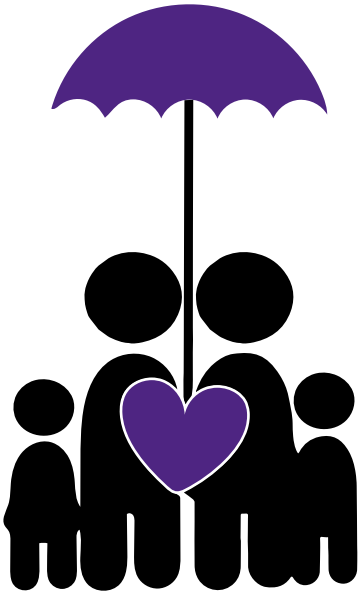
Service Employees Benefit Fund



Summary Plan Description

Effective 8/1/2023

August 1, 2023

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 August 1, 2023. If you have questions about the benefits to which you are entitled before that date, you should contact the Fund Office for more information.

CAUTION - 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 or your work under a participation agreement as approved by the Trustees. 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 (or Participation 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 the 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 [or domestic partner if allowed by your employer] and dependents) for benefits will terminate effective upon the terms described in the letter to you outlining your termination of 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.

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 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 and the Plan is required under applicable law to allow such enrollment. In addition, if you have a new dependent as a result of marriage, affirmed domestic partnership (if permitted by your employer), 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

Employers with No Premium-Paid Waiting Period
With Termination the Last Day of the Month the Premium is Paid

1199 SEIU Regional Pension Fund	Hamburg School
ABM – Met Life/NYSUT - Albany	HCSG @ Newfane
ABM – NYSUT - CNY	Holy Cross Cemetery
ABM - WNY	Holy Sepulchre Cemetery
Absolut @ Three Rivers	Home Aides of CNY
Acacia Park Cemetery	Jewish Home of CNY
Akima @ Buffalo Detention Center	JLL @ Bristol
Alice Hyde Hospital	K & G Property Management
ARAMARK @ Hartwick College	Loretto Health & Rehab
Atalian Global Services @ Huron	Masonic Care Community
Auburn Community Hospital	Massena Hospital
Autumn View Healthcare Facility	McAuley Residence
Bard College	Menorah Park Group Residences
Batavia Bus	Millard Fillmore Suburban
Bethany Gardens	Mount Calvary Cemetery
Birnie Bus (Syracuse)	Mount Olivet Cemetery
Bishop Rehab & Nursing	Mt. St. Mary Hospital
Buffalo General Hospital	Newfane Rehabilitation
Canisius College	Niagara Falls Memorial Hospital
Canton Potsdam Hospital	Niagara Falls Mem. Hosp. Health Home
Carthage Area Hospital	Northgate Healthcare Facility
Cayuga Centers	Oaks at Dewitt
Cayuga Nursing & Rehab	Oakwood Cemetery
Central Square Schools	Oishei Children's Hospital
Chenega @ Buffalo Detention Center	Oneida Center for Rehab & Nursing
Claxton-Hepburn Medical Center	Our Lady of Peace
Collar City Nursing & Rehab	Pathways
Community Memorial Hospital	Pembroke Schools
Compass Group @ D'Youville College	Pollak Innovative Management @ Newfane
Comprehensive Rehab @ Williamsville	Quest
Contract Specialists	Rochester Regional Joint Board
Crouse Hospital	Rosewood Rehab & Nursing
CVPH	Safire Rehab at Northtowns
Elderwood at Williamsville	Samaritan Keep Home
Ellicott Center @ Waterfront	Samaritan Medical Center
Elmlawn Cemetery	Samaritan Summit Village
ESM Schools	SBM @ State Farm
Finger Lakes Racetrack	Schoellkopf Health Center
First Class Maintenance	Schofield Residence
Garden Gate Healthcare Facility	Seneca Health Care Center
Gate of Heaven Cemetery	Service Employees Pension Fund
GDI Services @ Pall Trinity	Service Employees Benefit Fund
Global @ Verizon (Albany, Buffalo, Syracuse)	Sodexo @ Clarkson University
Gouverneur Hospital	Sodexo @ Hobart & William Smith Colleges
Gowanda Nursing Home	Sodexo @ Nazareth College

Employers with No Premium-Paid Waiting Period
With Termination the Last Day of the Month the Premium is Paid
(Continued)

Sodexo @ Sisters Hospital	Tonawanda City Schools
SP Plus	Touchpoint @ Lourdes Hospital
St. Adalbert Cemetery	Town of Marshall
St. Lawrence University	UG2 @ LeMoyne College
St. Luke Health Services	Vestal Hills
Syracuse University	Weinberg Campus
The Commons on St. Anthony	William George Agency
The Cottages @ Garden Grove	Williamsville Suburban Nursing & Rehab
The Grand Rehab & Nursing	

Employers with a Two-Month Premium-Paid Waiting Period
With Termination the Last Day of the Month the Premium is Paid

Alexandria Central School	VA Medical – Buffalo
Atalian Global Services @ Utica College	VA Medical – Erie
Corporate Maintenance @ BC/BS	VA Medical – Syracuse
Cortland, City of	VA Medical – Canandaigua
Durham School Services - Minetto	Vanderheyden Hall
First Student-Auburn/Syracuse	Waterville Schools
Oswego, City of	West Genesee Schools
Utica City Schools	West Monroe, Town of
VA Medical – Albany	

Employers with a Six-Month Premium-Paid Benefit Waiting Period
Weekly Disability Coverage Only

CDS Monarch	Liverpool Schools
Corning Center	Local 200United
Forestville Schools	Lyncourt Schools
Guilfoyle Ambulance	North Syracuse Schools
Jordan - Elbridge Schools	Hamilton, Village of

B. ELIGIBILITY RULES FOR DEPENDENTS

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

1. Your lawful spouse or your domestic partner*;

2. Your children through the end of the month in which they turn 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.

*Notwithstanding anything to the contrary herein, SEBF provides coverage for eligible Domestic Partners unless the employer opts-out of such coverage. For more information regarding which employers currently allow coverage for Domestic Partners, please contact the Fund Office. 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.

