SERVICE EMPLOYEES BENEFIT FUND

Summary Plan Description

Effective January 1, 2015

January 1, 2015

To All Covered Participants:

The Board of Trustees is pleased to provide you with this booklet which describes the benefits provided by the Service Employees Benefit Fund ("SEBF", "Fund", or "Plan"). This booklet applies to benefits in effect as of January 1, 2015. If you have questions about the benefits to which you are entitled before that date, you should contact the Fund Office for more information.

> **<u>CAUTION</u> - This booklet and the Fund Office personnel are your authorized sources for Plan information. The Trustees have given no one else authority to speak for them regarding the Plan. No employer, supervisor, SEIU Local 200United or 1199SEIU United Healthcare Workers East representative, or union steward is authorized to discuss your rights under the Plan.**

Your benefits are provided by the Fund through your work in covered employment related to collective bargaining agreements maintained by SEIU Local 200United or 1199SEIU United Healthcare Workers East. You may not be entitled to all the benefits described in this booklet. A summary of the benefits provided by your employer pursuant to your collective bargaining agreement is included at the end of this booklet, but you should contact the Fund Office for questions about which benefits apply to you.

The Trustees are responsible for the operation and administration of our Fund. Their goal is to maintain the maximum benefits the Fund can provide for the greatest advantage of each covered employee and their dependents. Although we tried to fully explain the Plan in this booklet, at some time you may have a question that is unanswered here. If so, contact the Fund Office for an answer to your question.

We will help you in any way possible to make sure you receive your covered benefits promptly. If you need additional information or assistance, please call or write the Fund Office.

Sincerely,

BOARD OF TRUSTEES

SERVICE EMPLOYEES BENEFIT FUND

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I. ELIGIBILITY RULES

A. ELIGIBILITY RULES FOR PARTICIPANTS

You will be covered by the Service Employees Benefit Fund Plan under one of the following categories:

1. You work for an employer in a bargaining unit for which contributions are due to this Plan pursuant to a collective bargaining agreement or a participation agreement maintained by SEIU Local 200United or 1199SEIU United Healthcare Workers East, and you satisfy the eligibility rules described in this Section; or

2. You work for any employer that is required to make payments or contributions to the Fund as defined in the Fund's Restated Agreement and Declaration of Trust, including any Employer that agrees to contribute to the Fund on behalf of non-bargaining unit employees with such contributions subject to approval by the Trustees pursuant to a written participation agreement, and you satisfy the eligibility rules described in this Section.

Your eligibility terms for SEBF benefits are set forth in the collective bargaining agreement or participation agreement that applies to your employment. Those eligibility provisions must comply with the Affordable Care Act. Upon being deemed eligible, your employer shall offer you the opportunity to enroll in SEBF benefits no later than the 60th day after achieving such eligibility. If elected, SEBF coverage will be effective the first day of the month following enrollment, with contributions to be tendered pursuant to the SEBF Collections Policy. Your coverage depends upon the timely receipt by the Fund of the required contributions for your benefits.

The Fund's Trustees will decide all questions about eligibility, and their decisions will be final and binding on you. The Trustees may change, temporarily waive, or modify the eligibility rules if they determine that it is in the best interest of the Benefit Fund and the eligible participants and their dependents.

IMPORTANT: In the event your employer fails to tender to the Fund Office the required employer contributions pursuant to the Fund's Collections Policy, your eligibility (and that of your spouse and dependents) for benefits will terminate effective upon the terms described in the letter to you describing this termination of the coverage. Your entitlement to further benefits after this notice will depend on whether your employer (i) tenders to the Fund all contributions and other payments required (as solely determined by the Board of Trustees); and (ii) enters into a written arrangement for the payment of monies due to the Fund under the terms and conditions solely determined and approved by the Board of Trustees.

Your coverage under the Plan may also be limited by the Plan's "re-entry rules." An employer "withdraws" from this Fund if, as determined by the Trustees in their sole and exclusive discretion, that employer ceases covered operations or ceases to have an obligation to contribute to the Fund. Once an employer withdraws from the Fund, the Trustees will not allow the withdrawn employer to resume participation, or re-enter the Fund, within the three-year period (1092 days) immediately following the date of withdrawal. In accordance with this re-entry rule, you will not be covered by the Plan while a withdrawn employer is waiting to re-enter the Fund.

If you become temporarily totally disabled during your eligibility waiting period, your months of completed reported employment are included as part of your waiting period if you return to regular work with your employer within four months from your temporary total disability date. If you are absent from work on your initial eligibility date except due to a health factor as defined in the Health Insurance Portability and Accountability Act of 1996, your eligibility will begin the first day of the month after you return to employment for which contributions are received.

Annual Enrollment Period

The Plan, in conjunction with your employer's policies, provides an annual enrollment period, so you can elect coverage for yourself and your dependents if you did not previously sign up for coverage when you were first eligible to enroll. In other words, the annual enrollment period is typically available for participants who previously declined enrollment for insurance coverage from the Plan.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, affirmed domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the change in status.

You and your dependents may also enroll in this Plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program ("CHIP") and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends. You and your dependents may also enroll in this Plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

Identification Cards

After you become eligible for coverage, you will receive identification card(s) for medical, prescription, dental, and/or optical benefits as appropriate. **These cards do not guarantee coverage or payment of your claim(s).** The card identifies you as a participant in the Plan and informs your doctor, hospital, dentist, or other provider of the Plan's name, address, and telephone number to submit claims.

BENEFIT FUND PARTICIPATING EMPLOYERS

Eligibility Rule No. 1

Employers with a Two-Month Premium-Paid Waiting Period
And Two-Month Extension Before Termination

Effective November 1, 2014, Eligibility Rule No. 1 will no longer apply if your package of benefits includes medical benefits. The Rule applies for other packages of benefits.

Durham/A & E Transport/Syracuse	Menorah Park
Durham/A & E Transport/Minetto	Michaud Health Services
Alexandria Central School	Oakwood Cemetery
Birnie Bus Syracuse	Oswego, City of
Brockport Central Schools	Republic Parking
Central Parking	Saranac Lake, Village of
Clarkson College/ARA	Longley Jones @ Skyline Apartments
Claxton-Hepburn Medical Center	St. Luke Health Services
Clinton, Village of	Temco @ Utica College
Corporate Maintenance @ BC/BS	Touchpointe @ Lourdes
Cortland, City of	Utica City Schools
First Student-Auburn/Syracuse	VA Medical – Albany
Guilfoyle Ambulance	VA Medical – Buffalo
Hamilton, Village of	VA Medical – Erie
Hartwick College/ARA	VA Medical – Syracuse
The Oaks at Dewitt	VA Medical – Canandaigua
Longley Jones @ Skyline	Vanderheyden Hall
Sodexo @ Lemoyne	Waterville Schools
Marshall, Town of	West Genesee Schools
Matrix @ OCC	West Monroe, Town of

Eligibility Rule No. 2
Employers with a One-Month Premium-Paid Waiting Period
And One-Month Extension Before Termination

Effective November 1, 2014, Eligibility Rule No. 2 will no longer apply if your package of benefits includes medical benefits. The Rule applies for other packages of benefits.

Auburn Memorial Hospital	Jewish Home of CNY
Carthage Area Hospital	The Cottages @ Garden Grove
Cayuga Ridge	

Eligibility Rule No. 3
Employers That Have No Premium-Paid Waiting Period
With Termination the Last Day of the Month the Premium is Paid

ABM – Syracuse	Masonic Care Community
ABM @ LeMoyne	Matrix @ Pall Trinity
Absolute @ Three Rivers	McAuley Residence
Acacia Park	Millard Fillmore Suburban
Alice Hyde Hospital	Mount Calvary Cemetery
Auburn Senior Services	Mount Olivet Cemetery
Autumnview Manor	Mt. St. Mary
Batavia Bus	Newfane Rehabilitation
Bethany Gardens	Niagara Falls Memorial
Blocher Homes, Inc.	Northgate Manor
Buffalo General Hospital	Our Lady of Peace
Canisius College	Pathways
Canton Potsdam Hospital	Pembroke Schools
Central Square Schools	Quest
Children's Hospital	Rochester Regional Joint Board
Community Memorial Hospital	Rose Dental
Contract Specialists	Rosewood –Albany
Corporate Maintenance @ NYSUT	Schoellkopf Health Center
Crouse Hospital	Schofield Residence
CVPH	SEBF Office Staff
Diamond Hill	Seneca Manor
Dutch Manor	Service Employees Pension Fund
Eastern Niagara Hospital	Sodexo @ William Hobart
Elderwood at Williamsville	Sodexo @ Sisters Hospital
Elmlawn Cemetery	St. Lawrence University
ESM Schools	St. Francis Home
Finger Lakes Racetrack	Syracuse University
First Class Maintenance	Temco @ Huron Endicott
Focus Rehab/Senior Living	The Avenue
Garden Gate Manor	The Crossings
Gate of Heaven Cemetery	The Pines
Global @ Verizon	The Springs
Gowanda Nursing Home	Tonawanda Schools
Hamburg School	Unity House
Hawthorne Health/Harbour Health	Upstate Cleaning
Holy Cross Cemetery	Waterfront
Holy Sepulchre Cemetery	Weinberg Campus
Home Aids of CNY	William George Agency
Loretto	1199Upstate-Buffalo Pension Fund
Main Seneca	

Eligibility Rule No. 4
Employers with a Six-Month Premium-Paid Benefit Waiting Period
Weekly Disability Coverage Only

Continuing Development Services	Local 200United
Fayetteville Manlius Schools	Liverpool Schools
Forestville Schools	Lyncourt Schools
Founders Pavilion	North Syracuse Schools

B. ELIGIBILITY RULES FOR DEPENDENTS

Your Dependents for purposes of the Plan's **Medical Benefits** are any of the following:

1. Your lawful spouse or your domestic partner;

2. Your children up to age 26, where "children" include your biological children, adopted children, stepchildren, children for whom you are the legal guardian, and children who have been placed with you for adoption by an authorized placement agency, or by judgment, decree, or other order of any court of competent jurisdiction; and

3. Your unmarried children who are dependent on you for support and maintenance and are incapable of self-support due to a total and permanent mental, developmental, or physical disability after age 26. For the Plan to cover your child as a disabled dependent, you must submit proof of your child's incapacity at no expense to the Fund at least thirty one (31) days prior to the first taxable year that your child will attain the age of 26 (or in the case of a newly eligible participant, no later than 31 days after the participant first becomes eligible under the Plan), and at reasonable intervals when requested by the Board of Trustees.

If you are a newly hired employee, you must enroll for dependent coverage within thirty (30) days of your date of eligibility. Dependent coverage may be delayed until the Fund Office can determine whether dependent coverage is valid. For a list of the documents necessary to establish dependent status, contact the Fund Office.

Certain collective bargaining agreements allow for your "domestic partner" to receive benefits as your dependent. In order to enroll your "domestic partner" in benefits with the Fund, you and your domestic partner must complete the election process. A "domestic partner" means an individual with whom you currently have a committed family relationship that has existed for at least six (6) months and meets the following conditions: (a) you and your domestic partner must intend to continue living together in the future; (b) you and your domestic partner must be 18 years of age or older; (c) you and your domestic partner must be mentally competent to form a committed family relationship; (d) you cannot be the parent, child, sibling, grandparent, or any other blood relation with your domestic partner that would bar marriage under the laws in the State where you and the domestic partner reside; (e) you and your domestic partner must execute the required affidavit and affirmation required by the Fund's Trustees; (f) you must agree to immediately notify the Fund of any change or termination in your status as domestic partners; (g) you must agree to indemnify the Fund for any damages caused by providing benefits to your domestic partner in

violation of applicable law; and (h) you and your domestic partner must share joint responsibility for one another's common welfare and basic needs, evidenced by submitted proof of at least three of the following items: (i) common ownership or leasehold in real property; (ii) common ownership of a motor vehicle; (iii) joint bank accounts or credit cards; (iv) designation as a beneficiary for life insurance or retirement benefits; (v) naming each other in personal wills, durable powers of attorneys, or healthcare proxies; or (vi) other proof that would be sufficient to establish economic dependence on one another.

Your Dependents for purposes of the other Plan Benefits (*e.g.*, Optical, Dental, and Dependent Death Benefits) offered under the Plan are the same as listed above, except for children who are completely dependent on you for financial support and maintenance through December 31 of the calendar year in which they attain age 19. For such children, eligibility may continue until the close of the calendar year before the child turns age 25, so long as the child lives with you in the United States for more than one-half of the taxable year, and the child is enrolled in an accredited school or college as a continuous full-time student for the number of hours or courses that the educational institution considers to be continuous full-time attendance during some part of each of any five calendar months during the taxable year.

Benefit coverage begins from birth for a newborn child regardless of whether the child is born prematurely or has congenital defects or birth abnormalities. If you are a part-time employee eligible for individual benefit coverage and change to full-time status with eligibility for family coverage, your dependents will become eligible for benefits according to the eligibility rules for your employer. Dependent eligibility will continue as long as the Fund receives the <u>full</u> premium necessary for the dependent coverage. If the payroll deduction is not made by your employer because you are not on the payroll the week of the deduction, it is your responsibility to arrange for the missed deduction with your employer.

Notwithstanding any of the above, the Fund will also provide benefits pursuant to the terms of a Qualified Medical Child Support Order ("QMSCO"), as defined in Section 609 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), as a result of any domestic relations matter. You may submit the QMSCO as proof of support. You or your dependents may obtain, without charge, a copy of the Plan's QMSCO procedures from the Fund Office.

C. EXTENDED DISABILITY BENEFITS

If you or your dependents are "totally disabled" on the date benefit eligibility would otherwise terminate, the benefit coverage will be extended for medical expenses resulting directly from the disability if:

(a) the disabled person was entitled to benefits for the expense before their eligibility termination date; and

(b) the person is continuously disabled to the date each expense is incurred; and

(c) the disabled person has no coverage for the medical expenses under any insurance policy or any other plan providing similar benefits on the date of each expense.

Extended Benefit Coverage

Benefits that were covered at the person's eligibility termination date will be extended for the following medical expenses incurred directly because of the disability:

i. Hospital benefits for a hospitalization beginning within three months after termination of eligibility;

ii. Surgical benefits for an operation within three months after termination of eligibility; and

iii. Major Medical benefits for covered medical expenses incurred within six months after termination of eligibility.

Definition of "Totally Disabled"

Totally disabled means that due to an injury or illness:

(a) you or your dependent are unable to work in your regular occupation and are not working for pay or profit; or

(b) you or your dependent are unable to do most of the normal activities of a person of the same age and gender who is in good health.

Exclusions: There is no benefit coverage for a disabled person's expenses that are unrelated to the disability. There is no benefit coverage if you or your dependents are on leave under the Family and Medical Leave Act. There is no extended coverage for any family members other than for the disabled individual under this provision.

D. FAMILY AND MEDICAL LEAVE

Under the Family and Medical Leave Act ("FMLA"), you may be eligible for up to 12 weeks of unpaid leave for any of the following reasons:

i. To care for your newly born or adopted child;

ii. To care for your spouse, child, or parent who has a serious health problem; or

iii. If you have a serious health problem which prevents you from performing your job.

In order for you to be eligible for such a leave, your employer must have been obligated to make contributions to the Fund on your behalf for at least 1,250 hours in the preceding twelve (12)

month period. You must also have worked for that employer for at least twelve (12) months immediately preceding the date your leave will commence.

However, not all employers are covered by the FMLA. To be subject to the Act, an employer must have at least fifty (50) employees for each working day for each of twenty (20) work weeks in the current or preceding calendar year. Additionally, you must: (i) work at a location where the employer has at least 50 employees; or (ii) work within 75 miles of one or more work sites where the employer has 50 or more employees.

Your employer must notify the Fund that you are on leave for one of the purposes described in the Act, must continue to include you on its monthly remittance report to the Plan, and must continue to make contributions on your behalf. Your employer should report for you to the Fund during your leave of absence. The reports will describe your service as if you were working instead of exercising your rights under the Act for a leave of absence.

