INTRODUCTION

PLAN 1 SUMMARY PLAN DESCRIPTION BOOKLET

This booklet contains a summary in English of the benefits available under Plan 1 of the Local 25 S.E.I.U. Welfare Fund. If you have any difficulty understanding any part of this booklet, contact the Fund Office. The address and telephone number of the Fund Office is:

Este folleto contiene un resumen en ingles de sus beneficios disponibles bajo el plan del Local 25 S.E.I.U. Welfare Fund. Si tiene alguna dificultad en entender cualquier parte de este folleto, favor de comunicarse con las Oficinas de Fondo. La direccion y telefono de la Oficina de Fondo es:

Sprawozdanie to posiada wytlumaczenie waszego planu oraz praw w pobieraniu swiadczen wedlug ustalonego programu Local 25 S.E.I.U Welfare Fund. Jezeli masz problem ze zrozumieniem planu, dzwon do Welfare Fund. Podajemy adres i numer telefonu biura Welfare Fund:

Ova knijizica daje vam kraci sadrzaj beneficija na engleskom jeziku prema planu Local 25 S.E.I.U. Welfare Fonda. Ako imate poteskoca u razumjevanju bilo kojeg dijela ove knjizice, kontaktirajte ured Fonda. Adresa i telefonski broj Fonda:

LOCAL 25 S.E.I.U. FUND OFFICE
111 East Wacker Drive, 17th Floor
Chicago, Illinois 60601-4200
Telephone: (312) 233-8888
Fax: (312) 233-8839
Claim Department Telephone: (312) 233-8899
Claim Fax: (312) 233-8835

Open Monday through Friday, 8:30 a.m.-5:00 p.m.

Local 25 S.E.I.U. Welfare Fund also sponsors a Plan 2 and Plan 3 for employees and their dependents, and a Plan 4 for employees only. The benefits and rules for these Plans are described in separate Summary Plan Description (SPD) booklets.

TABLE OF CONTENTS

IMPORTANT INFORMATION

EMERGENCIES AND SERIOUS HEALTH PROBLEMS

1. If you have a "**life-threatening emergency**," call 911. Then you (or someone acting for you) must contact UHS as soon as medically possible. A UHS doctor must supervise your treatment and follow-up care. If you need to contact UHS for an emergency, call (312) 423-4200. Ask for the Medical Management Department, extension 3231.

2. If you develop a serious health problem, call **(312) 423-4200**. There is a **24-hour answering service** to help you. For more information, see page 18.

HOW YOUR BENEFITS ARE PROVIDED

Your Local 25 SEIU Welfare Fund benefits are either self-funded or provided through contracts with various health care providers, as shown below:

Insured	**Self-Funded**
Medical (physician) care - UHS	Weekly disability benefits
Dental - BCBSIL	Hospital benefits
Vision - UHS	Hospital PPO - BCBSIL
Prescription drugs - Union Pharmacy Service (UPS)	

UHS REFERRALS

A UHS referral does not guarantee that the services will be covered. You should call the Fund Office before seeking care to find out whether your treatment is covered.

RESPONSIBILITIES OF PARTICIPANTS

You, as a participant in this Plan, must meet certain responsibilities in order to stay eligible and to get benefits from the Plan.

1. You and your spouse should read this Summary Plan Description (SPD booklet).

2. Be sure the information on your Enrollment Card on file at the Fund Office is correct and current.

3. Tell the Fund Office right away if your address changes.

4. Take or send the following documents to the Fund Office:

   - ❒ A copy of your marriage certificate.
   - ❒ Copies of birth certificates for everyone in your family (including yours).
   - ❒ For children mentioned in a divorce decree or other court order, copies of the divorce decree/court order regarding custody and financial responsibility for the child(ren).

5. Tell the Fund Office right away if your family status changes because of marriage, birth or adoption of a child, death, divorce, or a child losing dependent status.

6. Tell the Fund Office if you or a dependent become totally disabled or become eligible for Medicare.

7. When you have a claim for benefits, follow the directions in "How to File a Claim" on page 57 so that your benefits can be paid promptly.

8. If you are making self-payments for COBRA Coverage, be sure the Fund Office gets your payments, in the correct amount, on or before the due date.

UHS FACILITIES

Main Telephone Number: (312) 423-4200

Extensions:
Member Services: 3285, 3291
Medical Management: 3231
Claims: 3262

Website: www.unionhealth.org

MAIN FACILITY (POLK STREET)

Primary and Specialty Care
(including eye care)

1634 West Polk Street, Chicago, Illinois 60612

This UHS facility has extended hours on weekends and some nights.