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 full 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 ("QMCSO"), 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 QMCSO as proof of support. You or your dependents may obtain, without charge, a copy of the Plan's QMCSO 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, as explained below, 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, and must continue to make contributions on your behalf.

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 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 to the extent required by 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 from the date of your absence from employment. In addition, your dependent(s) may be eligible for health care coverage under the Civilian Health & Medical Program of the Uniformed Services ("CHAMPVA"). This Plan will coordinate coverage with CHAMPVA in accordance with applicable law.

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. Coverage is available for care and treatment that is medically necessary, where the charges are reasonable, and the services, supplies, and care are not experimental.

The Fund will only pay medical and prescription drug benefits related to charges that are usual, customary, and reasonable ("UCR" or "allowable"), 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 or their designee in their exclusive discretion.

A. MEDICAL BENEFITS

The Schedule of Medical Benefits is a summary of the PPO medical plan which is administered by Excellus BlueCross BlueShield ("Excellus").

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 Excellus 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 at www.excellusbcbs.com/sebf or contact 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 when an out-of-network provider is used. The deductibles begin again each calendar year.

Copayment or Copay

A "copayment" or "copay" is a specified dollar amount 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 Schedule of Medical Benefits reflect the 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 and generally will only apply to out-of-network benefits.

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's prescription drug coinsurance costs reach $1,200, all subsequent covered prescriptions for that individual 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 Excellus Plan 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 Excellus.

No Surprises Act

Notwithstanding anything to the contrary in this Summary Plan Description, the Plan will comply with applicable requirements of the No Surprises Act relating to the coverage of emergency medical conditions.

Type of Care/Plan Benefits	In-Network	Out-Of-Network
BluePPO Plan Features		
Primary Care Physician (PCP)	Not required	
Referrals	Not required	
Pre-Certification	Required for all inpatient admissions (excluding maternity). Provider notification is required for certain Medical Specialty Drug (MSD) and certain Behavioral Health Services. 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 coverage	Qualified dependents covered to age 26 (end of month)	
Domestic partner	Covered (if eligible)	
Coverage Period	January 1st - December 31st	
Plan cost-sharing highlights		
Telemedicine visit with MDLIVE	**FREE VISIT - $0 Copay** Register online at ExcellusBCBS.com/Telemedicine or download the MDLIVE App.	No Coverage
Office visit copay (Includes Telehealth visits) Primary Care Physician	$40 Copayment	Covered at 70% of allowance, subject to the deductible
Office visit copay (Includes Telehealth visits) 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 (Medical Only. RX has a separate Out-of-Pocket Maximum)	$5,150 Individual $7,900 Family	None
Inpatient Hospital/Facility Copayment	$500 Per Admission Limit: $1,500 maximum copayment, per person, per calendar year	Covered at 70% of allowance, subject to the deductible. Precertification applies
Lifetime maximum	None	

Type of Care/Plan Benefits	In-Network	Out-Of-Network
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**	
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 (including 3-D imaging)	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		
Telemedicine visit with MDLIVE	**FREE VISIT - $0 Copay** Register online at ExcellusBCBS.com/Telemedicine or download the MDLIVE App.	No Coverage
Diagnostic office visits (Includes Telehealth 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

Type of Care/Plan Benefits	In-Network	Out-Of-Network
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
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[1]		
Emergency room care	**No Coverage for Non-Emergency 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 in accordance with the No Surprises Act (Copayment waived if admitted inpatient)
Freestanding urgent care center	$40 Copayment	Covered at 70% of allowance, subject to the deductible unless the No Surprises Act mandates other reimbursement/cost-share

[1] ***For purposes of this Plan, a covered "Emergency Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in the Emergency Medical Treatment and Active Labor Act ("EMTALA"), including: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.***

With respect to an Emergency Condition, covered "Emergency Services" are a medical screening examination (as required under EMTALA or as would be required under EMTALA if it applied to an Independent Freestanding Emergency Department) which is within the capability of the emergency department of a Hospital (or Independent Freestanding Emergency Department), including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital (or Independent Freestanding Emergency Department) and such further medical examination and treatment as are required to stabilize the patient, regardless of the department of the Hospital in which further examination or treatment is furnished. Excellus determines whether a facility qualifies as an Independent Freestanding Emergency Department.

"Emergency Services" also include certain post-stabilization services, unless the following conditions are met:

(1) The attending emergency physician or treating provider has determined that you are able to travel using nonmedical transportation or non-emergency medical transportation to an available In-Network Provider or Facility located within a reasonable travel distance, taking into account your medical condition and any other relevant factor;

(2) If the Provider is an Out-of-Network Provider, (a) the Provider gives you notice that the services rendered will be performed by an Out-of-Network Provider, and you consent to waive your rights under the surprise bill requirements, and (b) you or your authorized representative are in a condition to provide informed, voluntary consent; and

(3) ***The Provider satisfies any additional applicable laws and requirements including, without limitation, those provided in guidance issued by the Department of Health and Human Services.***

Type of Care/Plan Benefits	In-Network	Out-Of-Network
Observation stay	$100 Copayment per visit then Covered in Full (Copayment waived if admitted inpatient)	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
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. Limit 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.

Type of Care/Plan Benefits	In-Network	Out-Of-Network
Infusion Therapy (Facility Charge)	$40 Copayment Precertification applies	Covered at 75% of allowance, subject to the deductible. Precertification applies
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. 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. 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% (100% if autism assistive communicative device) 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
Infertility Services	Covered same as similar services under the benefit plan. Limits: Artificial Insemination: 4 cycles per lifetime. IVF: 1-cycle per lifetime. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible Limits: Artificial Insemination: 4 cycles per lifetime. IVF: 1-cycle per lifetime. INN & OON limits are combined
Routine Hearing Exam	$40 Copayment Limit: 1 exam every 24 months. INN & OON limits are combined	Covered at 70% of allowance, subject to the deductible. Limit: 1 exam every 24 months. INN & OON limits are combined
Hearing Aids	$40 Copayment Limit: $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.

