IMPORTANT PHONE NUMBERS

Benefit Fund's Member Services Department	Aetna Member Services Department	Cigna Member Services Department
(646) 473-9200	(866) 658-2455	(800) 244-6224 (CIGNA24)

DISCLAIMER

This document is not the official Summary Plan Description (SPD) of the 1199SEIU Greater New York Benefit Fund for New Jersey Area Members. Please consult the SPD for a full description of your Fund benefits. In case of any conflict between this document and the SPD, the terms of the SPD shall govern.

Members can request a Summary Plan Description (SPD) by calling the Member Services Department at (646) 473-9200. Outside New York City area codes, call (800) 575-7771. Westchester and upstate counties, call (877) 557-1199. The SPD is also available on the Fund's website at www.1199SEIUBenefits.org.

1199SEIU Funds
Benefit and Pension

1199SEIU GREATER NEW YORK BENEFIT FUND
for New Jersey Area Members

330 West 42nd Street

New York, NY 10036-6977

(646) 473-9200

Outside New York City area codes: (800) 575-7771

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MARCH 2012

1199SEIU

Greater New York Benefit Fund for New Jersey Area Members

Overview of Your Benefits

COVERAGE	IN-NETWORK BENEFITS ONLY
Deductible (per contract year) Once Family Deductible is met, all family members will be considered as having met their deductible for the remainder of the contract year.	• $225 per individual/$450 per family
Member Coinsurance Applies to all expenses unless otherwise stated	• Covered 85%
Payment Limit (per contract year) Certain member cost-sharing elements may not apply toward the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the contract year.	• $800 per individual/$1,600 per family (excludes deductible)
Contract Year Maximum	• $50,000 per member increasing to $75,000 per member effective January 1, 2012
Primary Care Physician Selection	• Optional
Referral Requirement	• None
PREVENTIVE CARE	
Routine Adult Physical Exams/Immunizations 1 exam per 12 months for members over age 18	• 100% after office visit co-pay
Routine Well-Child Exams/Immunizations	• 100%
Routine Gynecological Care Exams 2 exams per 12 months. Includes routine tests and related lab fees.	• 100% after $10 office visit co-pay
Routine Mammograms 1 baseline between ages 35 to 39 1 per year for covered females age 40 and over	• 100%
Routine Digital Rectal Exam/Prostate–specific Antigen Test Covered 1 per 12 months for males age 40 and over	• 100%
Colorectal Cancer Screening For all members age 50 and over	• 100%
Routine Hearing Exams	• Not Covered

COVERAGE	IN-NETWORK BENEFITS ONLY
PHYSICIAN SERVICES	
Office Visits to Primary Care Practitioner (PCP) Includes services of an internist, general physician, family practitioner or pediatrician	• $10 office visit co-pay
Specialist Office Visits	• $10 office visit co-pay
Allergy Testing	• Covered as either PCP or specialist visit
Allergy Injection	• $10 office visit co-pay (Serum – no charge if dispensed in a doctor's office)
Diagnostic Procedures If performed as part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost–sharing.	• Covered 85% after deductible is met
EMERGENCY MEDICAL CARE	
Urgent Care Provider (benefit availability may vary by location)	• $75
Non-Urgent Use of Urgent Care Provider	• Covered
Emergency Room	• $125 co-pay (waived if admitted)
Non-Emergency Care in an Emergency Room	• Not Covered
Ambulance	• Covered 85% after deductible is met
HOSPITAL CARE	
Inpatient Coverage The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.	• Covered 85% after deductible is met
Inpatient Maternity Coverage The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.	• Covered 85% after deductible is met
Outpatient Surgery	• Covered 85% after deductible is met
Outpatient Hospital Expenses (excluding surgery) The member cost-sharing applies to all Covered Benefits incurred during a member's outpatient visit.	• Covered 85% after deductible is met

COVERAGE	IN-NETWORK BENEFITS ONLY
The following dental benefits are provided by Cigna subject to co-payments and limitations as described. Other than in emergency situations, benefits are not provided for services rendered by a non-participating dentist.	
DENTAL	
Benefits provided for full-time members and their eligible dependents only, and Genesis employees and their eligible dependents based upon your family election.	• Each individual must select a Cigna dentist as their designated (or primary care) dentist. • Other than for emergencies, services must be performed by your designated Cigna participating dentist. • Referrals required for some specialists • Co-payments and limitations may apply for some procedures, excluding essential oral pediatric services. • No annual maximum
The following benefits are provided directly by the Benefit Fund:	
PRESCRIPTION DRUGS	
	• FDA-approved prescription medications for FDA-approved indications, except plan exclusions • $10 co-pay for generic drugs and $15 co-pay for preferred brand-name drugs • Use Participating Pharmacies • Maintenance drug access program for chronic conditions – *The 90-Day Rx Solution* • Comply with the Benefit Fund's prescription programs, including prior authorization when required. • Please refer to "What Is Not Covered" in Section II.L. • For a complete list of these programs, call the Benefit Fund at (646) 473-9200 or visit www.1199SEIUBenefits.org. • Please note "What Is Not Covered" in Section VII.