While you are on leave, you (and your eligible dependents, if any) will continue to participate in the Plan just as if your employment had not stopped, unless your employer fails to make the required contributions for you. Your eligibility for continued benefits under the Family and Medical Leave Act will be terminated upon the occurrence of any of the following events:

a) Your employer fails for any reason to make the required contributions to the Plan on your behalf while you are on leave; or

b) You exhaust the twelve (12) weeks of leave to which you are entitled under federal law; or

c) You or your employer notifies the Fund that you do not intend to return to the employer's employment. (NOTE: If you do not return to work for your employer at the end of your leave, you may be responsible for repaying the employer contributions made for you during the leave.)

In the event your employer ceases to make contributions on your behalf, you will be provided an opportunity to elect continuation coverage in accordance with the provisions of the section of the Summary Plan Description entitled "COBRA Continuation Coverage".

E. USERRA COVERAGE

If you enter active military service, you will be offered the opportunity to continue medical and dental coverage under the Plan for yourself and your dependents pursuant to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If your active military service is less than 31 days, your Employer must continue to pay your contributions for your coverage during that leave. If you go into active military service for more than 31 days, you may be able to continue your medical and dental coverage at your own expense for up to twenty-four (24) months. This continuation right operates in the same way as COBRA (see the section entitled "COBRA Continuation Coverage"). In addition, your dependent(s) may be eligible for health care coverage under the Civilian Health & Medical Program of the Uniformed Services ("CHAMPUS"). This Plan will coordinate coverage with CHAMPUS.

F. NOTIFICATION RESPONSIBILITIES

Immediately notify the Fund Office in writing if you:

1. Change your address;

2. Get married, legally separated, or divorced;

3. Obtain a new dependent by marriage, birth, adoption, or legal guardianship;

4. Want to name or change your beneficiary;

5. Obtain employment outside your collective bargaining agreement;

6. Receive New York State Disability benefits for an off-the-job illness or injury;

7. Receive Workers' Compensation benefits for an on-the-job illness or injury;

8. Terminate your employment for any reason; and

9. End your committed family relationship with your domestic partner named in the most current "Affirmation of Domestic Partnership" while he or she is covered by the Service Employees Benefit Fund within thirty (30) days of the relationship ending.

II. MEDICAL AND OTHER BENEFITS

All benefits are subject to the exclusions and limitations described more fully in the rest of this booklet including, but not limited to the Trustees' determination that care and treatment is medically necessary, that charges are reasonable, and that services, supplies, and care are not experimental.

A. MEDICAL BENEFITS

The Schedule of Medical Benefits is a summary of the PPO medical plan which is administered by Excellus BlueCross BlueShield ("Excellus"). For a more detailed description of the medical benefit plan, contact the Fund Office.

Excellus has entered into agreements with hospitals, physicians, and other health care providers to charge reduced fees to persons covered under the Plan through a network. Contact the Fund Office for more information about the composition of the provider network.

It is your choice whether to use the network providers. A list of network providers is available as a separate document, which will be provided to you, without charge, upon request to the Fund Office.

Deductible

A "deductible" is a fixed dollar amount of covered medical expenses that you pay each calendar year before the Plan begins to pay benefits. This Plan has individual and family calendar year deductibles. The deductibles begin again each calendar year.

Copayment or Copay

A "copayment" or "copay" is a specified dollar amount or percentage required to be paid by you each time a particular service is used. Typically, there may be copayments on some services; other services may not have any copayments.

Per Admission Copayment

A "per admission copayment" is an amount you are required to pay when you or a covered dependent have a stay in an inpatient facility.

Payment Percentage

The "payment percentages" listed in the Schedule of Medical Benefits reflect the percentage of covered medical expenses that the Plan pays. Once applicable deductibles have been met, the Plan will pay a percentage of the covered medical expenses, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense.

You are responsible for full payment of any non-covered expenses you incur.

Out-of-Pocket Maximum

The "out-of-pocket" maximum is the total amount you will have to pay in a calendar year related to covered medical and prescription drug expenses. Once you satisfy the "out-of-pocket" maximum, the Plan will pay 100% of the covered expenses for the rest of that calendar year. The "out-of-pocket" maximum for in-network claims for individuals is a total of $6,350 consisting of $5,150 in medical claims and $1,200 in prescription drug claims. The "out-of-pocket" maximum for in-network claims for a family is a total of $12,700 consisting of $7,900 in medical claims and $4,800 in prescription drug claims. The "out-of-pocket" maximum does not apply to out-of-network expenses.

As described in more detail in the Section dealing with your prescription drug benefits, once an individual participant's prescription drug coinsurance costs reach $1,200, all subsequent covered prescriptions for that individual participant will be paid by the Plan at 100% through the balance of that calendar year. Once a participant's family's prescription drug coinsurance costs reach $4,800, all subsequent covered prescriptions for that participant's family will be paid by the Plan at 100% through the balance of that calendar year.

Precertification Benefit Reduction

The Schedule of Medical Benefits includes a precertification program. Failure to pre-certify your out-of-network, covered expenses when required will result in a $400 benefit reduction to each type of expense. For more information about the precertification program, contact the Fund Office.

SCHEDULE OF MEDICAL BENEFITS

Type of Care/Plan Benefits	In-Network	Out-Of-Network
Excellus BluePPO Plan features		
Primary Care Physician (PCP)	Not required	
Referrals	Not required	
Pre-Certification	Required for all inpatient admissions (excluding maternity). Includes Home Health Care, Infusion Therapy, Durable Medical Equipment over $200, MRI, CAT Scans and PET Scans	
Pre-Certification Penalty	No Penalty for In-Network Providers	$400 Penalty, Per Occurrence
Out of network benefits	Covered, unless noted. Please note: The amount the plan pays for covered services is based on an allowed amount. If an out of network provider charges more than the allowed amount, you will have to pay the difference between the actual charge and the allowed amount.	
Out of area benefits	Coverage provided worldwide through the BlueCard® program	
Dependent/Student coverage	Qualified dependents and students are covered to age 26 (end of month)	
Domestic partner	Covered	
Coverage Period	January 1st - December 31st	
Plan cost-sharing highlights		
Office visit copay (Primary Care Physician)	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Office visit copay (Specialist)	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Coinsurance	0%, unless noted	30% of allowance, unless noted
Deductible	None	$1,000 Individual $2,000 Family
Out of pocket maximum	$6,350 Individual ($5,150 Medical and $1,200 Prescription) $12,700 Family ($7,900 Medical and $4,800 Prescription)	None
Inpatient Hospital/Facility Copayment	$500 Per Admission Limit: $1,500 maximum copayment, per individual, per person, per calendar year	None
Lifetime maximum	None	
Wellness Incentives		
Stay healthy with great programs and incentives!	**Blue365** - Take advantage of exclusive discounts on health and wellness products and services, including fitness, exercise, nutrition, elective procedures and hearing aids. For additional information on **Blue365**, please visit: **www.excellusbcbs.com/sebf**	

SCHEDULE OF MEDICAL BENEFIT

Preventive Health Care Services*		
Well child visits	Covered in Full	Covered at 100% of allowance, subject to the deductible
Adult routine physical exam	Covered in Full	Covered at 100% of allowance, subject to the deductible
Adult immunizations	Covered in Full	Covered at 100% of allowance, subject to the deductible
Mammography	Covered in Full	Covered at 70% of allowance, subject to the deductible
Pap smear	Covered in Full	Covered at 70% of allowance, subject to the deductible
Routine GYN exam	Covered in Full	Covered at 70% of allowance,subject to the deductible
Prostate cancer screening	Covered in Full	Covered at 70% of allowance, subject to the deductible
Colonoscopy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Physician Office Services		
Diagnostic office visits	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Surgery	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Advanced Imaging Services (Includes PET Scans, CAT Scans, MRI's and Nuclear Medicine)	$75 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Diagnostic X-Rays	Covered in Full	Covered at 70% of allowance, subject to the deductible
Diagnostic laboratory and pathology	Covered in Full	Covered at 70% of allowance, subject to the deductible
Allergy testing	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Allergy treatment including serum	Covered in Full	Covered at 70% of allowance, subject to the deductible
Chemotherapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Radiation therapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Infusion therapy	Covered in Full	Covered at 70% of allowance, subject to the deductible

SCHEDULE OF MEDICAL BENEFIT

Maternity Services		
Prenatal Care	Covered in Full	Covered at 70% of allowance, subject to the deductible
Hospital care for mom (including delivery)	$500 Copayment then Covered in Full	Covered at 70% of allowance, subject to the deductible
Newborn nursery care	Covered in Full	Covered at 70% of allowance, subject to the deductible
Inpatient Hospital Benefits		
Hospital benefits	$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Physician visits in the hospital	Covered in Full	Covered at 70% of allowance, subject to the deductible
Inpatient physical rehabilitation	$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible.Limit: 60 days per calendar year.Precertification applies
Surgery (Professional charge)	Covered in Full	Covered at 70% of allowance, subject to the deductible
Anesthesia	Covered in Full	Covered at 70% of allowance, subject to the deductible
Emergency Care		
Emergency room care	$100 Copayment per visit then Covered in Full (Copayment waived if admitted inpatient) **No Coverage for Non-Emergency care**	$100 Copayment per visit then Covered at 100% of allowance (Copayment waived if admitted inpatient) **No Coverage for Non-Emergency care**
Freestanding urgent care center	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Ambulance (Ground or Air)	$50 Copayment then Covered in Full	$50 Copayment then Covered at 100% of allowance

SCHEDULE OF MEDICAL BENEFIT

Outpatient Hospital Benefits		
Advanced Imaging Services (Includes PET Scans, CAT Scans, MRI's and Nuclear Medicine)	$75 Copayment, then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Diagnostic X-Rays	Covered in Full	Covered at 70% of allowance, subject to the deductible
Diagnostic laboratory and pathology	Covered in Full	Covered at 70% of allowance, subject to the deductible
Surgical care (Facility Fee: Includes Ambulatory Surgery Center)	$75 Copayment then Covered in Full	Covered at 70% of allowance, subject to the deductible
Chemotherapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Radiation therapy	Covered in Full	Covered at 70% of allowance, subject to the deductible
Mental Health and Chemical Dependence		
Inpatient mental health care	$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Outpatient mental health care	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Inpatient chemical dependence	$500 Copayment then Covered in Full Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies
Outpatient chemical dependence	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Other Services		
Skilled nursing facility	$500 Copayment then Covered in Full. Limit: 60 visits per calendar year. Limits are combined INN and OON. Precertification applies	Covered at 70% of allowance, subject to the deductible. Limit: 60 visits per calendar year. Limits are combined INN and OON. Precertification applies
Home care	$40 Copayment Limit: Total of 40 visits per calendar. Limits are combined INN and OON. Precertification applies	Covered at 75% of allowance, subject to deductible. Limit: Total of 40 visits per calendar. Limits are combined INN and OON. Precertification applies
Hospice	$500 Copayment then Covered in Full. Precertification applies	Covered at 70% of allowance, subject to the deductible. Precertification applies.
Infusion Therapy (Facility Charge)	$40 Copayment Precertification applies	Covered at 75% of allowance, subject to the deductible. Precertification applies

SCHEDULE OF MEDICAL BENEFIT

Outpatient therapy (Physical and Occupational)	$40 Copayment Limit: Combined total of 60 visits per calendar. Includes aggregate of visits for INN and OON and professional and facility covered services.	Covered at 70% of allowance, subject to the deductible. Limit: Combined total of 60 visits per calendar. Includes aggregate of visits for INN and OON and professional and facility covered services.
Outpatient therapy (Speech)	$40 Copayment Limit: Total of 20 visits per calendar year. Includes aggregate of visits for INN and OON and professional and facility covered services.	Covered at 70% of allowance, subject to the deductible. Limit: Total of 20 visits per calendar year. Includes aggregate of visits for INN and OON and professional and facility covered services.
Cardiac & Pulmonary Rehabilitation	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Diabetic insulin and supplies	Covered only through your Prescription Drug Plan with Express Scripts.	Covered only through your Prescription Drug Plan with Express Scripts.
Durable medical equipment	Covered at 80% Precertification applies if over $200	Covered at 70% of allowance, subject to the deductible. Precertification applies if over $200
External prosthetics	Covered in Full	Covered at 70% of allowance, subject to the deductible
Chiropractic	$40 Copayment Limit: 20 visits per calendar year. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible Limit: 20 visits per calendar year. INN & OON limits are combined
Acupuncture	$40 Copayment Limit: 20 visits per calendar year. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible Limit: 20 visits per calendar year. INN & OON limits are combined
Routine Hearing Exam	$40 Copayment Limit: 1 exam every 24 months. INN & OON limits combined	Covered at 70% of allowance, subject to the deductible. Limit: 1 exam every 24 months. INN & OON limits are combined
Hearing Aids	$40 CopaymentLimit: $2,500 maximum per 12 months. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible.Limit: $2,500 maximum per 12 months.INN & OON limits are combined
Accidental Dental	Covered at 80%, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly.	Covered at 70% of allowance, subject to the deductible for accidental injury to sound, natural teeth and for care due to congenital disease or anomaly.
Prescription Drug Coverage:	**Administered through Express Scripts www.express-scripts.com 1-866-544-2926**	

SCHEDULE OF MEDICAL BENEFIT

* Preventive Services are not subject to Cost-Sharing when performed by a Participating Provider and provided in accordance with the comprehensive guidelines (including age and visit guidelines) supported by the Health Resources and Services Administration (HSRA) or if the items or services have a "A" or "B" rating from the United States Preventive Services Task Force (USPSTF), or the immunizations are recommended by the Advisory Committee on Immunization Practices (ACIP).

NOTICE: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

B. PRESCRIPTION DRUG BENEFITS

The prescription drug benefits offered by this Plan are provided through Express Scripts. Upon enrollment, you will be provided with a prescription drug identification card and outline of benefits. Claim forms are not needed to obtain prescription benefits through the retail network pharmacy service. To request prescription benefits, you simply present your Express Scripts identification card and prescription to the pharmacist. You may get your medications through the Express Scripts network of participating retail pharmacies or through the Express Scripts Home Delivery Pharmacy Service. Some features of your prescription drug benefits are as follows:

- There is no deductible in your Prescription Plan managed by Express Scripts (retail and/or mail order).

- You pay 30% in coinsurance, based on a union-negotiated discount cost, for generic and brand name drugs.

- You pay 50% in coinsurance, based on a union-negotiated discount cost, for proton pump inhibitors (PPIs) and non-sedating (and low-sedating) antihistamines (NSAs).

- There is a mandatory mail feature for maintenance or long-term medications after the third refill at a retail pharmacy.

As described in more detail in the definition of "out-of-pocket" maximums above, the Fund has limits on the amount that you will pay per calendar year for prescription drugs under this Plan. Once an individual participant's prescription drug coinsurance costs reach $1,200, all subsequent covered prescriptions for that individual participant will be paid by the Plan at 100% through the balance of that calendar year. Once a participant's family's prescription drug coinsurance costs reach $4,800, all subsequent covered prescriptions for that participant's family will be paid by the Plan at 100% through the balance of that calendar year.

Note: If your prescription is written in a way which allows the pharmacist to dispense the generic, yet you want the brand name equivalent, you will be charged the brand name coinsurance PLUS the difference in cost between the generic drug and the brand name drug.

Features	**Retail Program**	**Mail Service Program**
When to use	When you need a prescription drug on a short-term or immediate basis, (for example, an antibiotic to treat strep throat)	For prescriptions you use on a regular basis (for example, medication to reduce blood pressure, asthma, diabetes, etc.)
Supply Per Prescription/Refill	Up to 30 days	Up to 60 days
Prescription Drug Deductible	None	None

Your cost per prescription or refill at participating pharmacies is 30% (except for PPIs and NSAs, for which your cost is 50%) of the negotiated discounted cost. At non-participating pharmacies, you pay in full and submit a claim for the Fund to reimburse you at the approved rates. Reimbursement will be the amount that would have been charged by a participating pharmacy less the applicable coinsurance.