Type of Care/Plan Benefits	In-Network	Out-Of-Network
Prescription Drug Coverage	**See Prescription Drug Coverage section.**	
Smoking Cessation (42 day program)	**<u>This FREE Quit Smoking Program through Wellframe® includes:</u>** The Wellframe® App connects you to Care Managers to provide confidential, text- based, one-on-one outreach using a smartphone or tablet. You will recieve guidance, support and a personalized care plan to help you Quit Smoking. **HOW CAN I GET STARTED?** Visit wellframe.com/download on your smartphone or tablet to install the Wellframe app. Download the Wellframe app and select Create New Account. Your access code is: **EXCELLUS**	
Excellus BlueCross BlueShield Customer Care: 1-877-650-5840 www.excellusbcbs.com/sebf		

* 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).

Telemedicine Program

Participants and their eligible dependents enrolled in SEBF Medical Benefits may utilize the Excellus BlueCross BlueShield Telemedicine Program through MDLIVE for appropriate covered services. The Program provides on-demand or by appointment doctor visits and behavioral health visits by telephone or web-based video with participating physicians.

As an SEBF participant, you will receive information regarding how to register for the Program and, once registered, how to utilize the Program.

You will not be charged for a Telemedicine visit under this Program for covered services so long as you are registered, and the vendor is able to confirm your SEBF coverage at the point of service.

Novel Coronavirus (COVID-19) ("Coronavirus")

1. Participants will be responsible for any applicable copayments, coinsurance and deductibles for COVID-19 treatment including, but not limited to, inpatient hospital, provider office visits, urgent care visits, and emergency room visits.

2. Participants will be responsible for applicable copayments, coinsurance, and deductibles for: (a) covered diagnostic tests (approved and authorized by applicable law) for the Coronavirus; and (b) health care provider office visits, urgent care visits, or emergency room visits resulting in testing for the Coronavirus.

B. PRESCRIPTION DRUG BENEFITS

The prescription drug benefits offered by this Plan are provided through Excellus BlueCross BlueShield. Upon enrollment, you will receive an Excellus ID card to use for both your medical and prescription drug coverages. You may get your medications through the Excellus BlueCross BlueShield network of participating retail pharmacies as well as the Excellus BlueCross BlueShield Home Delivery Pharmacy Service or Wegmans Mail Order. Some features of your prescription drug benefits are as follows:

- There is no deductible in your Prescription Plan managed by Excellus BlueCross BlueShield (retail and/or mail order).
- You pay 30% in coinsurance for generic, brand and specialty drugs.
- You pay 50% in coinsurance for Proton Pump Inhibitors PPIs (heartburn medications) and Antihistamines NSAs (allergy medications).
- There is an out-of-pocket maximum of $1,200 for individuals and $4,800 for family coverage
- There is a mandatory mail feature for maintenance or long-term medications after the third refill at a retail pharmacy. **If you choose to purchase your maintenance medication at a retail pharmacy after the third fill, you will be responsible for 100% of the cost of the medication.**

Out-of-Pocket Maximums

The Fund has limits on the amount that you will pay per calendar year for prescription drugs**.** 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.

Generic Advantage Program (GAP): If you choose a brand name medication when a generic equivalent is available, you will pay the coinsurance amount PLUS the difference in cost between the generic drug and the brand name drug. The difference that you pay between the brand name cost and the generic cost is not applied to your out-of-pocket maximum.

Features	Retail Pharmacy	Mail Service
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%). At non-participating pharmacies, you pay in full and submit a claim to Excellus BlueCross BlueShield to reimburse you at the negotiated rates. Reimbursement will be the amount that would have been charged by a participating pharmacy less the applicable coinsurance. Out-of-network prescription costs do not apply to the out-of-pocket maximum.

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

To find a participating pharmacy visit the Excellus BlueCross BlueShield website (www.excellusbcbs.com/sebf) or contact Excellus BlueCross BlueShield Customer Care at 1-877-650-5840 (toll free).

The Fund requires use of a Mail Order Program for Maintenance/Long-Term Medications through the Excellus BlueCross BlueShield Pharmacy as well as Wegmans Mail Order. 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 *Excellus BlueCross BlueShield Pharmacy or Wegmans Mail Order*.

- 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 mandatory mail order.

- 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 *Excellus BlueCross BlueShield Mail Order or Wegmans Mail Order*. If you choose to purchase the medication at a retail pharmacy after the third fill, you will be responsible for its total cost.

If you choose to use the Excellus BlueCross BlueShield mail order service, visit the (express-scripts.com) or call 1-877-650-5840. To set up a Wegmans Home Delivery mail order account call 1-800-586-6910.

Accredo, Excellus BlueCross BlueShield's 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 total cost. If you have any questions regarding *Accredo* or specialty drugs, please contact *Accredo* directly at 1-800-922-8297.

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, 1-800-922-8297, 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, such medications will not be covered, and you will be responsible for the total cost of the medication. If your Specialty drug qualifies for the SavonSP Program, you must confirm enrollment in the SavonSP Program. Specialty drug cost sharing under the SavinSP Program does not count towards your out-of-pocket maximum.

Prior authorization and step therapy (you must try a designated drug to treat your condition before the Fund will cover any other drug for that condition) requirements apply to certain medications. For example, prior authorization is required for prescription drugs designated as "specialty" medications by Excellus BlueCross BlueShield and administered by a health care professional in clinics, hospitals, or provider offices. If you or your provider have any questions regarding this prior authorization, or if you would like a list of designated specialty drugs, please contact Excellus BlueCross BlueShield at 1-877-650-5840.

The Excellus BlueCross BlueShield Advanced Opioid Management Program will apply to SEBF prescription drug coverage of opioids. As part of the Opioid Management Program, supply limits, prior authorization and review may be required for certain opioid prescriptions. You will be notified if any of the above measures are deemed necessary with respect to your opioid prescription. For any questions regarding this Program, you should contact Excellus BlueCross BlueShield.

The Fund does provide coverage for medically necessary CAR-T therapy. CAR-T therapy takes cells from the patient's body, genetically alters them outside of the body, then reintroduces them into the body as alternatively-functioning cells. Examples of CAR-T therapies include, but are not limited to, Kymriah and Yescarta.