SATELLITE FACILITIES

Primary Care

North

4701 North Cumberland Avenue, Suite 21-26, Norridge, IL 60706

South

2800 West 87th Street, Chicago, IL 60652

West

610 South Maple Avenue, Suite 2300, Oak Park, IL 60304

3535 East New York Street, Suite 210, Aurora, IL 60504

East

1325 West Howard Street, Evanston, IL 60202

UHS CONTRACTED PHYSICIANS

SOUTH SUBURBAN FACILITIES

Adult General Medicine

17400 S. Kedzie Ave, Suite 106, Hazel Crest, IL 60429
6700 W. 167th Street, Suite 4&5, Tinley Park, IL 60477
12800 S. Ridgeland Avenue, Suite 2E, Palos Heights, IL 60463

Obstetrics & Gynecology

3700 West 203rd Street, Suite 110, Olympia Fields, IL 60461
1890 Silver Cross Boulevard, Suite 310, New Lenox, IL 60451

Pediatrics

4440 W. Lincoln Highway, Matteson, IL 60443
10225 W. Lincoln Highway, Frankfort, IL 60423

WEST SUBURBAN (AURORA) FACILITIES

Family Practice

2320 South Route 59, Plainfield, IL 60586

Adult General Medicine

1300 North Highland Avenue, Suite 2, Aurora, IL 60506

Obstetrics & Gynecology

2418 West Indian Trail Road, Suite B, Aurora, IL 60506

Pediatrics

2121 Ridge Ave, Suite 101, Aurora, IL 60504

UHS contracted physicians and locations are subject to change.

ABOUT YOUR UHS SUBSCRIPTION CERTIFICATE - This booklet summarizes the services and benefits provided by Union Health Service (UHS) as stated in the UHS Subscription Certificate. If there is any discrepancy between the Subscription Certificate and this booklet, the terms of the Certificate shall govern. You can get a UHS Subscription Certificate by contacting the Fund Office or UHS.

SCHEDULE OF BENEFITS

Notes about the Medical Expense Benefit:

- All benefits and limitations apply to each covered person (your or your dependent) separately.
- You are considered to be **"In-Plan"** if you get medical care at a UHS facility, or if your care is provided by or arranged by a UHS doctor.
- **"Out-of-Plan"** means that a UHS doctor did NOT provide, recommend, refer, or arrange for your care or treatment.
- You must call the Review Organization for any Out-of-Plan hospitalization. **Call 1 (800) 367-1934.**
- All benefits are subject to coordination of benefits (see page 38). If another healthcare plan is primary, you must follow the rules of the primary plan.
- Plan payments shown are ONLY for covered expenses if you are eligible for benefits. Plan payments are subject to the rules and limitations explained in this SPD booklet.

MEDICAL EXPENSE BENEFITS

UHS Services	UHS Facility
Medical services provided by UHS at UHS	100%

Medical Expense Benefit (continued)		
"Year" means a calendar year.	**In-Plan**	**Out-of-Plan**
Deductibles		
Deductible for inpatient treatment of each sickness	$0	$500 per sickness
Deductible for inpatient treatment of all injuries caused by the same accident	$0	$500 per accident
Noncompliance deductible for each hospital confinement when you do not follow the Hospital Review Program rules (page 21)	$0	$100
Deductible for treatment at an emergency room or emergency treatment center for a condition that does not meet the definition of "emergency" (page 52)	$0	$500 per visit
Plan Co-Pay Percentages (Out-of-Plan benefits are subject to the deductibles shown above)		
Inpatient hospital & skilled nursing facility	100%	80%
Outpatient hospital	100%	not covered
Emergency treatment (as defined by the Plan – see page 52)	100%	80% facility only
Psychiatric visits	100%	not covered
All other covered expenses, including physicians and other non-hospital expenses (as described on pages 22-27)	100%	not covered
Special Limitations		
Chiropractic Treatment - Maximum amount payable	$1,000 per year	not covered

Medical Expense Benefit (continued)		
Special Limitations (continued):	**In-Plan**	**Out-of- Plan**
Speech Therapy for treatment of a congenital defect - Maximum amount payable	$2,000 per year	not covered
Hospital Room & Board - Maximum covered expense, including intensive care units	semi-private rate	
Hospice Care - Maximum benefit	$10,000 lifetime	not covered
Home Health (Nursing) Care - Maximum amount payable *Benefits paid for non-self-administered injectable drugs and portable oxygen supply units do not apply to this calendar year maximum amount.* *UHS may, on a case-by-case basis, authorize additional home health care (see page 24).*	$10,000 per year	not covered
Skilled Nursing Facility Care - Maximum allowable days of confinement *UHS may, on a case-by-case basis, authorize additional days of skilled nursing facility care (see page 24).*	30 per calendar year	

Your health care provider is the Union Health Service (UHS)—not Blue Cross Blue Shield of Illinois (BCBSIL). BCBSIL provides access to its provider network, but UHS determines which inpatient and outpatient hospitals and facilities you should use.