The Plan will not cover specialty pharmacy medications that are dispensed in a physician's office. You must obtain the prescription for the specialty pharmacy medication from Accredo, 1-800-922-8279, and have the prescription mailed directly to you or to your physician. If you obtain specialty pharmacy medications from a home infusion company, a doctor's office or from another pharmacy after October 1, 2010, such medications will not be covered, and you will be responsible for the full cost of the medication.

Birth control pills are covered under this prescription benefit as follows: generic birth control pills will be covered at 100% and brand name birth control pills will be subject to coinsurance, as described in the Plan, unless a physician indicates a medical necessity for prescribing the brand name birth control pills. Family Planning Benefits include any prescription drugs or contraceptive devices approved for family planning by the Federal Drug Administration for members or their spouses.

To find out whether a pharmacy participates in the Express Scripts program, ask your retail pharmacist if they participate in the Express Scripts Prescriptions Plan or visit the Express Scripts website (www.Express-Scripts.com) and use the online pharmacy locator. Alternatively, you could call Express Scripts Member Services at 1-866-544-2926 (toll free). If you choose to use the *Express Scripts Pharmacy* mail order service, you may request "Ordering Medications" forms through the Express Scripts website (www.Express-Scripts.com) or by calling 1-866-544-2926, 24 hours per day, 7 days per week, except Thanksgiving and Christmas. In addition:

- To refill an *Express Scripts Pharmacy* mail order service prescription using the Express Scripts automated system, call 1-866-544-2926.

- To receive instructions about how your doctor can fax your prescription to the *Express Scripts Pharmacy*, have your doctor call 1-888-327-9791.

- To arrange credit card payment for all of your *Express Scripts Pharmacy* service orders, call 1-866-544-2926.

The Fund also offers a Mail Order Program for Maintenance/Long-Term Medications through the *Express Scripts Pharmacy* mail order service. Some features of the Mail Order Program are as follows:

- You can get up to a 60-day supply of covered maintenance medications (also known as long-term medications) through the *Express Scripts Pharmacy*.

- Maintenance medications are those drugs you take on a long-term basis (*three months or more*). Maintenance medications may include oral contraceptives and medication for chronic diseases and conditions such as asthma, high cholesterol,

high blood pressure, diabetes, etc. Controlled substances are not subject to the mandatory mail order rule.

- You may fill a maintenance or long-term medication up to three times at your local participating retail pharmacy, but beginning with the fourth fill, you must fill the prescription through the *Express Scripts Pharmacy*. If you choose to purchase the medication at a retail pharmacy after the fourth fill, you will be responsible for its full cost.

- You have four ways of filling your maintenance or long-term prescriptions through the *Express Scripts Pharmacy*. (i) MAIL your maintenance prescription to the *Express Scripts Pharmacy* by completing a mail order form (available at www.Express-Scripts.com or by calling Express Scripts at 1-866-544-2926). Then send the completed form along with your 60-day prescription and your payment to the address on the form; (ii) your doctor may FAX your maintenance prescription directly to the *Express Scripts Pharmacy*. Ask them to phone 1-888-327-9791 for instructions on how to fax your prescription directly. (Only doctors can fax prescriptions to the pharmacy.); or (iii) you may WALK IN TO RITE AID (New York and New Jersey) to fill your prescriptions for maintenance prescriptions through the *Express Scripts Pharmacy* (Central Supply).

  Here's how it works if you fill your prescription for maintenance prescriptions at Rite Aid:

  - ✓ Present your maintenance prescription along with your prescription drug ID card to the pharmacist.
  - ✓ Pick up your prescription about 8 days later from the same pharmacy.
  - ✓ Pay the appropriate amount in coinsurance when you pick up your order.
  - ✓ Order your refills at the same Rite Aid pharmacy.
  - ✓ For refills remaining on long-term prescriptions filled at retail, log into www.Express-Scripts.com, scroll down the Order Center page to "Transfer your retail prescriptions to mail service" to select the medications you'd like to transfer to the *Express Scripts Pharmacy*. Express Scripts will do the rest.

On-Line Services. If you have internet access, you can take advantage of Express Scripts' award-winning, consumer-friendly website. More than 84 million active members have registered on www.Express-Scripts.com to: (i) Compare the cost of brand name and generic drugs at retail and via mail order; (ii) obtain order forms, claim forms, and envelopes; and (iii) submit mail order refills and check the status of mail order prescriptions.

Accredo, Express Scripts' Specialty Pharmacy, is mandatory for anyone on a Specialty Medication. Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Whether they are administered by a healthcare professional,

self-injected or taken by mouth, specialty medications require an enhanced level of service. If you use a pharmacy other than *Accredo* to purchase specialty medications, you will be responsible for the full cost. If you have any questions regarding *Accredo* or specialty drugs, please contact *Accredo* directly at 1-800-922-8279.

To promote your health and wellness, the Fund offers the following program to discourage the use of tobacco products. The Fund offers a $500 per person benefit for smoking cessation products. The smoking cessation products should be purchased at the pharmacy without using your insurance card, then submit the proof of purchase to the Fund. After reviewing your receipts, the Fund will reimburse you directly. Although the Fund will reimburse you for one or more products up to a maximum of $500, the total amount paid per person cannot exceed $500, except to the extent required by the rules related to Preventative Care as described in this Plan.

C. PREVENTATIVE CARE AND CLINICAL TRIALS

Preventive Services

This Plan covers a comprehensive range of preventive services that are recommended by physicians and other experts without cost-sharing (i.e., without charges such as copayments, coinsurance or deductibles) when the services are provided by an in-network provider. Specifically, the covered preventive services include the following categories of services:

1. Evidence-based preventive services: Preventive services with a "grade" of A or B by the U.S. Preventive Services Task Force, including, but not limited to, breast and colon cancer screenings, screening for vitamin deficiencies during pregnancy, screenings for diabetes, high cholesterol and high blood pressure, and tobacco cessation counseling.

2. Routine vaccines: Standard vaccines recommended by the Advisory Committee on Immunization Practices ranging from routine childhood immunizations to periodic tetanus shots for adults.

3. Preventive services for children: Preventive services for children recommended and developed by the Health Resources and Services Administration with the American Academy of Pediatrics, including, but not limited to, regular pediatrician visits, vision and hearing screening, developmental assessments, immunizations, and screening and counseling to address obesity and help children maintain a healthy weight.

4. Preventive services for women: These services have been identified by the independent Institute of Medicine and endorsed by the Health Resources and Services Administration. They include: (1) Breastfeeding support, supplies, and counseling; (2) screening and counseling for interpersonal and domestic violence; (3) screening for gestational diabetes; (4) DNA testing for high-risk strains of HPV; (5) counseling regarding sexually transmitted infections, including HIV; (6) screening for HIV; (7) contraceptive methods and counseling; and (8) well woman visits.

The guidelines for preventive services covered by the Plan are regularly updated to reflect new scientific and medical advances. As new services are approved, the Plan will cover them with no cost-sharing for plan years beginning one year later. A list of the covered services is available at https://www.healthcare.gov/what-are-my-preventive-care-benefits/.

Sometimes preventive services are included with other services as part of an office visit. The Plan may impose cost-sharing to an office visit: (a) if the preventive service is billed separately (or is tracked as individual encounter data separately) from the office visit; or (b) if the recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from the office visit, the primary purpose of the office visit is something other than the delivery of the recommended preventive service. In such a case, the Plan may still impose a copayment, coinsurance or a deductible. The Plan may not impose cost-sharing to an office visit if: (a) the preventive service is not billed separately (or is not tracked as individual encounter data separately) from the office visit; and (b) the primary purpose of the visit is the delivery of the recommended preventive service. The Plan may impose cost-sharing for these preventive services when provided by an out-of-network provider.

Participation in Clinical Trials

The Fund shall not cease coverage for any participant's or beneficiary's participation in a clinical trial or deny coverage for routine patient costs for items and services furnished in connection with a participation's or beneficiary's participation in a clinical trial, to the extent required by the regulations of the United States Department of Health and Human Services.

The Trustees reserve the right to use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service to the extent not specified in the particular recommendation or guideline. For instance, if an item or service described above is billed separately (or is tracked as individual encounter data separately) from an office visit, then the Trustees reserve the right to impose cost-sharing requirements with respect to the office visit. If an item or service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then the Trustees reserve the right to impose cost-sharing requirements with respect to the office visit.

D. OPTICAL BENEFITS

The Fund provides optical benefits for participants if the applicable collective bargaining agreement or participation agreement allows for these benefits. You may refer to the summary at the end of this booklet or contact the Fund Office to determine if you have optical coverage with the Fund. The optical benefits are not an integral part of the Fund's health plan, and you have the right to elect not to receive coverage for optical benefits. In order to elect not to receive coverage for optical benefits, contact the Fund Office for the applicable procedures.

The optical coverage includes reimbursement for optical services you receive up to $60 each year or up to $120 every two years for routine eye care expenses, *i.e.*, eye exam, eyeglass frames, and lenses. There is no extended optical coverage after termination of your benefit eligibility.

If you are eligible for Service Employees Benefit Fund Davis Vision optical coverage, you will receive benefits according to the following chart:

BENEFITS	**FASHION VALUE PLAN**
Frequency-Once Every:	Plan
Eye Examination inclusive of Dilation (when professionally indicated)	24 Months
Eyewear:	
Spectacle Lenses	24 Months
Frame	24 Months
Contact Lenses (in lieu of eyeglasses)	24 Months
Copayments	
Eye Examination	$15
Eyewear, glasses	$25
Contact Lenses Evaluation	$25
Frame	
In-Network Retail Allowance towards a Non-Collection Frame	Up to $60 plus 20% discount on overage
Exclusive Frame Collection (Davis Vision supplied) (in lieu of Frame Allowance):	
Fashion (up to $125 retail value)	Included
Designer (up to $175 retail value)	Included
Premier (up to $225 retail value)	$25

Spectacle Lenses	
All ranges of prescriptions and sizes	Included
Choice of glass or plastic lenses	Included
Oversize Lenses	Included
Contact Lenses (in lieu of eyeglasses)	
Elective Allowance towards Non-Formulary Contact Lenses	Up to $100 Plus 15% discount on any overage
Formulary with Fitting/Follow-Up Care (in lieu of Elective Allowance)	Included
Medically Necessary (with prior approval)	Included
Value-Added Features	
One-year Breakage Warranty	Included
Lens 1-2-3!® Membership	Included
Laser Vision Correction Discount	Included
Low Vision Coverage	Included
Out-of-Network Reimbursement Schedule	
Eye Examination and Materials, up to	$120

If you choose to visit an out-of-network doctor, you must pay the billed charges and you will be subsequently reimbursed up to $120 every two years for routine eye care expenses, *i.e.*, eye exam, eyeglass frames and lenses. After services have been received, you must submit an out-of-network claim form to Davis Vision along with copies of the itemized doctor's bills for your optical services. Reimbursement will be made directly to you.

E. DENTAL BENEFITS

This Plan provides dental benefits if the applicable collective bargaining agreement or participation agreement allows for these benefits. You may refer to the summary at the end of this booklet or contact the Fund Office to determine if you have dental coverage with the Fund. The dental benefits are not an integral part of the Fund's health plan, and you have the right to elect not to receive coverage for dental benefits. In order to elect not to receive coverage for dental benefits, contact the Fund Office for the applicable procedures.

Effective January 1, 2012, retirees may also be entitled to dental benefits pursuant to their applicable collective bargaining agreement.

The Dental Plans have no deductible and they will reimburse up to $1,500 per person per calendar year.

Basic Coverage

If you are eligible for Basic dental coverage, your coverage includes benefits listed in Section 1 (Preventive and Diagnostic Services). You have no coverage for services listed under Section 2 (Major Prosthetic Services) or Section 3 (Orthodontia Services).

Comprehensive Coverage

If you are eligible for Basic + Comprehensive coverage, you are entitled to all services listed in the dental schedule for Sections 1 and 2. You have no coverage for services listed under Section 3 (Orthodontia Services).

Orthodontia Coverage

If you are eligible for orthodontia coverage, your dependents are entitled to all services listed in the dental schedule for Sections 1, 2, and 3. Orthodontia benefits are available only to eligible dependent children under age 19.

Maximum Benefit

You and your eligible dependents will be paid the allowable dental reimbursement as listed in the Dental Schedule of Benefits up to a maximum of $1,500 per person per calendar year. The lifetime maximum benefit for orthodontia services is $1,500 per eligible dependent.

The following schedule lists commonly used procedures. For a full schedule of all available procedures related to the Plan, contact the Fund Office.

DENTAL SCHEDULE OF BENEFITS

SECTION 1
BASIC PLAN

Payments under this Section 1 include necessary preparatory and related services such as x-rays, local anesthesia and aftercare.

Preventive and Diagnostic Services

Procedure Code		Reimbursement
	Examinations	
0120	Periodic Oral Exam	$29
0150	Comprehensive Oral Exam	$29
	Radiographs (X-rays)	
0210	Intra-Oral, Complete Series	$58
0220	Intra-Oral, Single First Film	$14
0230	Intra-Oral, Each Additional	$7
0272	Bitewings – two films	$17
0274	Bitewings – four films	$29
0330	Panoramic	$40
	Prophylaxis (Cleanings)	
1110	Adult Prophylaxis – 12 years and older	$58
1120	Child Prophylaxis – under age 12	$43
1203	Fluoride Treatment – up to age 19	$16
1351	Sealants – up to age 14	$43
	Restorations (Fillings)	
2140	Amalgam One Surface	$55
2150	Amalgam Two Surfaces	$84
2160	Amalgam Three Surfaces	$106
2161	Amalgam Four Surfaces	$142
2330	Composite One Surface	$58
2331	Composite Two Surfaces	$87
2332	Composite Three Surfaces	$108
	Endodontic – Root Canals	
3220	Pulpotomy	$87
3310	Anterior Root Canal	$250
3320	Bicuspid Root Canal	$300
3330	Molar Root Canal	$450
3410	Apicoectomy, Anterior	$210

	Periodontics (treatment of gums and supporting structure of teeth)	
4210	Gingivectomy per Quadrant	$225
4260	Osseous Surgery per Quadrant	$350
4341	Perio-Scaling/Planing Per Quadrant	$58
4910	Periodontal Prophylaxis	$58
	Oral Surgery – Extractions	
7140	Simple Extraction	$60
7210	Surgical Extraction	$100
7220	Soft Tissue Impaction	$125
7230	Partial Bony Impaction	$200
7240	Full Bony Impaction	$300
	Adjunctive Services	
9110	Palliative Treatment	$29
9220	General Anesthesia (first 30 minutes)	$225
9310	Consultation	$87

BASIC PLAN COVERAGE ENDS HERE

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SECTION 2
COMPREHENSIVE PLAN

(Includes all BASIC services PLUS the following)

Major Prosthetic Services - Five year replacement limitation

	Crowns	
2740	Porcelain Crown	$493
2750	Porcelain to Metal Crown	$580
2790	Full Cast Metal Crown	$435
	Other Crown Services	
2920	Replacement Crown	$43
2950	Core Build-Up/Including Any Pins	$50
2952	Post and Core, indirectly fabricated	$145
2954	Post and Core, prefabricated	$145
6930	Replacement Fixed Partial Denture	$58
	Removable Prosthetics – Dentures	
5110	Complete Upper Denture	$600
5120	Complete Lower Denture	$600
5213	Upper Partial Denture/Resin Base	$540
5214	Lower Partial Denture/Resin Base	$540
5510	Repair Broken Full Denture Base	$87
5640	Replace One Broken Tooth on Denture	$87

5650	Add Tooth to Existing Partial Denture	$87
5730	Reline Full Upper Denture (Office)	$145
5750	Reline Full Upper Denture (Lab)	$232
	Bridge Crowns	
6240	Porcelain to High Noble Metal Pontic	$435
6750	Porcelain to High Noble Metal Crown	$580
6751	Porcelain to Base Metal Crown	$580
6752	Porcelain to Noble Metal Crown	$580

COMPREHENSIVE PLAN COVERAGE ENDS HERE

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SECTION 3
COMPREHENSIVE WITH ORTHODONTIA PLAN

(Includes all COMPREHENSIVE PLAN services PLUS the following)

Orthodontia Services

Procedure	
Diagnosis, construction, and Insertion of appliances	$210
Active Treatment Plan	
Monthly payment (20 months)	$60
Maximum for Active Treatment	$1,200
Passive Treatment Plan	
Payment per 6 month treatment	$30
Maximum for Passive Treatment	$90

COMPREHENSIVE WITH ORTHODONTIA PLAN COVERAGE ENDS HERE

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Dental Network Participating Dentists

Service Employees Benefit Fund has an agreement with certain participating dentists to provide paid-in-full benefits for the services listed on the dental benefit schedule. You are provided with a list of participating dentists upon enrollment and upon request. There is no additional charge to you for covered services within the $1,500 per person, per calendar year maximum. Our payment will be sent directly to the participating dentist unless otherwise indicated.