Diabetic Programs

1. Patient Assurance Program

   Participants will pay no more than $25.00 per 30 days for eligible Type 2 diabetic drugs through retail and mail order. Up to $50.00 is provided by manufacturer assistance. This assistance is applied at the point of sale. Please note that manufacturer assistance will not be applied to your out-of-pocket maximum under this Plan.

2. Insulin Out-of-Pocket Maximum

   Participants will not be required to pay more than $100.00 out-of-pocket for a 30-day supply of a covered prescription insulin drug through retail or mail order.

3. Cecelia Health

   Cecelia Health offers personalized coaching and clinical support to diabetic participants through their network of over 200 Certified Diabetes Educators. Cecelia Health will work with diabetic participants to proactively engage them to create a management plan.

   For more information regarding the above diabetic care programs, please contact Excellus BlueCross BlueShield at 1-877-650-5840.

C. PREVENTATIVE CARE AND CLINICAL TRIALS

Preventive Services

To the extent required by applicable law, 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. The covered preventive services generally 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, and 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.

Regardless of age or gender, breast cancer preventive screening without cost sharing includes diagnostic imaging (diagnostic mammograms, breast ultrasounds and MRIs).

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 participant'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.

Retirees may also be entitled to optical benefits pursuant to their applicable collective bargaining agreement. Eligible Retirees have the option to self-pay for optical coverage by remitting premiums directly to the Fund Office, with coverage to be effective as of the first day of the individual's retirement. Application for coverage and remittance of premiums are subject to Fund Office procedures.

The optical coverage includes reimbursement for optical services you receive up to $60 every 12 months or up to $120 every 24 months for routine eye care expenses, *i.e.*, eye exam, eyeglass frames, and lenses.

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	$10
Eyewear, glasses	$25
Contact Lenses Evaluation	$25
Frame	
In-Network Retail Allowance towards a Non-Collection Frame	Up to $75 plus 20% discount on overage
Exclusive Frame Collection (Davis Vision supplied) (in lieu of Frame Allowance):	
Fashion (up to $100 retail value)	Included
Designer (up to $160 retail value)	Included
Premier (up to $195 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 $60 every 12 months or $120 every 24 months 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.

Retirees may also be entitled to dental benefits pursuant to their applicable collective bargaining agreement. Eligible Retirees have the option to self-pay for dental coverage by remitting premiums directly to the Fund Office, with coverage to be effective as of the first day of the individual's retirement. Application for coverage and remittance of premiums are subject to Fund Office procedures.

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

ADA Code		Reimbursement
	Examinations	
0120	Periodic Oral Exam	$32
0150	Comprehensive Oral Exam	$40
	Radiographs (X-rays)	
0210	Intraoral-Complete Series	$90
0220	Intraoral-Periapical, 1st Film	$15

ADA Code		Reimbursement
0230	Intraoral-Periapical, Additional Films	$11
0272	Bitewings – two films	$22
0274	Bitewings – four films	$40
0330	Panoramic Image	$62
	Prophylaxis (Cleanings)	
1110	Adult Prophylaxis – 12 years and older	$65
1120	Child Prophylaxis – under age 12	$47
1208	Fluoride Treatment – up to age 19	$25
1351	Sealants – up to age 14	$43
	Restorations (Fillings)	
2330	Resin Based Composite, One Surface-Anterior	$78
2331	Resin Based Composite, Two Surfaces-Anterior	$110
2332	Resin Based Composite, Three Surfaces-Anterior	$124
2391	Resin Based Composite, One Surface-Posterior	$84
2392	Resin Based Composite, Two Surface-Posterior	$100
2393	Resin Based Composite, Three Surfaces-Posterior	$120
	Endodontic – Root Canals	
3220	Pulpotomy	$87
3310	Anterior Root Canal	$450
3320	Bicuspid Root Canal	$570
3330	Molar Root Canal	$720
	Periodontics (treatment of gums and supporting structures of teeth)	
4211	Gingivectomy One to Three Contiguous Teeth	$85
4260	Osseous Surgery per Quadrant	$550
4341	Periodontal Scaling & Root Planing Per Quadrant	$135
4910	Periodontal Maintenance	$72
	Oral Surgery – Extractions	
7140	Extraction, Erupted Tooth or Exposed Root	$114
7210	Surgical Removal of Erupted Tooth	$169
7220	Removal of Impacted Tooth-Soft Tissue	$275
7230	Removal of Impacted Tooth-Partial Bony	$330
7240	Removal of Impacted Tooth-Completely Bony	$420
	Adjunctive Services	
9110	Palliative Treatment	$40
9222	General Anesthesia – First 15 minute	$113
9243	Intravenous Conscious Sedation – 15 minute increments	$95
9310	Consultation	$87

BASIC PLAN COVERAGE ENDS HERE

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SECTION 2
COMPREHENSIVE PLAN *ONLY*
(includes all BASIC *procedures* PLUS the following)

Major Prosthetic Services – Five year replacement limitation

ADA Code		Reimbursement
	Crowns	
2740	Porcelain Crown	$668
2750	Porcelain to Metal Crown	$648
2790	Full Cast Metal Crown	$580
	Other Crown Services	
2920	Recement Crown	$58
2950	Core Build-Up/Including Any Pins	$128
2952	Post and Core, in Addition to Crown-Indirectly Fabricated	$210
2954	Post and Core, in Addition to Crown-Prefabricated	$162
	Removable Prosthetics – Dentures	
5110	Complete Upper Denture	$880
5120	Complete Lower Denture	$880
5213	Upper Partial Denture/Resin Base	$900
5214	Lower Partial Denture/Resin Base	$900
5640	Replace One Broken Tooth on Denture	$87
5650	Add Tooth to Existing Partial Denture	$87
5750	Reline Full Upper Denture (Lab)	$232
	Bridge Crowns	
6240	Porcelain to High Noble Metal Pontic	$567
6750	Porcelain to High Noble Metal Crown	$678
6751	Porcelain to Base Metal Crown	$600
6752	Porcelain to Noble Metal Crown	$600

COMPREHENSIVE PLAN COVERAGE ENDS HERE

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SECTION 3
COMPREHENSIVE WITH ORTHODONTIA PLAN

(Includes all BASIC AND COMPREHENSIVE PLAN services PLUS the following)
Orthodontia Lifetime Maximum Benefit (per eligible dependent) $1500

Orthodontia Services

Procedure	
Diagnosis, construction, and Insertion of appliances	$240
Active Treatment Plan	
Monthly payment (21 months)	$60
Maximum for Active Treatment	$1,200

* *

Dental Plan Limitations

Exams – two per calendar year
Cleanings – two per calendar year
Bitewing X-rays – four per 12 month period
Full Month or Panorex X-ray – one every three years
Fluoride covered to age 19 – two per calendar year
Sealants covered to age 14 – once in a three year period
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
Pulp Caps
Pulp Vitality Tests

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. For any questions regarding participating dentists, please contact the Fund Office. 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.