COVERAGE	IN-NETWORK BENEFITS ONLY
DISABILITY BENEFITS	
Member-Only Benefit	• Disability benefits are provided through your employer. • Member must submit proof to the Benefit Fund that disability benefits have been received to maintain your health coverage for up to 26 weeks. • Follow the same procedure if you are receiving Workers' Compensation. If you need help or advice in filing a Workers' Compensation claim, call the Benefit Fund at (646) 473-9200.
LIFE INSURANCE	
Member-Only Benefit	• Eligibility Class I – During your first year of service, benefit is $2,000. After your first year, based on your years of service and annual earnings up to a maximum of $25,000. • Eligibility Class II – During your first year of service, benefit is $1,250. Maximum benefit amount is $2,500. • Eligibility Class III – Maximum benefit amount is $1,250.
ACCIDENTAL DEATH AND DISMEMBERMENT	
Member-Only Benefit	• For accidental death or injury • Equal to, or one-half of, your life insurance
BURIAL	
Eligibility Class I: Member and Spouse Eligibility Class II: Member Only Eligibility Class III: Not covered	• Free burial plot with permanent care • Plots located in New York and New Jersey

LEGEND

Member:	You, the member
Spouse:	Your spouse, if eligible
Children:	Your children, if eligible
Family:	You, your spouse and your children, if eligible

COVERAGE	IN-NETWORK BENEFITS ONLY
MENTAL HEALTH SERVICES	
Inpatient Limited to 30 days per contract year The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.	• Covered 85% after deductible is met
Outpatient Limited to 30 visits per contract year The member cost-sharing applies to all covered benefits incurred during a member's outpatient visit. Maximums are combined for mental health and alcohol/drug abuse services.	• $10 co-pay
ALCOHOL/DRUG ABUSE SERVICES	
Inpatient Limited to 30 days per contract year The member cost-sharing applies to all covered benefits incurred during a member's impatient stay.	• Covered 85% after deductible is met
Outpatient Limited to 60 visits per contract year. The member cost-sharing applies to all Covered Benefits incurred during a member's outpatient visit. Maximums are combined for mental health and alcohol/drug abuse services.	• $10 co-pay
OTHER SERVICES	
Convalescent Facility Limited to 60 visits per contract year The member cost-sharing applies to all covered benefits incurring during a member's inpatient stay.	• Covered 85% after deductible is met
Home Health Care Includes private duty nursing Each visit by a nurse or therapist is one visit. Each visit up to four hours by a home health care aide is one visit.	• Covered 85% after deductible is met
Hospice Care – Inpatient The member cost-sharing applies to all covered benefits incurred during a member's inpatient stay.	• Covered 85% after deductible is met
Hospice Care – Outpatient The member cost-sharing applies to all covered benefits incurred during a member's outpatient visit.	• Covered 85% after deductible is met

COVERAGE	IN-NETWORK BENEFITS ONLY
Outpatient Short-Term Rehabilitation Includes speech, physical, and occupational therapy, limited to 20 visits per contract year	• $10 co-pay
Spinal Manipulation Therapy	• $10 co-pay
Durable Medical Equipment Maximum annual benefit of $700 per member per contract year	• Covered 85% after deductible is met
Diabetic Supplies	• Covered as any other medical expense
Contraceptive Drugs and Devices Not Obtainable at Pharmacy (includes coverage for contraceptive visits)	• Covered 85% after deductible is met. Payable as any other covered expense.
Transplants Coverage is provided at an IOE-contracted facility only ($10,000 travel max).	• Covered 85% after deductible is met. Payable as any other covered expense.
Mouth, Jaws and Teeth	• Member cost-sharing is based on the type of service performed and the place of services where it is rendered.
Vision	• One pair of glasses every 24 months, including contact lenses • Reimbursement to the member upon receipt of a claim • $125 allowance once every 24 months
FAMILY PLANNING	
Infertility Treatment	• Not Covered
Voluntary Sterilization Including tubal ligation and vasectomy	• Member cost-sharing is based on the type of service performed and the place of service where it is rendered.