Other Dental Providers

You can receive your dental care from any non-participating dentist and be reimbursed according to the dental benefit schedule. You will be responsible for any balance that may be due to the dentist.

Miscellaneous

Notwithstanding the Plan Exclusions, with the permission of the Trustees, dentists that are related to a Participant or Beneficiary may provide dental services. The Board of Trustees shall have the sole and exclusive right to decide whether such permission is granted.

Dental Plan Limitations

Exams – two per calendar year
Cleanings – two per calendar year
Bitewing X-rays – four per calendar year
Full Month or Panorex X-ray – one every three years
Fluoride covered to age 19
Sealants covered to age 14
Periodontal Scaling – two quadrants per visit
Full Mouth Debridement – limited to once per calendar year
Prosthetics (crowns, bridgework, partials and dentures) are limited to five year replacement

Dental Plan Exclusions

Cosmetic services
Bleaching
Implants
Oral hygiene instruction
Infection control
Temporary prosthetics
Adult fluoride

F. SUPPLEMENTAL DISABILITY BENEFITS

This Plan provides supplemental disability benefits if the applicable collective bargaining agreement or participation agreement allows for these benefits. You may refer to the summary at the end of this booklet or contact the Fund Office to determine if you have supplemental disability coverage with the Fund.

If you become disabled because of an injury or illness that requires regular care and treatment by a physician and keeps you from working at your regular job, you may be eligible for the supplemental disability benefits. This disability benefit is paid in addition to any benefits from Workers' Compensation or New York State Disability that you receive by filing a claim with your employer. This Plan's disability payment begins on the 8th consecutive day of disability and continues as long as you are disabled to a maximum of 26 weeks within a 52-week period. No disability is considered to begin more than three days before your first visit to a physician.

On-The-Job Coverage

If you become disabled because of an injury at work or work-related illness, this Plan will pay you $20 per week disability benefits in addition to benefits you may receive from Workers' Compensation.

Off-The-Job Coverage

If you become disabled because of a non-work-related injury or illness, this Plan will pay you $35 per week disability benefits in addition to benefits you may receive from New York State Disability.

Reinstatement of Disability Coverage

If you receive disability payments for the maximum 26 weeks within a 52-week period, you will again be eligible for supplemental disability benefits after working in contributed employment for four consecutive weeks.

G. WEEKLY DISABILITY BENEFITS

This Plan provides weekly disability benefits if the applicable collective bargaining agreement or participation agreement allows for these benefits. You may refer to the summary at

the end of this booklet or contact the Fund Office to determine if you have weekly disability coverage with the Fund. This benefit is payable to you if you are unable to work due to a disability caused by a non-work-related injury or illness.

In order to receive the weekly disability benefit, you or your employer must have paid at least six months worth of premiums for this benefit to the Plan. This benefit is offered to employees only, not dependents. If you have New York State Disability Insurance through your employer, you may still enroll for this coverage to supplement your employer's disability insurance benefit. The Fund will require proof of your disability from your physician, so your coverage is not terminated. The Fund may require you to submit continued proof of disability depending on the length of your disability.

Disability benefits are paid beginning the first day of disability due to a non-work related accident/injury and the eighth consecutive day due to a non-work related illness. There is no coverage for a work-related accident or illness. These incidents should be filed through Workers' Compensation.

Benefit Payment

You will receive one-half of your average weekly wage (averaged over the eight weeks prior to disability) up to a maximum of $170.00 per week. You may receive the benefit for a maximum of 26 weeks during one period of disability or within 52 consecutive weeks. If this benefit is employer-paid, Social Security tax will be withheld from your weekly payment and reported to the federal government. If this benefit is payroll-deducted, Social Security tax will not be withheld.

Benefit Waiting Period

There is a six-month waiting period of paid premiums before you are eligible for benefit payment. If you become disabled during the first six months of your enrollment:

- No premium payment is required during your disability;
- No benefit will be paid until you return to work and meet the six-month premium-paid waiting period;
- The premiums you paid before your disability will be included in the six-month waiting period if you continue paying the premium from the first month you return to work;
- If you do not resume paying the premium the first month back to work, you cannot reenroll for coverage until the next enrollment period that comes after 12 months from the last month the premium was paid. No prior paid premiums will be credited to your new six-month waiting period;

- You must send the Fund proof of disability from your physician in order to get credit for premiums that you paid during your waiting period before your disability began;

- Once you meet the six-month waiting period, you will be eligible to receive disability payments for any verified non-work related injury or illness, even if it is the same or related condition that you had before you met your waiting period; and

- The same rules apply to work-related disability only for the purpose of determining the date you finish your six-month waiting period.

Premium Payment

The coverage can be provided as an employer-paid benefit through contract negotiations or you can pay for it through a payroll deduction that requires your employer to send the Fund your full premium each month. If you pay all or part of the premium through a payroll deduction and it is discontinued for any reason except that you are on a work-related or non-work-related disability, you cannot reenroll for coverage until the enrollment period that comes after 12 months from the last month the premium was paid. No premium payment is required while you are on a verified work-related or non-work-related disability. You may contact the Fund Office to determine the amount of the weekly disability premium.

Exclusions

You will not be entitled to weekly disability benefits:

- for more than 26 weeks during one period of disability or within 52 consecutive weeks;

- for any disability period during which you are not under the care of a licensed physician;

- for any disability period during which the Fund does not receive a properly completed claim form or proof of continued disability when required;

- for any work-related injury or illness;

- for any continuing disability that began prior to your effective date;

- for any day of disability that you perform work for remuneration or profit;

- for any disability caused by your willful intent to make yourself or anyone else sick or injured;

- for any injury or illness due to an illegal act; or

- for any disability due to any act of war, declared or undeclared.

If you are a non-bargaining unit employee, you will be entitled to this benefit only if your employer has a Participation Agreement with the Fund for non-bargaining unit employees.

H. DEATH BENEFITS

This Plan provides death benefits if the applicable collective bargaining agreement or participation agreement allows for these benefits. You may refer to the summary at the end of this booklet or contact the Fund Office to determine if you have death benefits coverage with the Fund. The amount of the benefit is determined by the applicable collective bargaining agreement.

The death benefit is paid directly from this Fund instead of a life insurance company. The death benefits are payable to your named beneficiary if you die while eligible for these benefits. No death benefits are payable for a loss contributed to or caused by suicide or attempted suicide.

This Plan provides a $2,000 death benefit and a $2,000 accidental death and dismemberment (AD&D) benefit for retired Participants only (not spouses) as long as: (a) you were continuously eligible for active Participant medical coverage from the Fund in each of the 60 consecutive months immediately prior to your retirement date; (b) you are entitled to receive a monthly pension from the Service Employee Pension Fund of Upstate New York or the pension plan of a participating employer that is established and maintained according to the employer's collective bargaining agreement with 1199 SEIU United Healthcare Workers East or SEIU Local 200United; and (c) you were eligible for a death benefit through this Plan as an active Participant. Your Retired Participant coverage terminates on the date of your death.

To make sure your death benefits are paid to the person of your choice, you need to file a beneficiary card with the Fund Office. If you never completed an enrollment card naming a beneficiary, or if you want to change your beneficiary, you can obtain a card by calling the Fund Office. List all beneficiaries on the card if you want your death benefits to be paid to more than one person. Only the beneficiary or beneficiaries named on your card will be entitled to benefits. Whoever you name as your beneficiary is confidential. If there is no designated Beneficiary according to Fund records, the death benefits shall be paid as follows:

(a) First – to your widowed spouse or domestic partner. If your widowed spouse or domestic partner is not living, then

(b) Second – to your children in equal shares. If you do not have any children, then

(c) Third – to your parents or siblings in equal shares. If your parents and siblings are deceased, then

(d) Fourth – to your duly appointed and qualified executor and administrator. If no executor or administrator is appointed and qualified within 60 days following receipt by the Trustees of notice of the death of the Participant, then

(e) Fifth – the Trustees will take appropriate action to obtain a judicial determination as to the distribution of any death benefit.

I. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

This Plan provides accidental death and dismemberment benefits if the applicable collective bargaining agreement or participation agreement allows for these benefits. You may refer to the summary at the end of this booklet or contact the Fund Office to determine if you have accidental death and dismemberment benefits coverage with the Fund.

If you are an active participant eligible for death benefits from the Fund, the accidental death and dismemberment benefits are payable if, within 90 days of an accidental injury and because of the injury, you lose: (i) your life; (ii) a hand at or above the wrist joint; (iii) a foot at or above the ankle joint; or (iv) an eye causing complete, irrecoverable blindness.

Loss Of	**Benefit Payment**
Life	Full Amount
Both Hands or Both Feet or Sight in Both eyes	Full Amount
One Hand and One Foot	Full Amount
One Hand or One Foot and Sight in One Eye	Full Amount
One Hand or One Foot	One-Half the Full Amount
Sight in One Eye	One-Half the Full Amount

No more than your full accidental death and dismemberment benefit is payable for all losses because of one accident.

Proof of Eligibility

Payment will be made when the Fund Office receives proof that:

(a) you sustained an accidental injury that caused an injured loss; and

(b) the injury happened when you were eligible for coverage under this Plan; and

(c) the loss occurred within 90 days of the accidental injury.

Benefit Limitations

Benefits are paid for only losses caused by accidents. No benefits are payable for a loss contributed to or caused by:

1. Bodily or mental infirmity;

2. Disease, ptomaines or bacterial infections;*

3. Medical or surgical treatment;*

4. Suicide or attempted suicide;

5. Intentionally self-inflicted injury;

6. Committing or attempting to commit an assault or a felony;

7. Active participation in a riot;

8. Voluntary use of any controlled substance unless prescribed by a doctor; and

9. War or any act of war, declared or undeclared.

* Benefits will be paid for loss caused by an infection resulting from the injury or by surgery needed because of the injury.

There is no accidental death and dismemberment benefit for your covered dependents.

J. DEPENDENT DEATH BENEFIT

This Plan provides a benefit in the event of death of your dependent (including spouse, domestic partner, or dependent child) if the applicable collective bargaining agreement or participation agreement allows for these benefits. You may refer to the summary at the end of this booklet or contact the Fund Office to determine if you have this coverage with the Fund. The amount of the benefit is determined by the applicable collective bargaining agreement.

III. PLAN EXCLUSIONS

Notwithstanding any other provision of this booklet to the contrary, the Plan will not make payment or reimbursement for expenses incurred for, caused by, or resulting from the following:

1. Medical expenses incurred because of any work-related injury for any occupation or employment for wage or profit, or any work-related disease with benefits payable by Workers' Compensation or similar law (except life insurance, accidental death/dismemberment, and disability benefits);

2. Charges not specifically listed as covered medical services under this Plan;

3. Charges you or your dependents incurred before the date you each become eligible for coverage or after the date your coverage terminated;

4. Services that are not recommended or approved by a physician;

5. Expenses for any treatment, services, supplies, hospitalization, or any hospital charges that are not medically necessary and/or not ordered by a physician practicing within the scope of the physician's license;

6. Services with no charge billed to you or your dependents;

7. Charges with benefits payable by any other group insurance plan, including, but not limited to, group Blue Cross or Blue Shield plans, governmental plans under any name, mandatory no-fault insurance; or any other health plan;

8. Charges incurred for chronic hospital care when it: (a) is for custodial treatment of a permanent disease; (b) may be caused by nonreversible pathological alteration; or (c) may be expected to require a long period of supervision, observation or care;

9. Charges incurred while at a nursing home, place for the aged, place of rest, or an institution of training;

10. Any claim that is payable by Medicare or would be payable by Medicare if the covered person was properly enrolled for the applicable programs, unless as provided in the portion of this booklet dealing with the coordination of benefits with Medicare;

11. Cosmetic surgery unless it is: (a) necessary because of an accidental injury; (b) reconstructive surgery that is incidental to or after surgery because of trauma, infection, or other diseases of the involved part; or (c) reconstructive surgery because of a congenital disease or anomaly of a covered dependent child which resulted in a functional defect;

12. Charges for radial keratotomy or any other surgical procedure to correct myopia (near sightedness) or hyperopia (far sightedness);

13. Charges for experimental procedures as defined by this Plan;

14. Charges for confinement or services in a hospital or institution owned or operated by the federal government, except if injury or illness charges are not related to military service;

15. Reasonable and customary charges payable by this Plan for services and supplies unrelated to military service, incurred by: (a) you or your dependent at a Veteran's Administration facility; or (b) you, as an armed service retiree, or your dependent;

16. Charges for confinement or services in a hospital or institution owned or operated by a state or municipal government unless a charge is made;

17. Educational testing or training because of mental, nervous, or emotional conditions;

18. No benefits or plan assets will be paid or expended from this Plan to cover expenses related to an injury, condition, or disease resulting from directly or indirectly being engaged in, or incurred while committing, an Illegal Act. For the purpose of this exclusion, the term "Illegal Act" means any action or omission that is contrary to, or in violation of, any statute, rule, regulation, ordinance, court order, or other established custom having the force and effect of law. The Plan's Trustees reserve the exclusive right to determine, in their sole discretion, whether an action or omission is an Illegal Act based upon the facts and circumstances involved in the case and regardless of whether a criminal prosecution or conviction resulted. Additionally, no benefits or plan assets will be paid or expended from this Plan to cover expenses related to an injury, condition, or disease resulting from directly or indirectly being engaged in a war or any act of war, declared or undeclared, participating in a riot, or committing an intentional, self-inflicted act. The Plan's Trustees reserve the exclusive right to determine, in their sole discretion, whether charges are not covered because of this provision based upon the facts and circumstances involved in the case. In accordance with the source of injury rules established pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), this exclusion shall not be interpreted to exclude coverage related to injuries incurred as a result of domestic violence and/or self-inflicted injuries that are the result of depression or mental illness.

19. Charges for which some other third party is responsible unless you sign this Fund's Subrogation Agreement and other required documentation;

20. Charges for the donor, organ procurement, and patient and family transportation for organ and tissue transplants;

21. Charges for telephone consultations or for completion of claim forms or other medical reports;

22. Charges billed by providers other than hospitals, physicians, and other medical providers, including services provided by your immediate family members;

23. Charges for treatment leading to or in connection with transsexual surgery;

24. Charges for treatment of sexual dysfunction unrelated to organic disease; and

25. Charges that are not usual, customary, and reasonable. The Fund will only pay benefits related to charges that are usual, customary, and reasonable, meaning the level and amount of charges reflects the actual claims experience in a given area across a range of providers. In the determination of usual, customary, and reasonable, the Fund will consider the lowest of: (i) the actual charge for the service; (ii) the charge that the doctor or other provider usually charges at that time for the same or similar service or supply; or (iii) the charge that other doctors or providers in the same or similar geographic area charge for the same or similar service of supply. The term "area" as it would apply to any particular service, medicine, or supply means a zip code, county, or such greater area as is necessary to obtain a representative cross section of level charges. The part of the cost that exceeds that of any other services that would have been sufficient to satisfy and adequately diagnose or treat an individual's physical or mental condition will not be deemed as usual, customary, and reasonable. The determination as to whether a charge is usual, customary, and reasonable shall be made by the Fund's Trustees in their exclusive discretion.