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 Fund. 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 providing for this benefit.

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 also provides a $2,000 death benefit and a $2,000 accidental death and dismemberment (AD&D) benefit for retired Participants (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 form with the Fund Office. If you never completed an enrollment form naming a beneficiary, or if you want to change your beneficiary, you can obtain a form by calling the Fund Office. List all beneficiaries on the form if you want your death benefits to be paid to more than one person. Only the beneficiary or beneficiaries named on your form will be entitled to benefits. 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 $1,000 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.

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, 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"), to the extent required by law, 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 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. Please note that, for so long as Excellus BlueCross BlueShield allows the benefit to continue or the Trustees direct otherwise, telehealth services with your provider are covered subject to the terms of the Plan. These telehealth visits are separate and distinct from the Excellus BlueCross BlueShield commercial

Telemedicine Program which only includes visits with participating physicians in the Program;

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 of sexual dysfunction unrelated to organic disease. Notwithstanding anything to the contrary herein, the Plan does provide coverage for medically necessary transgender-covered healthcare services including treatment leading to or in connection with gender reassignment/gender affirming surgery;

24. Gene Therapy (other than CAR-T therapy). Gene therapy typically involves replacing a gene that causes a medical problem with one that does not, adding genes to help the body fight or treat disease, or inactivating genes that cause medical problems. The Fund does not cover any charges for gene therapy. Examples of gene therapy include, but are not limited to, Zolgensma and Luxturna;

25. Anti-amyloid agents. The Fund does not cover any charges for anti-amyloid agents, including, but not limited to, Aduhelm;

26. Allogenic processed thymus tissue agents. The Fund does not cover any charges for allogenic processed thymus tissue agents, including, but not limited to, Rethymic; and

27. Hypoplasminogenemia agents. The Fund does not cover any charges for hypoplasminogenemia agents, including, but not limited to, Ryplazim.

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.

If a breach of your unsecured health information (PHI) occurs, the Plan will notify you.

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 **Terry Moon** 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 Excellus BlueCross BlueShield. However, if you have questions about the initial handling of your medical claims, you can visit Excellus BlueCross BlueShield'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, either 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 for Medical Benefits (excluding Optical and Dental) 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 external review processes; and

d. The availability of, and contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

For Medical Benefit claims other than Dental and Optical, 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) [Medical (excluding Optical and Dental) only] 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 have 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 have 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 have 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 Excellus BlueCross BlueShield, 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 Medical Benefit Claims (excluding Optical and Dental): 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).

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 appeal 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.

For Medical appeals (excluding Optical and Dental) 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 external review processes; and

e. The availability of, and contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act Section 2793.

For medical appeals (excluding Optical and Dental), 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 by the Trustees (or their designee) or, if you pursue External Review, by the External Reviewer; such action may only be started after all administrative procedure set forth in this Plan have been exhausted by you. You may not assign, convey, or in any way transfer your right to bring a legal action against the Plan, or its Trustees, to anyone else.

Venue of any legal action, including, but not limited to, any challenge to an appeal denial, in connection with this Plan shall lie exclusively in the Federal District Court in Onondaga County, New York and all legal actions against this Plan and its Trustees may only be brought in the Federal District Court in Onondaga County, New York.

External Review (Medical [excluding Optical and Dental])

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 following external review procedures also apply to coverage decisions that involve a determination whether the Plan is complying with the surprise billing and cost sharing protections contained in the No Surprises Act.

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 Excellus. A copy of the full external review procedure will be provided upon request.

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.

Disability Claims and Appeals

The following also applies to any benefit determination conditioned on a finding of disability by the Plan. These rules do not apply to a determination conditioned on a finding of disability by a party other than the Plan (e.g. the Social Security Administration).

1. Adverse benefit determination notices will also include the following:
    a. Discussion of the decision including, if applicable, an explanation of the basis for disagreeing with or not following:
        (i) The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
        (ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
        (iii) A Social Security Administration disability determination regarding the claimant, presented by the claimant to the Plan.
    b. 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 the claimant's claim for benefits;
    c. Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
    d. For appeal determinations, any contractual limitations period contained in this SPD for filing a civil action and the calendar date deadline for doing so.
2. Before the Plan issues an adverse benefit determination on appeal, the Plan Administrator will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Trustees, or their designee (or at the direction of the Trustees or their designee) in connection with the claim. The information will be made available sufficiently

in advance of an appeal decision deadline so that the claimant has adequate time to response.

3. Before the Plan issues an adverse benefit determination on appeal based on a new or additional rationale, the Plan Administrator shall provide the claimant, free of charge, with the rationale. The information will be made available sufficiently in advance of an appeal decision deadline so that the claimant has adequate time to response.

4. The term "adverse benefit determination" also means a rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

5. To the extent required by applicable law, any notices will be provided in a culturally and linguistically appropriate manner.

6. To the extent the Plan violates any applicable claims and appeals procedures, a participant may request a written explanation of the violation from the Plan. The Plan will respond within ten days.

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.

