	
Deductibles	$20
Co-payments	$600
Co-insurance	$0
What Isn't Covered	
Limits or exclusions	$20
The total Joe would pay is	**$640**

*Note: These numbers assume Joe is in Eligibility Class I.

Mia's Simple Fracture

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

The plan's overall deductible	$200
Specialist co-payment	$10
Hospital (facility) co-insurance*	85%
Other co-insurance	0%

This EXAMPLE event includes services like:

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

In this example, Mia would pay:**

Cost Sharing	
Deductibles	$200
Co-payments	$200
Co-insurance	$80
What Isn't Covered	
Limits or exclusions	$0
The total Mia would pay is	**$480**

*Emergency room co-payment
**Note: Services covered for *both* Eligibility Class I and II.

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

Discrimination Is Against the Law

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

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

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

Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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