IV. CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003, a federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that health plans protect the confidentiality of your Protected Health Information ("PHI"). A summary of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you in accordance with HIPAA and which is available from the Plan's Privacy Official.

This Plan and the Plan Sponsor (the Plan Sponsor for HIPAA purposes is the Board of Trustees of the Service Employees Benefit Fund) will not use or disclose your PHI except as necessary for treatment, payment, health care operations and plan administration, or as permitted or required by law. Payment includes activities undertaken by the Plan to determine or fulfill its responsibility for coverage and the provision of plan benefits that relate to an individual to whom health care is provided. The activities include, but are not limited to, the following:

(a) determination of eligibility, coverage and cost-sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for a participant's claim);

(b) coordination of benefits;

(c) adjudication of health benefit claims (including appeals and other payment disputes);

(d) subrogation of health benefit claims;

(e) COBRA contributions;

(f) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(g) billing, collection activities and related health care data processing;

(h) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

(i) obtaining payment under a contract for reinsurance (including stop loss and excess loss insurance);

(j) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(k) utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(l) disclosure to consumer reporting agencies related to reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(m) reimbursement to the Plan.

Health Care Operations include, but are not limited to, the following activities:

(a) quality assessment;

(b) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(c) rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(d) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(e) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(f) business management and general administrative activities of the Plan, including, but not limited to management activities relating to the implementation of, and compliance with, HIPAA's administrative simplification requirements;

(g) resolution of internal grievances; and

(h) due diligence regarding a merger with a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the merger, will become a covered entity.

Only the employees of the Service Employees Benefit Fund who assist in the Plan's administration and the Board of Trustees of the Service Employees Benefit Fund will have access to your PHI. These individuals may only have access to use and disclose your PHI for plan administration functions. This Plan provides a complaint mechanism for resolving noncompliance matters. If these individuals do not comply with the above rules, they will be subject to disciplinary sanctions. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules.

The Plan will not, without your authorization, use or disclose your PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

HIPAA provides that this Plan may disclose your PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that it agrees to: (a) not use or further disclose the information other than as permitted or required by the Plan documents or as required by law; (b) ensure that any agents, including a subcontractor, to whom it provides PHI received from this Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (c) not use or disclose the information for employment-related actions and decisions unless authorized by you; (d) not use or disclosure the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by you; (e) report to this Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) make PHI available to you in accordance with HIPAA's access requirements; (g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA; (h) make available the information required to provide an accounting of disclosures; (i) make its internal practices, books, and records relating to the use and disclosure of PHI received from this Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by this Plan with HIPAA; (j) if feasible, return or destroy all PHI received from this Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) maintain adequate separation between the Plan and the Plan Sponsor. The Plan Sponsor has made such Certification to the Plan.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with this Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Effective April 21, 2005, the Plan Sponsor will:

(a) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) ensure that the adequate separation between the Plan and the Plan Sponsor, as required by HIPAA, with respect to electronic protected health information, is supported by reasonable and appropriate security measures;

(c) ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate security measures to protect the information; and

(d) report to the Plan any security incident of which it becomes aware concerning electronic protected health information.

This Plan's privacy notice provides a summary of your rights under HIPAA's privacy rules. Please contact **Tammy A. McManus** if: (a) you wish to obtain a copy of the notice; (b) you have questions about the privacy of your health information; or (c) you wish to file a complaint under HIPAA.

V. CLAIM FILING INSTRUCTIONS

Send Your Claims to the Fund Office

Typically, your physician or medical service provider will submit medical claims on your behalf to the Fund or the insurance carrier, Excellus BlueCross BlueShield. However, if you have questions about the initial handling of your medical claims, your can visit the insurance carrier's website (www.excellusbcbs.com/sebf) or call (877) 650-5840.

All dental, optical, and disability claims must be sent to the Fund Office with an itemized bill or a properly completed claim form and any other information required to process your claim. Send these claims to:

Service Employees Benefit Fund
P.O. Box 1240
Syracuse, NY 13201

No benefit payment will be made until the Fund Office receives all required information.

A. CLAIM FILING DEADLINES

The Fund will pay benefits for the period covered by the statement on the claim form or itemized bill that you submit to the Fund Office. If the disability continues beyond that period, another claim form must be filed. The deadline to file a claim for dental and optical benefits with the itemized bill is 90 days after the date of service. No itemized bill is needed for a dental claim if your dentist completes the claim form. Claim forms for supplemental and weekly disability benefits must be completed by you, your physician, and your employer, and submitted within 90 days after your original disability date. Claim forms for death benefits and accidental death and dismemberment benefits must be fully completed and submitted within 90 days from the date of death or accident.

Final Deadline: The final deadline to file a claim for any benefit is 12 months from the date of the service or other event that led to the claim. No benefit payment will be made if a claim is filed after the final deadline.

B. PHYSICAL EXAMINATIONS

Our Fund will have the right and opportunity, at its expense, to examine any claimant at all reasonable times while that person's claim is pending.

C. PAYMENT OF BENEFITS

The Fund will pay dental, optical, and disability benefits as soon as possible after the Fund Office receives the correctly completed claim form, itemized bills, and all other information needed to properly process your claim and approve the payment of the claim. Death benefits will be paid to your designated beneficiary and according to the Plan rules for paying death benefits.

D. CLAIM REVIEW AND APPEAL PROCEDURES

Initial Decisions

Time Frames

Medical Benefits (Including Optical, Prescription Drug and Dental Benefits)

For these medical claims, the rules that apply depend on the type of claim. There are four types of claims: Pre-Service, Urgent, Concurrent, and Post-Service. A Pre-Service Claim is any claim with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. An Urgent Care Claim is a Pre-Service Claim for medical care or treatment in which application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. A Concurrent Care Claim is a claim involving a pre-approved, ongoing course of treatment, including a request for extension of a course of treatment. A Post-Service Claim means any claim that is not a Pre-Service claim, i.e., prior Plan approval is not a prerequisite to obtaining medical care and payment is being requested for medical care already rendered to the claimant.

Pre-Service Claims

The receipt of some medical benefits may be conditioned on advance approval from the Plan Administrator. Claims for such benefits are considered Pre-Service Claims, as defined above. For Pre-Service Claims, you will be notified of the Plan's determination (whether adverse or not), within a reasonable period, but not later than 15 days after receipt of the claim. The 15-day period may be extended for up to 15 days for matters beyond the Plan's control if, before the end of the initial 15-day period, you are notified of the reasons for the extension and of the date by which the Plan Administrator expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and the claimant will have 45 days from receipt of the notice to provide the specified information. A decision will then be made within 15 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information. In addition, if the claim is improperly filed, the Plan Administrator will provide notice of the failure within 5 days.

Urgent Care Claims

The rules are slightly different for Pre-Service Claims that involve urgent care, i.e., Urgent Care Claims. For Urgent Care Claims, you will be notified by the Plan Administrator regarding the benefit determination (whether adverse or not) as soon as possible, and not later than 72 hours after receipt, unless you fail to provide sufficient information to decide the claim. In the case of a failure to provide sufficient information or to follow filing procedures, you will be notified of the failure as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information needed to complete the claim. Notification of the decision on that claim will then be provided within 48 hours after the Plan Administrator's receipt of the specified information or the

end of the additional period afforded you to provide such information. Notification can be made orally, provided a written or electronic communication is provided within 3 days of the oral notification.

Concurrent Care Claims

If the Plan Administrator has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment is an adverse benefit determination. You will receive notice of such an adverse determination sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the reduction or termination occurs. Also, for any request to extend an urgent care ongoing course of treatment beyond the initially-prescribed period of time, you will be notified of the determination (whether adverse or not) within 24 hours after receipt of the claim, if the claim is made at least 24 hours before the end of the initially-prescribed period of time or number of treatments.

Post-Service Claims

For Post-Service Claims, you will be notified of any adverse benefit determination within a reasonable period, but not later than 30 days after receipt of the claim. The 30-day period may be extended for up to 15 days for matters beyond the plan's control if, before the end of the initial 30-day period, the plan notifies you of the reasons for the extension and of the date by which the plan expects to render a decision. If the extension is needed because you did not submit the information necessary to decide the claim, the notice of extension will describe the required information and give you at least 45 days from receipt of the notice to provide it. A determination will then be made within 15 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information.

Supplemental Disability and Weekly Disability Benefits

If your claim for Supplemental Disability or Weekly Disability Benefits is denied in whole or in part for any reason, then within 45 days after the Plan receives your claim, the Plan will send you written notice of its decision. This period may be extended for up to two 30-day periods due to matters beyond the control of the Plan. For any extensions, the Plan will provide advance written notice indicating the circumstances requiring the extension and the date by which the Plan expects to render a decision. Any notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues (if any), and you shall be afforded at least 45 days within which to provide specified information (if applicable). A decision will then be made within 30 days after the earlier of the date you supply the requested information or the date by which you must provide the additional information.

Participant Death Benefit, Participant Accidental Death & Dismemberment Benefit, and Dependent Death Benefit

If your claim for Participant Death Benefit, Participant Accidental Death & Dismemberment Benefit and Dependent Death Benefit is denied in whole or in part for any reason, then within 90 days after this Plan receives your claim, this Plan will send you written notice of its decision unless special circumstances require an extension, in which case the Plan will send you written notice of the decision no later than 180 days after the Plan receives your claim. If an extension is necessary, you will be given written notice of the extension before the expiration of the initial 90-day period, which shall indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the benefit determination. However, any decision regarding a death benefit that is based on a finding of total and permanent disability is subject to the same rules that apply to Disability Benefits.

Content of Notification of Initial Adverse Benefit Determination

In an initial notification of adverse benefit determination, the notification shall set forth:

1. The specific reasons for the adverse determination;

2. Reference to the specific plan provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the determination is based;

3. A description of any additional material or information necessary for you to complete the claim and an explanation of why such material or information is necessary;

4. A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;

5. In the case of an adverse determination involving the claim for urgent care, a description of the expedited review process applicable to such claims;

6. If an internal rule, guideline, or protocol was relied upon in making the adverse determination, the rule, etc., or a statement that the rule was relied upon and that a copy of it will be provided free of charge upon request; and

7. If the adverse benefit determination is based on medical necessity or experimental treatment, either an explanation of the scientific judgment for the determination, applying the plan's terms to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request.

Notice of an adverse benefit determination will also include the following:

a. Information sufficient to identify the claim, including the date of service, the health care provider, the claim amount, any applicable denial code and its corresponding meaning (if applicable), including a description of the Plan standards used in denying

the claim, and a description of your right to request diagnosis and treatment codes and their corresponding meanings (if applicable);

b. A description of the Plan's standard that was used in denying the claim;

c. A detailed description of the available internal appeals and external review processes, including information regarding how to start an appeal; and

d. The availability of, and contact information for, the New York State Department of Financial Services for additional information or assistance with your claim.

The Plan (or the insurer, if applicable) will also disclose, free of charge, any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim, and any new or additional rationale on which a final adverse benefit determination will be based. This information will be made available sufficiently in advance of an appeal decision deadline so that the claimant has adequate time to respond.

Appeals of Adverse Benefit Determinations

An adverse benefit determination is defined as: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, or failure to provide or make payment that is based on a determination of a participant's eligibility to participate in this Plan; (2) a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and (3) a rescission of coverage, which is defined as any cancellation or discontinuance of coverage that has a retroactive effect, except to the extent that it results from fraud, the misrepresentation of a material fact, or the failure to pay a required premium or contribution toward the cost of coverage.

If you are not satisfied with the reason or reasons why your claim was denied, then you may appeal to the Board of Trustees. To appeal an adverse determination of all health-related benefits, you must follow the procedures set forth in the Plan document. You must be given at least 180 days to file an appeal. To appeal an adverse benefit determination of a Participant Death Benefit, Participant Accidental Death & Dismemberment, or Dependent Death Benefit claim, you must follow the procedures set forth by the Plan and must be given at least 60 days to file an appeal. To appeal an adverse benefit determination of a Supplemental Disability or Weekly Disability Benefit claim, you must follow the procedures set forth in the Plan document and be given 180 days to file an appeal. Notwithstanding anything in this paragraph to the contrary, for Concurrent Claims involving a reduction or termination of a pre-approved, ongoing course of treatment, you will be afforded a reasonable period of time to appeal.

For appeals to the Board of Trustees, your correspondence (or your representative's correspondence) must include the following statement: "I AM WRITING IN ORDER TO APPEAL YOUR DECISION TO DENY ME BENEFITS. YOUR ADVERSE BENEFIT DETERMINATION WAS DATED _____, 20____." If this statement is not included, then the Trustees may not understand that you are making an appeal, as opposed to a general

inquiry. If you have chosen someone to represent you in making your appeal, then your letter (or your representative's letter) must state that you have authorized him or her to represent you with respect to your appeal, and you must sign such statement. Otherwise, the Trustees may not be sure that you have actually authorized someone to represent you, and the Trustees do not want to communicate about your situation to someone unless they are sure he or she is your chosen representative.

You shall have the opportunity to submit written comments, documents, records, and other information related to the claim for benefits. You shall also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In addition, in regard to all appeals other than those involving Participant Death Benefits, Participant Accidental Death & Dismemberment Benefits, and Dependent Death Benefits: (1) the review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination nor the subordinate of such individual; (2) insofar as the adverse benefit determination is based on medical judgment, the Board will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment; (3) such health care professional shall not be the individual, if any, who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and (4) medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the adverse benefit determination, will be identified.

Special Rule Regarding Urgent Care Claims:

If Urgent Care Claims are involved, you may request an expedited appeal, either orally or in writing, and all necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan (or the insurance company, as applicable) by telephone, facsimile, or other similarly expeditious method. Further, if the appeal involves an Urgent Care Claim, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative. In certain circumstances, you may also have the right to request an expedited independent external review as described under the Section titled "External Review," below.

Appeals of Adverse Eligibility Determination

If you disagree with the determination of the Fund Manager contained in the Fund Manager's letter addressed to you regarding your loss of eligibility due to your contributing employer's failure to pay premiums, you are entitled to appeal the Fund Manager's determination to the Board of Trustees. You must appeal to the Trustees in writing within 30 days of the date of the letter, and your letter must include the following statement: "I AM WRITING IN ORDER TO APPEAL THE FUND MANAGER'S DETERMINATION TO DENY ME ELIGIBILITY FOR BENEFITS (WHETHER REGARDING A PENDING CLAIM OR ELIGIBILITY FOR A

POTENTIAL CLAIM). THE FUND MANAGER'S LETTER DENYING MY ELIGIBILITY WAS DATED _____, 20__." If you have chosen someone to represent you in making your appeal, then your letter (or your representative's letter) must state that you have authorized him or her to represent you with respect to your appeal, and you must sign such statement.

Determinations on Appeal

Time Frames

Pre-Service Claims: The Plan Administrator will notify you of the decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the request for review. Any insurer will decide appeals of claims in accordance with the ERISA regulations within the same time frame (except that if the insurer provides two (2) levels of appeal, the decision has to be made within 15 days at each level).

Urgent Care Claims: The Plan Administrator will decide and communicate to you its decision on appeal as soon as possible, taking into account medical exigencies, but not later than 72 hours after receipt of the request for review. The insurance company will decide appeals of insured claims within the same time frame in accordance with ERISA regulations.

Post-Service Claims: The Plan Administrator will notify you of its decision on appeal within a reasonable period of time appropriate to the medical circumstances, but not later than 60 days after receipt of the request for review (except that if an insurer provides two (2) levels of appeal, the decision has to be made within 30 days at each level).