Although it is not currently anticipated that the Trustees will terminate this Plan, the Trustees necessarily reserve the right to terminate it at an indefinite point in the future. If this Plan is terminated for any reason, the assets remaining in the Trust Fund will be utilized to pay necessary administration costs and remaining benefits until such assets are depleted. If all assets are so expended, no further benefits would be provided by this Plan. Upon termination of this Plan, Participants and Eligible Dependents would have no further rights or vested interests in this Plan. Furthermore, the benefits provided by this Plan are not guaranteed, are not vested upon retirement, and are not deferred income. Additionally, the benefits provided by this Plan are subject to modification or termination by the Trustees, even if such action is not financially necessary.

Thus, the continuation of benefits for all Participants and Eligible Dependents and the eligibility rules for benefits under this Plan are subject to modification and revision by the Trustees. No Participant or Eligible Dependent has a vested right or contractual interest in the benefits provided. The provision of benefits to individuals under this Plan will be reviewed periodically by the Trustees.

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" includes, but is not limited to, 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 plan where, 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 this plan.

"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 that constitutes a QMCSO 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 pay 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.

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.**

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.

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.

The Trustees have the right to disregard any findings, determinations, conclusions, or judgments regarding a third party action relating to your obligation to reimburse the Fund. The Trustees have the right to independently determine whether reimbursement is required and/or how the Fund receives the appropriate reimbursement or credit, including reduction of future benefits for you, your Spouse, Domestic Partner or dependents.

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.

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. The Trustees have determined that 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.

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.

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. 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.

9. 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 after using up all other extended coverages available under the Plan to that individual.

10. 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.

11. 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.nystateofhealth.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.

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 to your provider. Claims may only be processed from the itemized bills that you or the providers send. If payment is for reimbursement of a bill that you have already paid, the check is made payable to you, the participant. This also includes payments for your dependents.

K. PLAN DEFINITIONS

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. "**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.

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

3. "**Covered Expenses**" are the usual, 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 usual, reasonable and customary.

4. "**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.

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

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

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

8. "**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.

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

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

    (a) "**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 group health plan ("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 and employees as determined by the written agreements defining their participation. The funding medium involves the Plan using contributions to pay premiums for coverage. The benefits from the Plan are not guaranteed.

Names, Titles, and Business Addresses of the Trustees

Elizabeth L. Golembeski, Union Trustee
SEIU Local 200United
701 Erie Blvd West
Syracuse, NY 13204

Kevin Lockhart, Union Trustee
1199SEIU United Healthcare Workers East
250 S. Clinton Street, Suite 200
Syracuse, NY 13202

Scott R. Phillipson, Union Trustee
SEIU Local 200United
701 Erie Blvd West
Syracuse, NY 13204

Grace Bogdanove, Union Trustee
1199SEIU United Healthcare Workers East
2421 Main St, Suite 100
Buffalo, NY 14214

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

Laura Dowling, Employer Trustee
First Student
344 6th North St.
Syracuse, NY 13208

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:

Terry Moon, Fund Manager
Service Employees Benefit Fund
P.O. Box 1240
Syracuse, NY 13201-1240

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.

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 575
Boston, MA 02203
Telephone: 617-565-9600

N. PROTECTION FROM SURPRISE BILLS

A "Surprise Bill" is a bill you receive for a covered service in the following circumstances:

(1) Emergency Services performed by an Out-of-Network Provider with respect to an Emergency Condition;

(2) Air ambulance services performed by an Out-of-Network Provider; and

(3) For certain non-Emergency Services performed by an Out-of-Network Provider at a participating Hospital, ambulatory surgical center and Independent Freestanding Emergency Department.

There are special reimbursement rules that apply to Surprise Bills when determining the Plan's payment to the Out-of-Network Provider. These special reimbursement rules will always apply to the following covered non-Emergency Services when performed by an Out-of-Network Provider at an In-Network Hospital, ambulatory surgical center or Independent Freestanding Emergency Department:

(1) Covered services performed by an Out-of-Network Provider when an In-Network Provider is unavailable at the time the healthcare services are performed at the In-Network Hospital, ambulatory surgical center or Independent Freestanding Emergency Department;

(2) Covered services performed by an Out-of-Network Provider as a result of unforeseen, urgent medical issues that arise at the time such services are performed, even if you previously consented to the Out-of-Network Provider performing such services;

(3) Covered services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;

(4) Covered services provided by assistant surgeons, hospitalists, and intensivists; and

(5) Diagnostic services, including radiology and laboratory services.

A Surprise Bill does not include a bill for healthcare services when an In-Network Provider is available and you elected to receive services from an Out-of-Network Provider or, with respect to non-Emergency Services (other than those specified above) performed by an Out-of-Network Provider in a participating Hospital, ambulatory surgical center or Independent Freestanding Emergency Department if the Out-of-Network Provider has obtained your consent to receive the services after providing you with required notice and satisfying all other consent requirements applicable to the Out-of-Network Provider. If the Out-of-Network Provider follows the notice and consent requirements and you consent to receiving the services, the Plan's normal reimbursement rules with respect to Out-of-Network Providers will apply with regard to those services and you may be balance billed.

For Surprise Bills, the Plan will reimburse the Out-of-Network Provider an initial payment equal to the Recognized Amount. The Out-of-Network Provider must hold you harmless for any charges for the Surprise Bill that exceed your cost-sharing under the Plan (i.e. Copayment, Deductible or Coinsurance) for In-Network Providers. Your cost-sharing will be calculated based off of the Recognized Amount and will count towards your In-Network Deductible, if any, and your In-Network Out-of-Pocket Maximum.

For purposes of this Section, the "Recognized Amount" means the lesser of the billed charges or the "Qualifying Payment Amount." The "Qualifying Payment Amount" is the amount determined by the Plan in accordance with the requirements of 29 CFR 2590.716-3.

The provisions specified in this Section and in the Plan are designed to comply with the group health plan requirements of the No Surprises Act. The provisions are based on regulations published by the U.S. Department of the Treasury, Department of Labor, and Department of Health and Human Services (the "Departments") and will be interpreted to be consistent with those regulations. If the Departments issue additional guidance regarding the requirements of the No Surprises Act, the Plan will comply with the additional or modified requirements as required by such guidance.