If your UHS doctor arranges special services for a family member that are not provided at a UHS facility, you should call the Fund Office to confirm whether the treatment will be covered by the Plan. A referral does not guarantee that the services will be covered. (See "Medical Expense Benefit Covered Expenses" starting on page 22.)

Remember—Your benefits are much better if you stay In-Plan.

UNION PHARMACY SERVICE (PRESCRIPTION DRUG INSURANCE)

YOUR CO-PAYS for covered prescription drugs purchased at a participating pharmacy (including the UHS Polk Street facility):	
Formulary generics	$10
Formulary brand name drugs	$20

There is no coverage for any drug not on the formulary.

Notes about the Union Pharmacy Service Benefit:

- If the discounted price for your drugs is less than the fixed co-pay amount shown above, you will only have to pay the discounted price.
- You must pay the full price for non-formulary medications. However, certain drugs may be discounted if you use a participating pharmacy.

DENTAL INSURANCE

Dental benefits for you and your dependents are provided through the BlueCare® Dental DMO Plan 740. The BlueCare Dental program requires you and your dependents to pick a participating dental office. You will have to get your dental care at this dental office. The Plan does not cover dental care received outside the DMO program. However, treatment for non-occupational injury to sound natural teeth may be covered under the medical plan.

WEEKLY DISABILITY BENEFITS

For eligible employees only.

Amount of weekly benefit (per period of disability):	
For the first 13 weeks of disability	$200
For the second 13 weeks of disability	$100
Day that benefits start:	
For non-occupational injury	1st day
For non-occupational sickness: If confined to a hospital before the 8th day If outpatient surgery is performed before the 8th day	 1st day of confinement Day of surgery
Other disabilities due to sickness	8th day

DISMEMBERMENT BENEFITS

For eligible employees only.

For loss of:	
Both hands, both feet, sight of both eyes, one hand and one foot, or one hand and sight of one eye	$1,000
One hand, or one foot, or sight of one eye	$500
Thumb and index finger of either hand	$250

BENEFITS PROVIDED THROUGH UHS

The following pages are a SUMMARY of the services and supplies that UHS doctors provide at UHS facilities.

It is to your advantage for you and your family to receive your medical care through UHS. UHS facilities provide many services and supplies free of charge to you and your dependents. If you use UHS doctors, or if your care is arranged by UHS doctors, the Plan generally pays 100% of the cost. (See the Schedule of Benefits beginning on page 8 for exceptions and maximum benefits for certain types of care.)

The main purpose of your Plan is to keep you and your family healthy. When you first become covered, you should make an appointment at a UHS facility for yourself and each of your dependents for a physical examination and medical history.

Having an examination while you are well lets you become familiar with UHS facilities, staff, and your own personal doctor. It gives you the chance to ask questions about regular check-ups and other preventive steps that will help keep you healthy. It also lets UHS doctors start a medical history for each family member.

For a complete list of the services provided by UHS, please keep reading this SPD or request a copy of your UHS Subscription Certificate.

MEDICAL CARE AVAILABLE THROUGH UHS

Medical services at UHS are provided by a group of doctors, including specialists in the major fields of medicine and surgery who work as a team, supported by a staff of technical and nursing personnel.

Necessary hospital care for you or your dependent will be arranged by a UHS doctor at a hospital where the doctor has staff privileges. (If a hospitalization is not arranged by a UHS doctor, the hospital expenses will be paid under the Out-of-Plan Schedule of Benefits (see pages 9-10).)

HOW TO USE UHS

This section explains how to make appointments at UHS facilities and how to arrange for different types of medical care. The same procedures apply to your dependents.

The addresses of the UHS facilities are shown on pages 6-7.

MAKING APPOINTMENTS

- Contact UHS at **(312) 423-4200**. An automated operator will connect you with the facility or department you want to use. The UHS Member Service Department will check your eligibility for UHS coverage.
  - ❒ Have the following information handy: Your name, Social Security number or alternate/unique I.D. number, home address and telephone number, Local number and name of your employer.
  - ❒ Also give your date of birth and, if you have one, your personal chart number (for a dependent, give his name, date of birth, and personal chart number).
- Routine physicals will be scheduled in about 4-6 weeks.
- If you are sick and need to see a doctor immediately, UHS has physicians available by telephone 24 hours a day, seven days a week.
- UHS has a call-first policy (additional information is available through the UHS Member Service Department).
- If you can't keep an appointment, please telephone and cancel it at least 24 hours in advance of the appointment so that another patient can be scheduled at that time.