Supplemental Disability Benefit, Weekly Disability Benefit, Participant Death Benefit, Participant Accidental Death & Dismemberment Benefit, and Dependent Death Benefit Claims: Appeals of adverse Supplemental Disability Benefit and Weekly Disability Benefit determinations must be determined by the Plan within 45 days (plus a possible 45-day extension, if necessary). Appeals of adverse Participant Death Benefit, Participant Accidental Death & Dismemberment Benefit, and Dependent Death Benefit determinations must be determined by the Plan within 60 days (plus a possible 60-day extension, if necessary).

All Other Claims: The Trustees at their next regularly scheduled meeting will make a determination of the appeal. However, if the appeal is received less than 30 days before the meeting, the decision may be made at the second meeting following receipt of the request. If special circumstances require an extension of time for processing, then a decision may be made at the third meeting following the date the appeal is made. Before an extension of time commences, you will receive written notice of the extension, describing the special circumstances requiring the extension and the date by which the determination will be made. The Plan will notify you of the benefit determination not later than 5 days after the determination is made.

Content of Adverse Benefit Determination on Review

The Plan's written notice of the Board's decision will include the following:

1. The specific reasons for the adverse benefit determination;

2. Reference to specific plan provisions on which the determination is based;

3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

4. A statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, the notice will provide either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

6. If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, the written notice shall contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided upon request.

The notification of adverse benefit determination on review shall also set forth the following:

a. Information sufficient to identify the claim, including the date of service, the health care provider, any applicable denial code and its corresponding meaning (if applicable), including a description of the Plan standards used in denying the claim, the claim amount, and a description of your right to request diagnosis and treatment codes and their corresponding meanings (if applicable);

b. A statement of your right to request an external independent review of the adverse benefit determination (if applicable);

c. A description of the Plan's standard that was used in denying the claim as well as a discussion of the decision;

d. A detailed description of the available internal appeals and external review processes, including information regarding how to start an appeal; and

e. The availability of, and contact information for, the New York State Department of Financial Services for additional information or assistance with your claim.

The Plan (or the insurer, if applicable) will also disclose, free of charge, any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim, and any new or additional rationale on which a final adverse benefit determination will be based. This information will be made available sufficiently in advance of an appeal decision deadline so that the claimant has adequate time to respond.

The Trustees' Decision is Final and Binding

The Trustees' (or their designee's) final decision with respect to their review of any appeal will be final and binding upon you because the Trustees have exclusive authority and discretion to determine all questions of eligibility and entitlement under the plan. Any legal action against this Plan must be started within 180 days from the date the adverse benefit determination denying your appeal is deposited in the mail to your last known address.

As an alternative to seeking legal action concerning the Trustees' final decision, you also have the right to request an independent external review of your appeal within 4 months of receipt of the adverse benefit determination as described in the section titled, "External Review," below. More detailed information regarding your right to request an external review will also be provided by the insurance company.

External Review

You have the right to request an independent external review of an adverse benefit determination within four (4) months after receipt of the notice of an adverse benefit determination. This right only extends to adverse benefit determinations by the health insurance carrier or its designee utilization review organization that involve medical judgment or a rescission in coverage.

The external review will be made by an independent review organization with health care professionals who have no conflict of interest with respect to the benefit determination. Except for approved expedited external reviews, this external review is only available once you have exhausted the internal grievance process. You may request an external review by completing the request for external review with the insurance company. A copy of the full external review procedure will be provided upon request. You may also contact the New York State Department of Financial Services with any questions.

An expedited external review is available in the following two situations:

1. After an Adverse Initial Determination: An adverse initial determination involves a medical condition where the timeframe for completing an expedited appeal would seriously jeopardize the claimant's life or health or would jeopardize ability to regain maximum function, and the claimant requests an expedited appeal.

2. After an Adverse Appeal Decision: A final internal appeal decision involves a medical condition where the timeframe for completing a standard external review would

seriously jeopardize the claimant's life or health or would jeopardize ability to regain maximum function, or the appeal decisions concerns an admission, availability of care, continued stay, or a health care item or service for which the claimant received emergency services but has not been discharged from a facility.

Claims and appeals adjudicated in accordance with these procedures are handled in a manner designated to ensure the independence and impartiality of the person involved such that decisions regarding hiring, compensation, termination, promotion, or similar matters with respect to any individual (such as claims adjustor or medical expert) are not made based on the likelihood that the individual will support the denial of benefits.

E. PLAN INTERPRETATION AND DETERMINATIONS

The Trustees are responsible for interpreting this Plan and for making determinations under the Plan. In order to carry out this responsibility, the Trustees have exclusive authority and discretion: to determine whether an individual is eligible for any benefits under the Plan; to determine the amount of benefits, if any, an individual is entitled to from the Plan; to determine or find facts that are relevant to any claim for benefits from the Plan; to interpret all of the Plan's provisions; to interpret all of this booklet's provisions; to interpret the provisions of any Collective Bargaining Agreement or written Participation Agreement involving or impacting this Plan; to interpret the provisions of the Trust Agreement governing the operation of this Plan; to interpret all of the provisions of any other document or instrument involving or impacting this Plan; and, to interpret all of the terms used in the Plan, this booklet and in all of the other previously mentioned agreements, documents, and instruments.

All such determinations and interpretations made by the Trustees, or their designee shall be final and binding upon any individual claiming benefits under the Plan and upon all employees, all employers, the SEIU Local 200United or 1199SEIU United Healthcare Workers East, and any party who has executed any agreement with the Trustees or the SEIU Local 200United or 1199SEIU United Healthcare Workers East; shall be given deference in all courts of law, to the greatest extent allowed by applicable law; and, shall not be overturned or set aside by any court of law unless the court finds that the Trustees, or their designee, abused their discretion in making such determination or rendering such interpretation.

Benefits under this Plan will be paid only if the Trustees decide, in their discretion, that you are entitled to them.

VI. GENERAL INFORMATION

A. INFORMATION CONCERNING ALL COVERAGES

This Fund provides self-insured benefits for medical, dental, optical, prescription drug, supplemental disability, weekly disability, death benefit, and accidental death and dismemberment benefits. Plan benefits for active or disabled participants are not guaranteed and may be changed by the Board of Trustees. The Trustees reserve the right to amend, modify, or discontinue the types and amounts of benefits provided by the Plan; the eligibility rules (including those providing, extending or accumulating eligibility even if extended eligibility was already accumulated); or, all or part of this Plan whenever, in their judgment, conditions make it necessary.

All Plan provisions are subject to the rules and regulations adopted by the Board of Trustees and the Trust Agreement which established the Fund and governs it. The nature and amount of Plan benefits are subject to the actual Plan as it exists on the date the claim is incurred. Contact the Fund Office if you have any questions about the terms of the Plan or proper payment of benefits.

B. NO LIABILITY FOR PRACTICE OF MEDICINE

Neither the Plan, the Trustees, nor any of their designees are engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care, or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, the Trustees, nor any of their designees will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

C. COORDINATION OF BENEFITS

The hospital, doctor, dentist, prescription drug, and optical benefits provided by our Plan are designed to help meet the cost of treatment and services you receive. No benefits are intended to be paid over the actual cost that you are charged.

Coordination of Benefits with Other Plans

Some people have other insurance coverage besides coverage from this Plan. When this happens, the amount of benefits payable under this Plan will consider any coverage a Participant or Beneficiary has under "other plans" so that the combined benefits under this Plan and the "other plans" will not be more than the total expenses incurred. Information necessary for the administration of this Coordination of Benefits provision will be required at enrollment or at the time a claim is submitted. If you are a person with other or additional benefit coverage, you must make full disclosure at enrollment or when filing a claim with this Plan. If you fail to disclose "other plan" information, this may be considered a fraudulent claim and disqualify you from receiving benefits from this Plan.

For coordinating benefits of other or additional coverage, "Plan" means any of the following which provides benefits or services for medical, prescription, dental, or optical treatment:

(a) any group insurance or group remittance subscriber contract;

(b) employer-sponsored coverage;

(c) group contracts other than individual insurance issued on a franchise basis;

(d) coverage under a governmental plan by virtue of employment;

(e) coverage required or provided by law; and

(f) medical benefits coverage in group and individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" contracts.

"Plan" does not include a state plan under Medicaid; benefits under a law or plan when, by law, its benefits are excess to those of any private insurance plan; or individual insurance for which the person is the policyholder and pays 100% of the premium.

Payment of Coordinated Benefits

Our Plan will pay its regular benefits in full, or in a reduced amount which, when added to benefits provided by other plans, will equal no more than 100% of the "allowable expenses" incurred. "Allowable expenses" are any necessary and reasonable expenses for medical services, treatment, or supplies covered by one of the plans under which you or your dependents are covered.

"Primary" and "Secondary" Plans

When coordinating benefits, if you have coverage from more than one plan, the "primary" plan pays first and the "secondary" plan pays next to make up the difference, but the total benefits paid by both the primary and secondary plans will not exceed 100% of the allowable expenses incurred. In addition, no plan will pay more benefits than it would normally provide without this special coordination of benefits provision. When another plan does not contain a Coordination of Benefits provision, it will always be considered the primary plan. Payment under the secondary plan is made after the amount payable by the primary plan has been determined.

Coordination of Benefits for Participants, Spouses, and Domestic Partners

If there is duplicate coverage provided by this Plan and another plan with a coordination of benefits provision, the Plan covering the person incurring the claim as an employee is the primary plan regardless of contrary terms maintained by the other plan. If the person who receives care is covered as an active employee under one plan and as an inactive employee under another, the coverage through active employment pays first as the primary plan. If husband and wife (or participant and domestic partner) are both covered as participants by this Plan and both have family coverage, benefits will be paid for both persons and their dependent children as if two separate plans were involved. If a person is covered by two plans through two jobs, the plan that covered the person longer pays first.

Coordination of Benefits for Dependent Children

For dependent children, primary plan status is determined under the following standards:

a. Under the "Birthday Rule" for coordinating benefits, the plan of the parent with the earliest birthday in the year (excluding year of birth) is the primary plan. The plan of the parent with the latest birthday (excluding year of birth) is the secondary plan.

b. When the parents are divorced, legally separated (per a judgment of separation or a duly executed and acknowledged separation agreement), or the participant and domestic partner have submitted a "Termination of Domestic Partnership," the order of the payment rule is as follows:

   i. the plan of the parent with custody is primary, and the other parent's plan is secondary, and

   ii. if the parent with custody is remarried, or has entered into and affirmed a committed family relationship that meets the definition and requirements of domestic partnership, as defined and prescribed by the Fund, the order of payment is: (1) the plan of the parent with custody; (2) the plan of the step parent with custody, and (3) the plan of the parent without custody.

c. If there is a court decree stating that one plan is responsible for your children's health care expenses, such parent's plan will pay first. That court decree will supersede any other rule above.

To implement these standards, send the claims for benefits to the primary plan first for payment. If you, your spouse, or your domestic partner are both covered as eligible participants by this Plan, benefits will be coordinated and paid for your eligible dependent children as if two separate plans were involved.

This Plan's Right to Make Coordination of Benefit Payments

Whenever payments are made by another plan that were to be made by this Plan according to the coordination of benefit rules, this Plan will have the right to pay that plan to satisfy the intent of the coordination of benefit rules. Whenever this Plan pays out more than is necessary to satisfy the intent of this coordination of benefits rule, this Plan has the right to recover the excess payment from any person to or for whom such payments were made, any other insurance company, or any other organization or plan. Payments made and the amounts paid are exercisable alone by this Plan and in its sole discretion. They are considered as benefits paid by this Plan; and, to the extent of these payments, this Plan is fully discharged from liability.

Coordination of Benefits Claim Filing Information

Whether this Plan is primary or secondary, the Fund Office needs all necessary information about other insurance coverage completed on your claim form before payment will be made for any claim involving coordination of benefits. If this Plan is primary, send the Fund Office your

original itemized bills along with your completed claim form. If this Plan is secondary, send your bills to your primary carrier first. After you receive payment or rejection of your claim from the primary carrier, send the Fund Office a copy of your bills, the payment or rejection statement, and your completed claim form.

D. COORDINATION OF BENEFITS WITH MEDICARE

The Fund will play Plan benefits in accordance with the Medicare Secondary Payor ("MSP") regulations for you and your eligible dependent's healthcare expenses. Medicare primary plan status is determined pursuant to these regulations, and revisions or amendments to these regulations will automatically apply to the Fund.

For individuals who are eligible for Medicare due to age (65 and over) or due to disability, Medicare is secondary to the Plan that covers this person as an active employee or the dependent of an active employee. For retirees or others who are not actively employed, Medicare is secondary only to the extent permitted by the MSP regulations. For individuals eligible for Medicare due to End-Stage Renal Disease ("ESRD"), Medicare is secondary for the first thirty months following the month of the first eligible ESRD treatment for this person. Once Medicare eligibility is established due to ESRD, the eligible person is entitled to full Medicare coverage. Medicare benefits are not limited to ESRD expenses.

If Medicare is found to be the primary payer for you or your dependent, the usual Plan benefit for a covered service will be reduced by the Medicare payment for that service. The Plan will pay the balance of the usual Plan benefit, if any, which results from this reduction. The combination of the Plan payment and the Medicare payment shall not exceed the usual Plan benefit for a covered expense. This integration will apply to persons eligible for Medicare whether or not actually enrolled in Medicare. If a Medicare eligible person is not enrolled in Medicare Part A or Part B and Medicare is found primary, the Medicare benefit will be estimated and used to reduce allowable fees. **This could result in significant reduction or denial of the Plan benefits.**

If the provider accepts Medicare assignment of benefits, the allowable fee will be the same fee allowed by Medicare. However, if the provider does not accept Medicare assignment, the allowable fee will be based on the usual, customary, and reasonable charge or the charge as determined by Medicare limiting charge regulations, whichever is the lower charge. According to Medicare regulations, a beneficiary cannot be billed the difference between the Medicare allowed amount and the provider's charge when that provider accepts Medicare assignment. If a provider does not accept assignment, a beneficiary cannot be billed for charges more than the limiting charge established by Medicare for that service by that provider.

Please note: If you or your dependent is eligible for Medicare primary benefits, claims should be submitted to Medicare first. Medicare explanation of benefits should be attached to your health claims forms.

E. FRAUDULENT CLAIMS

If it is determined that a fraudulent claim has been submitted, it will not be payable. If payment has already been made, reimbursement will be pursued by the Fund in accordance with

the following section describing overpayments. The Trustees may also impose a penalty on the claim not to exceed an amount equal to twice the amount claimed through fraud and/or may remove an individual from further participation in the Plan for a period of time not to exceed five (5) years.

F. RIGHT OF RECOVERY

In the event that a participant or a third party is paid benefits from the Plan in an improper amount or otherwise receives Plan assets not in compliance with the Plan (hereinafter referred to as "overpayments" or "mistaken payments"), the Plan has the right to start paying the correct benefit amount. In addition, the Plan has the right to recover any overpayment or mistaken payment made to you or to a third party. The claimant, third party, or other individual or entity receiving the overpayment or mistaken payment must pay back the overpayment or mistaken payment to the Plan with interest at the rate of 2% per month. Such a recovery may be made by reducing other benefit payments made to or on behalf of you, your spouse, your domestic partner, or dependents, by commencing a legal action or by such other methods as the Trustees, in their discretion, determine to be appropriate. The claimant, third party, or other individual or entity shall reimburse the Plan for attorneys' fees and paralegal fees, court costs, disbursements, and any expenses incurred by the Plan in attempting to collect and in collecting the overpayment or mistaken payment of benefits. The determination as to these matters is solely made by the Trustees.

G. CLAIMS INVOLVING THIRD PARTY LIABILITY

Note: This provision applies to all participants, spouses, domestic partners, dependent children, and other beneficiaries with respect to all of the benefits provided under this Plan. For the purpose of this provision, the terms "you" and "your" refer to all the individuals classified above.

General

Occasionally, a third party may be liable for your medical expenses. This may occur when a third party is responsible for causing your illness or injury, or is otherwise responsible for your medical bills. The Trustees, in their discretion, may determine to not provide benefits under the Plan for you if a third party may be responsible for the payment of benefits, until a determination is made by the proper and final decision-maker regarding the third party's responsibility to you. The rules in this Section govern how the Plan pays benefits, if at all, in such situations.

