1199SEIU Greater New York Benefit Fund

Summary of Benefits and Coverage: What This Plan Covers and What It Costs

Coverage Period: Beginning 01/01/2013
Coverage for: Eligibility Class I & II
Plan Type: Taft-Hartley Trust Fund

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Fund's Summary Plan Description (SBD) at www.1199seiubenefits.org or by calling (646) 473-9200.

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

Eligibility Class II members receive the benefits for themselves and their eligible family members, except for dental care and most prescriptions (as indicated in the Limitations & Exceptions column).

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket limit.**	Not applicable because there's no **out-of-pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers call (646) 473-9200 or visit www.1199seiubenefits.org.	If you use a participating doctor or other healthcare **provider** (also called "preferred" or "in-network" providers), this plan will pay all or most of the costs of covered services. Be aware that your participating doctor or hospital may use a non-participating **provider** for some services. See the chart on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the participating **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your Summary Plan Description (SPD) for additional information about **excluded services.**

Questions: Call (646) 473-9200 or visit us at www.1199seiubenefits.org. If you aren't clear about any of the underlined terms used in this form, see the Glossary at www.1199seiubenefits.org or call (646) 473-9200 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered healthcare, usually when you receive the service.
- **Co-insurance** is **your** share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$5 co-pay/visit	$5 co-pay/visit You may be charged the amount the provider bills above the Fund's payment.	**Podiatry:** up to 15 treatments per year for routine care **Allergy:** up to 20 treatments per year including diagnostic testing **Dermatology:** up to 20 treatments per year **Chiropractic**: up to 12 treatments per year **Physical/Occupational/Speech Therapy:** up to 25 visits per discipline per year
	Specialist visit	$10 co-pay/visit	$10 co-pay/visit You may be charged the amount the provider bills above the Fund's payment.	
	Other practitioner office visit	No charge	You may be charged the amount the provider bills above the Fund's payment.	
	Preventive care/screening/ immunization	No charge	You may be charged the amount the provider bills above the Fund's payment.	
If you have a test	Diagnostic test (X-ray, blood work)	No charge	You may be charged the amount the provider bills above the Fund's payment.	None
	Imaging (CT/ PET scans, MRIs, MRAs)	$15 co-pay/visit	$15 co-pay/visit You may be charged the amount the provider bills above the Fund's payment.	Prior approval required.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.1199seiubenefits.org.	Generic drugs	$4 co-pay/retail prescription; $10 co-pay/mail order prescription	You may be charged the amount the provider bills above the Fund's payment.	No co-pay for, and coverage for Eligibility Class II limited to: contraceptive medication, medically necessary aspirin and certain preventive care supplements. Participating providers are pharmacies that accept Express Scripts. Prescriptions for chronic conditions must be filled through *The 90-Day Rx Solution*. Prior approval required for certain medications. Certain medications are subject to clinical program management. For non preferred drugs, you must also pay the difference between the preferred and non-preferred drug price.
	Preferred brand drugs	$12 co-pay/retail prescription; $20 co-pay/mail order prescription	You may be charged the amount the provider bills above the Fund's payment.	
	Non-preferred brand drugs	$12 co-pay/retail prescription; $20 co-pay/ mail order prescription. You will also be charged a differential.	You may be charged the amount the provider bills above the Fund's preferred drug price.	
	Specialty drugs	Generic and Brand co-pays apply (see above). You will also be charged a differential for non-preferred brand drugs.	You may be charged the amount the provider bills above the Fund's preferred drug price.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge for use of facility	You may be charged the amount the provider bills above the Fund's payment.	Prior approval required for certain procedures.
	Physician/ surgeon fees	No charge	You may be charged the amount the provider bills above the Fund's payment.	Prior approval required for certain procedures.
If you need immediate medical attention	Emergency room services	$75 co-payment if not admitted to hospital.	$75 co-payment if not admitted to hospital. If you go to the emergency room in a hospital with which the Benefit Fund does not have an emergency room contract, you may incur additional out-of-pocket costs.	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.
	Emergency medical transportation	No charge	If you use an emergency medical transportation provider with which the Benefit Fund does not have a contract, you may incur additional out-of-pocket costs.	Use of emergency medical transportation in non-emergency situations is not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you need immediate medical attention	Urgent care	No charge	You may be charged the amount the provider bills above the Fund's payment.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge for use of the facility	You may be charged the amount the provider bills above the Fund's payment.	Prior approval required for non-emergency admissions.
	Physician/ surgeon fees	No charge	You may be charged the amount the provider bills above the Fund's payment.	None
If you have mental health, behavioral health or substance abuse needs	Mental/ Behavioral health outpatient services	**Psychiatrist:** $20 co-pay/visit **Psychologist:** $15 co-pay/visit **Social Worker, Nurse Practitioner, Mental Health Counselor or Facility:** $10 co-pay/visit	**Psychiatrist:** $20 co-pay/visit **Psychologist:** $15 co-pay/visit **Social Worker, Nurse Practitioner, Mental Health Counselor or Facility:** $10 co-pay/visit You may be charged the amount the provider bills above the Fund's payment.	Coverage limited to 50 visits (combined mental health and substance abuse).
	Mental/ Behavioral health inpatient services	No charge	You may be charged the amount the provider bills above the Fund's payment.	Coverage limited to 30 days per year in a nongovernmental hospital. Prior approval required for non-emergency admissions.
	Substance use disorder outpatient services	No charge	You may be charged the amount the provider bills above the Fund's payment.	Coverage limited to 50 visits (combined mental health and substance abuse).
	Substance use disorder inpatient services	No charge	You may be charged the amount the provider bills above the Fund's payment.	Coverage for inpatient detoxification limited to 7 days within a 12-month period, maximum twice per lifetime. Coverage for inpatient rehabilitation limited to 30 days within a 12-month period for inpatient rehabilitation, maximum twice per lifetime. Prior approval required for non-emergency admissions.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you are pregnant	Prenatal and postnatal care	No charge	You may be charged the amount the provider bills above the Fund's payment.	Prior approval required for breastfeeding equipment. Lactation consulting covered when provided by certified providers only.
	Delivery and all inpatient services	No charge	You may be charged the amount the provider bills above the Fund's payment.	Prior approval required for inpatient stays longer than 48 hours (natural delivery) or 96 hours (caesarean delivery).
If you need help recovering or have other special health needs	Home health care	No charge	You may be charged the amount the provider bills above the Fund's payment.	Prior approval required. Coverage limited to 60 visits per year based on medical necessity.
	Rehabilitation services	No charge	You may be charged the amount the provider bills above the Fund's payment.	Prior approval required. Coverage for inpatient physical rehabilitation limited to 30 days per year in a nongovernmental hospital for acute care. Coverage for Outpatient Physical/Occupational/Speech Therapy services limited to 25 visits per discipline per year.
	Habilitation services	No charge	You may be charged the amount the provider bills above the Fund's payment.	Prior approval required. Not covered to the extent coverage is available from any other sources. Coverage for outpatient only. Outpatient Physical/Occupational/Speech Therapy services limited to 25 visits per discipline per year.
	Skilled nursing care	No charge	You may be charged the amount the provider bills above the Fund's payment.	Prior approval required. Services rendered in a skilled nursing facility are not covered.
	Durable medical equipment	No charge	You may be charged the amount the provider bills above the Fund's payment.	Prior approval required for certain items.
	Hospice service	No charge	You may be charged the amount the provider bills above the Fund's payment.	Prior approval required. Coverage is limited to 210 days of hospice care per lifetime in a hospice or hospital, or for outpatient home services provided by an accredited hospice organization.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If your child needs dental or eye care	Eye exam	No charge	You may be charged the amount the provider bills above the Fund's payment.	Maximum of one exam every 24 months.
	Glasses	No charge for frames or lenses included in the Fund's program.	You may be charged the amount the provider bills above the Fund's payment.	Coverage limited to one pair of Fund program prescription glasses or contact lenses every two years. Scratch-resistant and ultraviolet lens treatments are not covered.
	Dental check-up	No charge	You may be charged the amount the provider bills above the Fund's payment.	Coverage for Eligibility Class I only.