To the extent the Plan provides coverage for air ambulance or Emergency Services for an Emergency Condition and the cost-sharing applied to such air ambulance services or Emergency Services when rendered by an Out-of-Network Provider is different than the cost-sharing applied when such services are rendered by an In-Network Provider, to the extent necessary to comply with the No Surprises Act, the Plan will apply the same cost-sharing to air ambulance services or Emergency Services for an Emergency Condition when rendered by an Out-of-Network Provider as the cost-sharing that is applied to such services when rendered by an In-Network Provider.

O. TRANSITIONAL CARE

If you are in an ongoing course of treatment when your In-Network Provider leaves the network, then you may continue to receive covered services for the ongoing treatment from the former In-Network Provider for up to 90 days from the date your provider's contractual obligation to provide services to you under the Plan terminates. If you are pregnant, you may continue care with a former In-Network Provider through delivery and postpartum care directly related to the delivery.

The provider must accept as payment the negotiated fee that was in effect just prior to the termination of the relationship of the provider with the network. The provider must also provide the Plan with necessary medical information related to your care and adhere to any policies and procedures established by the Plan, including those for assuring quality of care and obtaining preauthorization and a treatment plan approved by the Plan. You will receive covered services as if they were being provided by an In-Network Provider and will be responsible only for any applicable cost-sharing.

In addition to the above, if you are considered a "continuing care patient" and any benefits under the Plan are terminated because of a change in the terms of participation of your provider in the network, you will be given notice of such change or termination and will have the right to elect to continue coverage under the Plan, with respect to that provider, under the same terms and conditions that were in effect on the date you are given notice of the provider's change in network status or termination of benefits as a result of change in network participation. If you elect to continue such coverage under the Plan, coverage for transitional care with respect to that provider will be provided under those same terms and conditions only for the period ending on the earlier of (1) 90 days from the date the notice is provided or (2) the date you are no longer considered a "continuing care patient". In addition, coverage under those same terms and conditions during

this period of transitional care is limited to the condition for which you were receiving care from your provider, that qualifies you as a "continuing care patient," prior to the provider's change in network status.

For purposes of this section, you are a "continuing care patient" if you meet any of the following conditions:

(1) You are undergoing a course of treatment for a "serious and complex condition." For this purpose, "serious and complex condition" means:

   a. An acute illness that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
   b. A chronic illness that is life threatening, degenerative, potentially disabling or congenital and requires specialized medical care for a prolonged period of time.

(2) You are undergoing a course of institutional or inpatient care from the provider.

(3) You are scheduled to undergo non-elective surgery, including post-operative care from the provider.

(4) You are pregnant and undergoing a course of treatment for the pregnancy from the provider.

(5) You are terminally ill (as defined in Section 1861 of the Social Security Act) and receiving treatment for the terminal illness from the provider.

Please note, if the provider was terminated by the network due to fraud, imminent harm to patients, or a final disciplinary action by a state board or agency that impairs the provider's ability to practice, continued treatment with that provider is not available.

If you have any questions with respect to this section, please contact Excellus at the telephone number listed on your identification card.

VII. SUMMARY OF BENEFITS PROVIDED BY PARTICIPATING EMPLOYERS

Employer	Benefits
ABM @ NYSUT-CNY	Medical, Dental, Optical, Death Benefit and Supplemental Disability
ABM@ Met Life/NYSUT-Albany	Medical, Dental
ABM-WNY	Medical, Dental, Optical, Death Benefit and Supplemental Disability
Absolut @ Three Rivers Nursing Home	Dental and Weekly Disability
Acacia Park Cemetery	Dental, Optical and Weekly Disability
Akima @ Buffalo Detention Ctr	Medical, Dental, Optical and Weekly Disability
Alexandria Central School	Dental, Optical and Weekly Disability
Alice Hyde Hospital	Medical, Dental, Optical and Weekly Disability
Aramark @ Hartwick College	Medical, Dental and Optical
Atalian Global @ Utica College	Dental, Optical, Death Benefit and Supplemental Disability
Atalian Global Services @ Huron	Medical, Dental, Optical, Death Benefit and Supplemental Disability
Auburn Community Hospital	Medical, Dental, Optical and Weekly Disability
The Commons on St. Anthony	Medical, Dental, Optical and Weekly Disability
Autumn View Healthcare Facility	Dental and Optical
Bard College	Medical and Optical
Batavia Bus	Dental
Bethany Gardens	Medical, Dental
Birnie Bus-Syracuse	Medical, Dental
Bishop Rehab & Nursing Ctr	Medical
Buffalo General Hospital	Dental
Canisius College	Dental and Weekly Disability
Canton Potsdam Hospital	Medical, Dental and Optical
Carthage Area Hospital	Medical, Dental and Optical
Carthage Hospital LPN/Tech	Medical, Dental with Orthodontia and Optical
Cayuga Centers	Dental
Cayuga Nursing & Rehab	Medical, Dental
CDS Monarch Inc.	Weekly Disability
Central Square Schools	Dental, Optical and Weekly Disability
Chenega @ Buffalo Detention Center	Medical, Dental, Optical and Weekly Disability
City Of Cortland	Dental and Weekly Disability
City Of Oswego	Dental with Orthodontia, Optical and Weekly Disability
Claxton Hepburn Medical Center	Medical, Dental, Optical and Weekly Disability
Collar City Nursing & Rehab Ctr	Medical, Dental, Optical and Weekly Disability
Community Memorial Hospital	Medical, Dental, Optical and Weekly Disability
Community Memorial Hosp-Non-Union	Medical and Optical
Compass Group @ D'Youville College	Medical, Dental, Optical, Death Benefit and Supplemental Disability
Comprehensive At Williamsville	Dental and Optical
Contract Specialists, Inc.	Medical, Dental, Optical, Death Benefit and Supplemental Disability
Corning Center	Weekly Disability