These rules have two purposes. First, the rules ensure that your benefits will be paid promptly. Often, where there is a question of third party liability, many months pass before the third party actually pays. These rules permit the Plan to pay your covered expenses until your dispute with a third party is resolved.

Second, the rules protect the Plan from bearing the full expense in situations where a third party is liable. Under these rules, once it is determined that a third party is liable in any way for the injuries giving rise to these expenses, this Plan must be reimbursed for the benefits it has advanced to you. That reimbursement must come out of any recovery whatsoever that you receive that is in any way related to the event which caused you to incur the medical expenses.

Rights of Subrogation and Reimbursement

If you incur covered expenses for which a third party may be liable, you are required to advise the Fund Office of that fact. By law, the Plan automatically acquires any and all rights which you may have against the third party. The Trustees may, in their sole discretion, require the execution of this Plan's Subrogation Agreement by you (or your authorized representative, if you are a minor or you cannot sign) before this Plan pays you any benefits related to such expenses. If the Trustees have required execution of the Plan's Subrogation Agreement, no benefits will be provided unless you, your spouse (if any), your domestic partner (if any), and your attorney (if any) sign the form. You must also notify the Plan before you retain another attorney or an additional attorney, since that attorney must also execute the Subrogation Agreement. The Plan's Subrogation Agreement must be signed by you and your attorneys and received at the Fund Office on the earlier of either (1) one year from the date of your accident; or (2) thirty (30) days after the date of the letter from the Fund Office forwarding the Subrogation Agreement to be signed or no benefits will be paid by the Plan for the expenses related to that accident.

IN NO EVENT SHALL THE FAILURE OF THE TRUSTEES TO REQUIRE EXECUTION OF THE SUBROGATION AGREEMENTS DIMINISH OR BE CONSIDERED A WAIVER OF THE PLAN'S RIGHT OF SUBROGATION AND REIMBURSEMENT.

At the Plan's request, you must complete a form(s) which includes, but is not limited to the following information:

1. The details of your accident or injury;

2. The name and the address of the person you claim caused the accident or injury as well as the name and address of that person's insurance company and attorney; and

3. The name and address of your attorney.

You must also:

1. Sign the Fund's Subrogation Agreement;

2. Have your attorney sign the Subrogation Agreement and return it to the Fund Office before any benefits are paid;

3. Provide the Fund Office with quarterly reports regarding the status of your third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.; and

4. Promptly respond to any inquiries from the Fund regarding the status of the third party claim or action including, but not limited to, motions, depositions, pretrial conferences, trial dates, settlement conferences, etc.

Your duty to provide this information to the Plan is a continuing one.

In addition to its subrogation rights, the Plan has the right to be reimbursed for payment made on your behalf under these circumstances. The Plan must be reimbursed from any settlement, judgment, or other payment that you obtain from the liable third party before any other expenses, including attorneys' fees and costs, are taken out of the payment regardless of how you or the Court characterize the nature of the recovery. In enforcing the Plan's rights to subrogation and reimbursement, the Trustees are not limited by any determination of the trier of fact as to the causal relationship between the injuries giving rise to these expenses and the liability of the third party if evidence exists which, in the opinion of the Trustees, supports causation.

The Plan must be paid in full without regard to whether you have received compensation for all of your damages and without regard to whether you have been "made whole". The Plan's rights of subrogation and reimbursement will not be affected, reduced or eliminated by the make-whole doctrine, comparative fault, or the common fund doctrine. The Plan has no responsibility to contribute to the payment of your attorneys' fees and costs with respect to any aspect of your representation including the third party action itself, the reimbursement action or any other matter.

Right of Future Subrogation and Reimbursement

In addition to satisfaction of the existing lien from any recovery by you, the Plan is also entitled to a future credit for future related expenses equal to the net proceeds received by you. "Net proceeds" shall be defined as the amount of your total recovery and/or judgment less payment in full of the amount of the Fund's lien, less payment of your attorneys' fees and costs related to the third party action. You must spend the net proceeds on medical or related expenses arising out of or related to the injuries which were the subjects of the third party action and which would have otherwise been covered by the Plan until the amount of the proceeds is exhausted.

It is only at that point that your further related Plan benefits will again be the responsibility of the Plan pursuant to the terms of the Plan. The Fund will not resume payment of medical and related benefits until such time as you have provided the Fund with proof that you have utilized the net proceeds of the recovery and/or judgment to pay for medical and related expenses arising out of or related to the injuries which were the subject of the third party settlement or action. The Fund will determine the net proceeds available for a future credit.

Assignment of Claim

You may not assign any rights or causes of action that you may have against any third-party tortfeasor without the express written consent of the Plan.

The Trustees, in their sole discretion, may require you to assign your entire claim against the third party to the Plan. If this Plan recovers from the third party any amount in excess of the benefits paid to you, plus the attorneys' fees, costs, and expenses incurred in making the recovery, then the excess will be paid to you.

Failure to Cooperate with Plan

You will be personally liable to the Plan for reimbursement owed to the Plan, and the Trustees will discontinue your benefits if any of the following occurs:

1. You fail to tell the Plan that you have a claim against a third party;

2. You fail to assign your claim against the third party to this Plan when required to do so;

3. You fail to cooperate with the Plan's efforts to recover the full amount of benefits paid by the Plan;

4. You fail to require any attorney you subsequently retain to sign the Plan's Subrogation Agreement;

5. You and/or your attorney fail to reimburse the Plan;

6. You fail to provide the Plan with medical or other authorization to obtain the necessary information; or

7. You or your attorney fails to file written quarterly reports regarding your case with the Fund Office.

This Plan may offset the amount you owe from any future claims submitted by you as well as by your dependents and beneficiaries and/or will discontinue benefits to you, your dependents and beneficiaries, or, if necessary, take legal action against you and you will be personally liable to this Plan for the Plan's attorney's fees and costs incurred in recovering that amount. The Board of Trustees has the sole discretion to determine whether you and your attorney have cooperated with the Fund's efforts to recover the entire amount of its lien. The reimbursement owed to the Plan may also, in the Trustees' discretion, be considered an overpayment or mistaken payment and must be repaid as provided in the section of this Plan dealing with overpayments and mistaken payments.

H. NON-ASSIGNABILITY AND SPENDTHRIFT CLAUSE

To the extent permitted by law, this Plan's benefits and payments are not assignable, otherwise transferable or subject to any claim made or legal action taken by any creditor of any person covered by our Plan, except as permitted by the "Assignment of Benefits" provision on the medical claim form.

I. COBRA CONTINUATION COVERAGE

1. What is COBRA continuation coverage?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") provides that you, your spouse, and your other dependents are entitled to elect to continue coverage on a self-pay basis under the Plan, under certain circumstances, if coverage would otherwise stop. ***Please note that neither Domestic Partners nor their dependents, absent some Federal requirement, are eligible for continuation of benefits under COBRA.***

2. Which employees are eligible for COBRA continuation coverage?

For individuals covered by the Plan as employees, COBRA continuation coverage may be elected upon loss of coverage under the Plan due to voluntary or involuntary termination of employment (for reasons other than gross misconduct) or because the employee no longer meets the eligibility requirements of the Plan due to a reduction in hours worked, including a strike, walkout or layoff.

3. When is my spouse eligible for COBRA continuation coverage?

Your spouse may elect COBRA continuation coverage upon the occurrence of any of the following events:

a. Your death.

b. Your spouse's loss of coverage under the Plan due to voluntary or involuntary termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff.

c. Divorce or judicial order of legal separation.

d. Your enrollment in Part A or Part B of Medicare.

4. When does my dependent child become eligible for COBRA continuation coverage?

Your dependent children can elect COBRA continuation coverage upon the occurrence of any of the following events:

a. Your death.

b. Your dependent child's loss of coverage under the Plan due to termination of your employment (for reasons other than gross misconduct) or because you no longer meet the eligibility requirements of the Plan due to a reduction in hours worked including a strike, walkout or layoff.

c. Divorce or judicial order of legal separation of the child's parents.

d. Your enrollment in Part A or Part B of Medicare.

e. The child ceases to qualify as an "eligible dependent".

If, while you are receiving COBRA continuation coverage, you have a newborn child or a child is placed with you for adoption, the child may be added to your coverage. You must, however, notify the Fund Office immediately of such a change.

5. How is a person eligible for COBRA continuation coverage notified of his or her eligibility?

Your employer has the obligation to notify the Fund Office of your death or your enrollment in Part A or Part B of Medicare. The Trustees have determined that because employees frequently work for more than one employer making contributions to the Plan and because of the difficulty which this causes employers in providing this notice, employment will be deemed to have terminated and/or the number of hours worked will be deemed to have been reduced when your regular group health care coverage terminates.

You have the responsibility to inform the Fund Administrator using the Fund's "Participant's Notice to Fund Administrator" form which can be obtained from the Fund Office of a divorce, judicial order of legal separation, a child's loss of status as an eligible dependent or the birth or adoption of a dependent. This notice must be given within 60 days after the occurrence of the qualifying event or the date coverage would be lost because of the event, whichever is later.

Failure to give notice to the Fund Administrator within the time limits may result in your ineligibility for COBRA continuation coverage.

After the Fund Administrator receives notice of the occurrence of one of the above qualifying events, the Fund Administrator will notify each eligible individual whether he or she has the right to elect COBRA continuation coverage and will send the materials necessary to make the proper election. In general, the Fund Administrator will notify eligible individuals of their COBRA rights within 14 days after receiving notice of the occurrence of one of the qualifying events described above or after it has determined that your regular group health care coverage has terminated.

6. When must the election be made?

The employee, spouse, and dependent children each have independent election rights. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children. Each individual will have at least 60 days from the date he or she would lose coverage because of one of the qualifying events described above or the date on which he or she is advised of the right to elect continuation coverage, whichever date is later, to inform the Fund Administrator that he or she wants COBRA continuation coverage. If no election of COBRA continuation coverage is made, the individual's group health coverage will terminate effective upon the qualifying event. You will not have another opportunity to elect continuation coverage. However, you may change your election within the 60 day period described above as long as the completed COBRA Election Form is received by the Fund Administrator on or before the due date. If you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date the completed Election Form is received by the Fund Administrator.

7. What type of benefits are available in COBRA continuation coverage?

The benefits an eligible individual is allowed to elect to receive will include all benefits the individual was entitled to before the occurrence of the event making the individual eligible for COBRA continuation coverage. However, no life insurance or disability benefits or accidental death and dismemberment benefits or other non-health benefits will be included.

8. What are the consequences of failing to elect or waiving COBRA continuation coverage?

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, prior to January 1, 2015, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You

will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

9. How long does COBRA continuation coverage last?

If the election is due to termination of your employment or a reduction in hours worked, COBRA continuation coverage will end 18 months after your other coverage ended. However, if you, your spouse or one of your dependent children is determined by the Social Security Administration to be disabled on the day regular coverage terminates or within 60 days thereafter, the disabled person can receive a total of 29 months of COBRA continuation coverage. If you are the disabled person, your spouse and your dependent children also qualify for 29 months of this coverage. For all other situations, such coverage is available for 36 months. COBRA continuation coverage will end at an earlier time for any of the following reasons:

a. The employer no longer provides group health coverage.

b. Failure to pay the monthly premium on time.

c. The individual becomes covered under another group health plan (other than one sponsored by the employer) except for any period the other group health plan limits coverage of your preexisting conditions.

d. The individual becomes entitled to Part A or Part B of Medicare.

e. Circumstances are such that the individual's participation could be canceled if the individual were an active employee.

If any of these events occur, the Fund Office will send you a Notice of Termination of Coverage, explaining the reason the COBRA coverage terminated early, the date coverage terminated, and any rights the employee, spouse or dependent child may have under the Plan to elect alternate coverage.

10. How does COBRA continuation coverage affect eligibility for other extended benefits under the Plan?

Anyone who becomes eligible for COBRA continuation coverage, but who is also eligible for extended coverage under this Plan, will not begin his or her period of COBRA coverage until <u>after</u> using up all other extended coverages available under the Plan to that individual.

11. What is the cost of COBRA continuation coverage and how is the cost computed?

Each month, any individual electing COBRA continuation coverage will be required to make a payment to the Fund Office to continue COBRA continuation coverage. The monthly premium will be based on the average cost which the Plan incurs annually per participant plus a two percent administrative charge. The extra 11 months of COBRA continuation coverage available to disabled participants are at a monthly charge based on one and one-half times the average annual per participant cost incurred by the Plan.

12. Is there anything else I should know about COBRA continuation coverage?

COBRA continuation coverage is described in greater detail in a letter sent out by the Fund Office to each participant when the participant becomes eligible to participate in the Fund or when COBRA first became applicable to the Fund, if later. If you have any questions concerning COBRA continuation coverage, you should contact the Fund Administrator.

There may also be alternative health insurance coverage options for you and your family other than purchasing COBRA coverage from this Plan. When key parts of the health care law took effect in 2014, you became entitled to buy coverage through the Health Insurance Marketplace. The Marketplace is designed to help people without employer-sponsored coverage find health insurance that meets their needs and fits their budget. More information about the Health Insurance Marketplace generally is available at: www.HealthCare.gov.

In considering whether coverage through the Marketplace is better for you than COBRA coverage, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away. Information about the Marketplace can help you see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace.

In addition to the options available from the Marketplace, you may qualify for a special enrollment opportunity to obtain coverage from another group health plan for which you are eligible (such as a spouse's plan). Even if the other plan generally does not accept late enrollees, you may still qualify if you request enrollment within 30 days.

If you would like more information regarding the Marketplace, you should contact the Health Benefit Exchange Marketplace in your state of residence. For example, in New York State, the website for the Marketplace is: www.healthbenefitexchange.ny.gov.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website @ www.dol.gov/ebsa. (Addresses and telephone number of Regional and District EBSA Offices are available through EBSA's website.)

J. WHAT'S AN "E-O-B"? "

"E-O-B" is short for Explanation of Benefits, which is a computerized statement that you receive when a medical, dental, optical, or other applicable claim for you or your dependent have been processed.

Important E-O-B Information

The E-O-B has information on it that is important to you. It shows you:

(a) for whom (you or your dependent) the claim was processed;

(b) the amount of benefits considered for payment, the service(s) performed, and who the provider was;

(c) how much we paid you or the provider; and

(d) what benefits were not paid and the reason(s) why.

Keep Your E-O-Bs

Remember to keep your E-O-Bs because they can help you keep track of the balances that you are responsible for paying or submitting to other insurance. You also may need them for tax purposes. Have your E-O-B handy if you need to call about your claim.

Check Your E-O-Bs for Claim Payments

When you get a balance due statement from your provider, check your E-O-Bs to see if the claim has already been processed. If the claim isn't processed yet, do not send balance due statements. Claims may only be processed from the itemized bills that you or the providers send. If payment is for reimbursement of a bill that was already paid, the check is made payable to you, the participant. This also includes payments for your dependents. The E-O-B will comply with Department of Labor regulations concerning claims and applicable procedures.

K. PLAN DEFINITIONS

The Fund uses the Glossary of Health Coverage and Medical Terms promulgated by the Employee Benefit Security Administration, among other agencies, and the Glossary is available on the internet at: www.dol.gov/ebsa/pdf/SBCUniformGlossary. In addition, the following terms, which have the specific meaning set forth below, define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for under this Plan.

1. "**Assignment of Benefits**" is your option to instruct this Plan to pay providers directly for their services to the extent provided by this Plan. You can assign your benefits by completing that section on the claim form.

2. "**Beneficiary**" is a person designated by a Participant or by the terms of this Plan, who is or may become entitled to a benefit under this Plan.

3. "**Benefit**" or "**Covered Benefit**" is any of the scheduled payments or services provided by this Plan (or any other plan under coordination of benefits).