Excluded Services and Other Covered Services:

Services Your Plan Does NOT Cover (This is not a complete list. Check your SPD for other excluded services.)

- Acupuncture when administered by anyone other than a licensed medical physician
- Care provided in a skilled nursing facility
- Cosmetic surgery
- Habilitation services to the extent coverage is available from any other sources
- Infertility treatment
- Long-term care
- Weight-loss programs

Other Covered Services (This is not a complete list. Check your SPD for other covered services and your costs for these services.)

- Bariatric surgery (subject to prior approval)
- Chiropractic care: coverage limited to 12 treatments per year
- Dental care (Adult): Eligibility Class I only. Maximum benefit of $3,000 per person per year for Member Choice; maximum benefit of $1,200 per person per year for non-Member Choice
- Hearing aids: once every three years
- Lactation consulting provided by a certified provider
- Non-emergency care when traveling outside the U.S. – Some restrictions may apply
- Private-duty nursing (subject to prior approval)
- Routine eye care (Adult): one eye exam every two years; one pair of glasses or contact lenses every two years
- Routine foot care: coverage limited to 15 treatments per calendar year

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, federal and state laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at (646) 473-9200. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The Benefit 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-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 page.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,460
- **Patient pays:** $80*

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$50
Co-insurance	$0
Limits or exclusions	$30
Total	**$80**

***Note:** These numbers assume the patient is in Eligibility Class I; the only out-of-pocket expenses are co-pays and over-the-counter stool softener. Eligibility Class II is covered for prenatal vitamins but is not covered for most prescriptions.

Managing Type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,800
- **Patient pays:** $600*

Sample care costs:

Prescriptions	$2,900
Medical equipment and supplies	$1,300
Office visits and procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$600
Co-insurance	$0
Limits or exclusions	$0
Total	**$600**

***Note:** These numbers assume the patient is in Eligibility Class I. Eligibility Class II is not covered for most prescriptions.

Questions and Answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.