Corporate Maintenance @ BC/BS	Dental
Crouse Hospital	Dental, Optical and Weekly Disability
CVPH Medical Center	Dental
Durham School Services-Minetto	Dental
East Syracuse Minoa Ctrl	Dental, Optical and Weekly Disability
Elderwood At Williamsville	Dental and Optical
Ellicott Center	Dental and Optical
Elmlawn Cemetery	Dental
Finger Lakes Racetrack	Medical, Dental
First Class Maintenance @ UPS Albany	Medical
First Class Maintenance @ UPS Syr.	Medical, Dental, Optical, Death Benefit and Supplemental Disability
First Class Maintenance	Medical, Dental, Optical, Death Benefit and Supplemental Disability
First Student-Auburn	Dental and Optical
First Student-Syracuse	Dental, Optical and Weekly Disability
Forestville Central School	Weekly Disability
Service Employees Benefit Fund	Medical, Dental, Optical, Death Benefit, Weekly and Supp. Disability
Garden Gate Healthcare Facility	Dental and Optical
Gate Of Heaven Cemetery	Dental with Orthodontia and Weekly Disability
GDI Services @ Pall Trinity	Medical, Dental, Optical, Death Benefit and Supplemental Disability
Global @ Verizon	Medical, Dental, Optical, Death Benefit and Supplemental Disability
Gouverneur Hospital	Medical, Dental and Optical
Gowanda Nursing Home LPN/Pro/Tech	Dental with Orthodontia and Optical
Gowanda Nursing Home CNA'S	Dental and Optical
Guilfoyle Ambulance	Weekly Disability
Hamburg School District	Dental, Optical and Weekly Disability
Holy Cross Cemetery	Dental with Orthodontia and Weekly Disability
Holy Sepulchre Cemetery	Dental with Orthodontia and Weekly Disability
Home Aides Of CNY	Medical, Dental, Optical and Supplemental Disability
Integra Consulting, Inc	Medical, Dental and Optical
Jewish Home of Central NY	Medical, Dental, Death Benefit and Weekly Disability
Jordan - Elbridge Schools	Weekly Disability
JLL @ Bristol	Medical, Dental, Optical, Death Benefit and Supplemental Disability
K & G Property Mgmt. Services	Medical, Dental
Liverpool Schools	Weekly Disability
Local 1199 Regional Pension Fund	Dental with Orthodontia and Optical
Local 200United	Weekly Disability
Loretto Health & Rehab	Medical, Dental and Weekly Disability
Lyncourt Schools	Weekly Disability
Masonic Care Community	Dental
Massena Hospital	Medical, Dental and Optical
McAuley Residence	Dental with Orthodontia and Optical
Menorah Park Residences (Jewish Home)	Medical, Dental, Death Benefit and Weekly Disability
Millard Fillmore Suburban	Dental and Optical
Mount Calvary Cemetery	Dental with Orthodontia

Mount St Mary's Hospital	Dental and Optical
Mt Olivet Cemetery	Dental with Orthodontia and Weekly Disability
Newfane Rehabilitation Ctr.	Dental and Optical
Niagara Falls Mem Med Ctr.	Dental and Optical
North Gate Healthcare Facility	Dental and Optical
North Syracuse Ctrl School	Weekly Disability
Oaks At Dewitt (Jewish Home)	Medical, Dental, Death Benefit and Weekly Disability
Oakwood Cemetery	Medical, Dental, Optical, Death Benefit, Weekly and Supp. Disabi
Oishei Children's Hospital	Dental with Orthodontia and Optical
Oneida Ctr For Rehab/Nursing	Dental and Optical
Our Lady of Peace	Dental and Optical
Pathways	Medical, Dental, Optical and Weekly Disability
Pembroke Schools	Dental and Optical
Pollak Innovative Mgmt. @ Newfane	Dental and Optical
Quest Services	Medical, Dental, Optical, Death Benefit and Supplemental Disability
Rochester Regional Joint Board	Dental with Orthodontia and Optical
Rosewood Rehab & Nursing Ctr	Medical, Dental, Optical and Weekly Disability
Safire of Northtowns	Dental and Optical
Samaritan Keep Home	Medical, Dental and Optical
Samaritan Medical Ctr	Medical, Dental and Optical
Samaritan Summit Village	Medical, Dental and Optical
SBM @ State Farm	Medical, Dental and Death Benefit
SBM Site Services @ Bristol	Medical, Dental, Optical, Death Benefit and Supplemental Disability
Schoellkopf Health Ctr	Dental and Optical
Schofield Residence Inc.	Dental and Optical
Seneca Health Care Center	Dental and Optical
Service Employees Pension Fund	Medical, Dental, Optical, Death Benefit, Weekly and Supp. Disability
Sodexo @ Clarkson University	Medical, Dental, Optical, Death Benefit and Weekly Disability
Sodexo @ Hobart/Wm Smith College	Medical, Dental and Optical
Sodexo @ Nazareth College	Medical, Dental and Optical
Sodexo @ Sisters Hosp	Dental with Orthodontia and Optical
SP Plus	Medical, Dental, Optical, Death Benefit and Supplemental Disability
St. Adalbert Cemetery	Dental with Orthodontia and Weekly Disability
St. Lawrence University	Dental, Optical and Weekly Disability
St. Luke Health Services	Medical and Optical
Syracuse University	Dental, Optical and Weekly Disability
The Cottages	Medical, Dental and Weekly Disability
The Grand Rehab & Nursing@ Delaware Pk	Dental and Optical
Tonawanda City School District	Dental, Optical and Weekly Disability
Touchpoint-Lourdes Hospital	Medical, Dental, Optical, Death Benefit and Supplemental Disability
Town Of Marshall	Medical, Dental, Optical and Weekly Disability
Town Of West Monroe	Dental
UG2 @ Lemoyne College	Medical, Dental, Optical, Death Benefit and Supplemental Disability

Utica City School District	Dental, Optical and Weekly Disability
V A Medical Center	Dental, Optical and Weekly Disability
Vanderheyden Hall	Dental, Optical and Weekly Disability
Vestal Hills Memorial Park	Medical
Village Of Hamilton	Death Benefit and Weekly Disability
Waterville Ctrl School	Dental, Optical and Weekly Disability
Weinberg Campus Inc	Dental with Orthodontia and Optical
West Genesee Central Schools	Dental, Optical and Weekly Disability
William George Agency	Dental and Optical
Williamsville Sub Nursing Home	Dental and Optical

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

250 S. Clinton Street, Suite 200
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(315) 218-6513
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