4. "**Covered Expenses**" are the reasonable and customary charges that you are billed for medically necessary treatment of conditions that are covered by this Plan.

   The health care terms "charges", "fees" and "expenses" do not include any amount for:

   (a) a service or supply generally accepted in health care practice as unneeded to diagnose or treat a condition, even if ordered by a physician;

   (b) repeated tests which are unneeded, even if ordered by a physician;

   (c) more than what is reasonable and customary.

5. "**Denial Notice**" is a written letter sent by the Fund Office or the Fund's service provider explaining why there is no Plan payment, in whole or in part, for the claim submitted for payment.

6. "**Eligible Expense**" is the maximum amount this Plan allows as a reasonable charge for the services provided.

7. "**Exclusions**" are specific conditions, circumstances and limitations listed in the Plan for which the Plan will not provide benefit payment.

8. "**Illness**" is a bodily disorder or disease.

9. "**Injury**" is trauma or damage to your body that is caused by an external force by accident.

10. "**No-Fault Motor Vehicle Plan**" is a motor vehicle plan required by law that provides medical or dental care payments that are made, in whole or in part, without regard to fault. A person subject to, but not complying with the law, will be deemed as having received the benefits required by law.

11. "**Participant**" is an employee of an employer who is or may become eligible to receive benefits under this Plan.

12. "**Totally Disabled**" or "**Total Disability**" is defined as follows:

    (a) "**Temporarily Totally Disabled**" as defined for Eligibility purposes, is your temporary inability to work in your usual employment due to illness or injury.

(b) "**Totally Disabled**" as defined for Extended Benefit Coverage, is your inability to work in your regular occupation due to an injury or illness and you are not working for pay or profit; or, your dependent is unable to do most of the normal activities of a person of the same age and sex who is in good health.

(c) "**Totally Disabled**" as defined for extending the Death Benefit, is determined by the disabled employee providing either a copy of the Social Security Disability Award or Workers' Compensation Total Disability Award as validation of his or her disability.

L. PLAN INFORMATION

Name of the Plan and Identification Number

The following information is provided according to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

Service Employees Benefit Fund
Federal Identification Number – 15-0613682
Plan Number – 501

Administration of the Plan

This Plan is administered by the Board of Trustees, which decides all matters concerning the Plan. Thus, the Board as a whole is the Plan Administrator. As such, the Board of Trustees (the "Trustees") is responsible for making decisions regarding, for example, the rules of eligibility, types of benefits offered, administrative policies, management of Plan assets, and interpretation of Plan Provisions. The Trustees' decisions are final and binding. The source of Fund contributions is the employers that sponsor the Plan as determined by the written agreements defining their participation. The funding medium involves the Plan using contributions to either pay premiums for coverage from an insurance company or pay benefits from Plan assets as determined by the Fund's Trustees. The benefits from the Plan are not guaranteed, and the administrative services provided by insurers are described in more detail in the medical benefits section of this booklet.

Names, Titles, and Business Addresses of the Trustees

Elizabeth L. Golembeski, Union Trustee
SEIU Local 200United
P.O. Box 1130
Syracuse, NY 13201

George Kennedy, Union Trustee
1199SEIU United Healthcare Workers East
2421 Main Street, Suite 110
Buffalo, NY 14214

Scott R. Phillipson, Union Trustee
SEIU Local 200United
P.O. Box 1130
Syracuse, NY 13201

Kathy Tucker, Union Trustee
1199SEIU United Healthcare Workers East
95 E. Main Street
2nd Floor, Suite 4
Gouverneur, NY 13642

Robert Wood, Employer Trustee and Chairman
Jewish Home

4101 East Genesee Street
Syracuse, NY 13214

Elizabeth Smith, Employer Trustee
Unity House of Cayuga County, Inc.
34 Wright Ave., Suite C
Auburn, NY 13021

John Murray, Employer Trustee
Loretto
700 E. Brighton Ave.
Syracuse, NY 13205

Name and Address of Agent for Service of Legal Process

The name and address of agent for service of legal process is:

Blitman & King LLP
Franklin Center, Suite 300
443 North Franklin Street
Syracuse, NY 13204-1415

Service of legal process can be made on the Board of Trustees or any individual Trustee.

Plan Year

The Plan Year begins on November 1 and ends on October 31.

Collective Bargaining Agreements

This Plan is maintained pursuant to Collective Bargaining Agreements executed by and between the SEIU Local 200United and 1199SEIU United Healthcare Workers East and Employers who make contributions to this Plan pursuant to the terms of a Collective Bargaining Agreement. Contributions are also made pursuant to written participation agreements between the Plan and certain employers. You may obtain copies of these Agreements upon written request to the Fund Manager. You may also obtain a complete list of the employers and employee organizations sponsoring the Plan, as well as a statement as to whether a particular employer or employee organization is a plan sponsor, upon written request to the Fund Manager. They are also available for examination at the Fund Office. The purpose of this Plan is to provide comprehensive welfare benefits to employees covered by such written Agreements and to the eligible dependents of such employees.

M. STATEMENT OF ERISA RIGHTS

Rights of Participants

As a Participant in the Service Employees Benefit Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

1. Examine, without charge at the Fund Office, all Plan documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prior to January 1, 2015, you may be entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. After December 31, 2014, no group health plan will be permitted to impose a preexisting condition limitation regardless of whether you have creditable coverage. Consequently, effective January 1, 2014, this Plan will no longer apply any preexisting condition exclusions, but the Plan will provide the certificate of creditable coverage through December 31, 2014 to reduce any preexisting condition limitation that may be imposed by another group health plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of this Plan. The people who operate your Plan called "Fiduciaries"

of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your Employer, SEIU Local 200United or 1199SEIU United Healthcare Workers East, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan such as Plan documents or the latest annual report, and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sue to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you should need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, or the division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The address for the Employee Benefits Security Administration, Boston Regional Office is as follows:

JFK Federal Building, Room 3575
Boston, MA 02203
Telephone: 617-565-9600

VII. SUMMARY OF BENEFITS PROVIDED BY PARTICIPATING EMPLOYERS

Employer	Benefits

ABM @ LeMoyne	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
ABM @ Dey's	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
ABM @ NYSUT	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Absolut @ Three Rivers	Basic and Comprehensive Dental and Weekly Disability
Acacia Park Cemetery	Basic and Comprehensive Dental, Optical and Weekly Disability
Alexandria Central Schools	Basic and Comprehensive Dental
Alice Hyde Hospital	Medical, Basic and Comprehensive Dental and Optical
Allright Parking	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Aramark @ Clarkson University	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Weekly Disability
Aramark @ Hartwick College	Medical, Basic and Comprehensive Dental and Optical
Auburn Memorial Hospital	Medical, Basic and Comprehensive Dental, Optical and Weekly Disability
Auburn Senior Services, Inc.	Medical, Basic and Comprehensive Dental and Optical
Autumn View Manor	Basic and Comprehensive Dental and Optical
Batavia Bus	Basic and Comprehensive Dental
Bethany Gardens	Medical, Basic and Comprehensive Dental
Birnie Bus – Syracuse	Medical, Basic and Comprehensive Dental
Blocher Homes, Inc.	Basic and Comprehensive Dental and Optical
Brockport Central Schools	Basic and Comprehensive Dental and Weekly Disability
Buffalo General Hospital	Basic and Comprehensive Dental
Canisius College	Basic and Comprehensive Dental and Weekly Disability
Canton Potsdam Hospital	Medical, Basic and Comprehensive Dental
Carthage Hospital-Serv. Maint.	Medical, Basic and Comprehensive Dental and Optical
Carthage Hospital-LPN/Techs	Medical, Basic and Comprehensive Dental with Orthodontia and Optical
Cayuga Ridge Extended Care	Medical, Basic and Comprehensive Dental
CDS Monarch, Inc.	Weekly Disability
Central Square	Basic and Comprehensive Dental, Optical and Weekly Disability
Children's Hospital	Basic and Comprehensive Dental with Orthodontia and Optical
City of Cortland	Basic and Comprehensive Dental and Weekly Disability
City of Oswego	Medical, Basic and Comprehensive Dental with Orthodontia, Optical and Weekly Disability
Claxton-Hepburn Medical Ctr.	Basic and Comprehensive Dental
Community Memorial Hospital	Medical, Basic and Comprehensive Dental, Optical and Weekly Disability
Contract Specialists, Inc.	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Corporate Maintenance Sys	Basic and Comprehensive Dental
Crouse Hospital	Basic and Comprehensive Dental, Optical and Weekly Disability
Champlain Valley Physician Hospital	Basic and Comprehensive Dental
Diamond Hill	Medical, Basic and Comprehensive Dental, Optical and Weekly Disability
Durham Schools	Basic and Comprehensive Dental
East Syracuse Minoa	Basic and Comprehensive Dental, Optical and Weekly Disability

Eastern Niagara Hospital	Basic and Comprehensive Dental and Optical
Elm Lawn Cemetery	Basic and Comprehensive Dental
Elderwood @ Williamsville	Basic and Comprehensive Dental and Optical
Fayetteville-Manlius School	Weekly Disability
Finger Lakes Racetrack	Basic and Comprehensive Dental
First Class Maintenance @ UPS	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
First Student-Auburn	Basic and Comprehensive Dental and Optical
First Student-Syracuse	Basic and Comprehensive Dental, Optical and Weekly Disability
Focus Rehab Nursing Center	Medical, Basic and Comprehensive Dental and Optical
Forestville Central School	Weekly Disability
Founder's Pavilion	Weekly Disability
Garden Gate Manor	Basic and Comprehensive Dental and Optical
Gate of Heaven Cemetery	Basic and Comprehensive Dental with Orthodontia and Weekly Disability
Global @ Verizon-Albany	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Global @ Verizon-Buffalo	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Global @ Verizon-Syracuse	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Gowanda Nursing Home	Basic and Comprehensive Dental and Optical
Guilfoyle Ambulance	Basic and Comprehensive Dental and Optical
Hamburg School District	Basic and Comprehensive Dental, Optical and Weekly Disability
Harbour Health Multicare Ctr.	Basic and Comprehensive Dental and Optical
Harvard Maintenance @ Bristol	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Hawthorn Health Multicare Ctr.	Basic and Comprehensive Dental and Optical
Holy Cross Cemetery	Basic and Comprehensive Dental with Orthodontia and Weekly Disability
Holy Sepulchre Cemetery	Basic and Comprehensive Dental with Orthodontia and Weekly Disability
Home Aides of CNY	Medical, Basic and Comprehensive Dental, Optical, and Supplemental Disability
Jewish Home	Medical, Basic and Comprehensive Dental, and Death Benefit
Liverpool School District	Weekly Disability
1199 SEIU Pension Fund	Basic and Comprehensive Dental with Orthodontia and Optical
Local 200United	Weekly Disability
Longley Jones @ Skyline Apts.	Medical, Basic and Comprehensive Dental and Death Benefit
Loretto	Medical and Basic and Comprehensive Dental
Lyncourt Schools	Weekly Disability
Main-Seneca Corp.	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Matrix @ Pall Trinity	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
McAuley Residence	Basic and Comprehensive Dental with Orthodontia and Optical
Menorah Park Group Residence	Medical, Basic and Comprehensive Dental, and Death Benefit
Michaud Health Services	Medical and Optical

Millard Fillmore Suburban	Basic and Comprehensive Dental and Optical
Mount Calvary Cemetery	Basic and Comprehensive Dental with Orthodontia
Mt. St. Mary Hospital	Basic and Comprehensive Dental and Optical
Mount Olivet Cemetery	Basic and Comprehensive Dental with Orthodontia and Weekly Disability
Newfane Rehabilitation Ctr.	Basic and Comprehensive Dental and Optical
Niagara Falls Memorial	Basic and Comprehensive Dental and Optical
North Syracuse Central Schools	Weekly Disability
Northgate Manor Nursing Home	Basic and Comprehensive Dental and Optical
Oaks at DeWitt	Medical, Basic and Comprehensive Dental, and Death Benefit
Oakwood Cemetery	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Onesource – ABM – WNY	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Our Lady of Peace	Basic and Comprehensive Dental and Optical
Pathways	Medical, Basic and Comprehensive Dental, Optical and Weekly Disability
Pembroke Schools	Basic and Comprehensive Dental and Optical
Quest Services	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Republic Parking	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Rochester Regional Joint Board	Basic and Comprehensive Dental with Orthodontia and Optical
Rose Dental	Basic and Comprehensive Dental
Rosewood-Albany	Medical, Basic and Comprehensive Dental, Optical and Weekly Disability
Service Employees Benefit Fund	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability and Weekly Disability
Service Employees Pension Fund	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability and Weekly Disability
Schoellkopf Health Center	Basic and Comprehensive Dental and Optical
Schofield Residence	Basic and Comprehensive Dental and Optical
Seneca Manor Nursing Home	Basic and Comprehensive Dental and Optical
Sodexo @ Hobart William Smith	Basic and Comprehensive Dental
Sodexo @ LeMoyne College	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Weekly Disability
Sodexo @ Sisters Hospital	Basic and Comprehensive Dental with Orthodontia and Optical
St. Francis Home For The Aging	Basic and Comprehensive Dental with Orthodontia and Optical
St. Lawrence University	Basic and Comprehensive Dental, Optical and Weekly Disability
St. Luke Health Services	Medical and Optical
Syracuse University	Basic and Comprehensive Dental and Optical
Temco @ Huron	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Temco @ Utica College	Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
The Avenue Nursing/Rehab.	Medical
The Cottages @ Garden Grove	Medical and Basic and Comprehensive Dental
The Crossings Nursing/Rehab.	Medical
The Pines of Poughkeepsie	Medical, Basic and Comprehensive Dental and Optical
The Springs	Medical

Tonawanda City School District	Basic and Comprehensive Dental, Optical and Weekly Disability
Touchpoint-Lourdes Hospital	Medical, Basic and Comprehensive Dental, Optical, Death Benefit and Supplemental Disability
Town of Marshall	Basic and Comprehensive Dental and Optical
Town of West Monroe	Basic and Comprehensive Dental
Unity House	Medical, Basic and Comprehensive Dental and Optical
Upstate Cleaning Services	Medical and Basic and Comprehensive Dental
Utica City School District	Medical, Basic and Comprehensive Dental, Optical and Weekly Disability
VA Medical Ctr.-Albany	Basic and Comprehensive Dental, Optical and Weekly Disability
VA Medical Ctr.-Buffalo	Basic and Comprehensive Dental, Optical and Weekly Disability
VA Medical Ctr.-Canandaigua	Basic and Comprehensive Dental, Optical and Weekly Disability
VA Medical Ctr.-Erie	Basic and Comprehensive Dental, Optical and Weekly Disability
VA Medical Ctr.-Syracuse	Basic and Comprehensive Dental, Optical and Weekly Disability
Vanderheyden Hall	Basic and Comprehensive Dental, Optical and Weekly Disability
Village of Clinton	Basic and Comprehensive Dental
Village of Hamilton	Death Benefit and Weekly Disability
Village of Saranac Lake	Basic and Comprehensive Dental
Waterville Central School	Basic and Comprehensive Dental and Weekly Disability
Weinberg Campus	Basic and Comprehensive Dental with Orthodontia and Optical
West Genesee Central Schools	Basic and Comprehensive Dental, Optical and Weekly Disability
William George Agency	Basic and Comprehensive Dental and Optical

SEIU PARTICIPATING LOCALS

1199SEIU UNITED HEALTHCARE WORKERS EAST

250 S. Clinton Street, Suite 200
Syracuse, NY 13202
Phone (315) 295-1843
Fax (315) 479-6716

SEIU Local 200UNITED

731 James Street, Suite 300
Syracuse, NY 13204
Phone (315) 424-1750
Fax (315) 479-9030

SERVICE EMPLOYEES BENEFIT FUND

You may call or write the Fund Office if you have questions about your benefits or if you need help filing your claims:

250 S. Clinton Street, Suite 200
Syracuse, NY 13202

(315) 218-6513
or
(855) 835-9720
Fax (315) 701-0686