UHS I.D. CARDS - When you or a dependent goes to UHS for the first time, a confidential medical record will be prepared and you (or your dependent) will get a UHS I.D. card. Each family member's card has his or her unique UHS I.D. number on it, as well as the person's name, birth date, and personal chart number.

When making or keeping future appointments, have the card handy so you can give the receptionist the patient's chart number. (You should carry your card in case you need it in an emergency.)

SERVICES AND SUPPLIES PROVIDED BY UHS

The following list is a **SUMMARY** of the services and supplies that are provided at UHS facilities by UHS doctors **at no cost to you unless otherwise stated**. For a complete list of the services provided by UHS, see your UHS Subscription Certificate.

Unless specified otherwise, these services are only provided by UHS doctors at UHS facilities.

- **Ambulance –** UHS-ordered transportation for authorized transfers.
- **Anesthesiology –** At UHS only.
- **Audiometry** (Hearing Screening) – At UHS or when arranged by UHS.
- **Chemical Dependency and Mental or Nervous Disorders:**
  - ❒ For outpatient treatment, UHS arranges care.
  - ❒ For inpatient treatment, UHS provides diagnosis of the condition and arranges treatment in a hospital or approved treatment facility.
- **Chemotherapy –** At UHS. (When arranged by UHS but performed at a hospital or an authorized oncologist's office as an outpatient, the services will be considered for payment under the Medical Expense Benefit.)
- **Colorectal Cancer Screening –** UHS provides screening flexible sigmoidoscopies at least once every 3-5 years for persons who are at least age 50. More frequent screenings may be provided as determined on a case-by-case basis by the person's primary care physician.

  Note: Persons who are at high risk of colorectal cancer are offered a colonoscopy at least once every ten years, or more frequently if medically indicated.
- **Diabetes Self-Care –** UHS will provide self-management training and education.
- **Doctor Consultations –** When arranged by UHS.
- **Drugs –** When administered at UHS.

- **Emergency Room –** Doctor and facility fees for emergency room care are considered for payment under the Medical Expense Benefit). See page 17 for important details.
- **Eye Care –** Provided at the Polk Street facility only (see page 6).
- **Family Planning Services –** At UHS. (Treatment or services for infertility are not covered.)
- **Hemodialysis –** UHS covers the cost of outpatient services if arranged by UHS.
- **Immunizations –** At UHS. Includes immunizations, booster shots and flu shots.
- **Laboratory Tests –** At UHS or as an outpatient at another facility when arranged by UHS.
- **Maternity (Obstetrical) Care**.
- **Mental or Nervous Disorders –** (Included in "Chemical Dependency and Mental or Nervous Disorders," above.)
- **Newborn Care –** At UHS.
- **Ophthalmology –** At UHS.
- **Pathology –** At UHS.
- **Podiatry –** At UHS.
- **Pre-Admission Testing –** At UHS.
- **Preventive Health Care and Examinations --**At UHS.
- **Radiation Therapy –** Covers doctors and facility fees (outpatient only) for therapy referred by UHS.
- **Radiology –** Tests performed at UHS or performed on an outpatient basis when arranged by UHS.
- **Speech Therapy –** Up to three outpatient visits for the initial speech evaluation and recommendation for follow-up treatment when the services are arranged by UHS.
- **Surgery –** Surgical services, on an inpatient or outpatient basis, performed or arranged by UHS doctors, including medically necessary assistant surgeon's fees. (Facility charges and other charges are considered for payment under the Medical Expense Benefit).

EYE CARE SERVICES AT UHS

Eye care services are available to ***all eligible family members*** at the Polk Street UHS facility. These services include eye examinations, prescriptions for eyeglasses and contact lenses, and treatment of eye diseases. Eye surgery is also provided by eye specialists. ***The Plan does not pay or reimburse any expenses incurred for eyeglasses or contact lenses.***

To make an appointment for eye care, contact the Polk Street facility at (312) 423-4200, extension 3220.

HOSPITAL CARE BY UHS DOCTORS

If you (or a dependent) are hospitalized by a UHS doctor, all arrangements for the hospital admission will be made by your doctor. The doctor will admit you to a hospital where he or she has staff privileges. There will be no charge for a UHS doctor's services in the hospital for medical care, surgery, consultations, or childbirth care.

UHS Core Hospitals - *UHS has made arrangements with certain core hospitals, and you should always use the hospital that UHS recommends. If you don't, your treatment will be considered Out-of-Plan—even if the hospital is in the BCBSIL PPO network.*

Benefits are paid by the Plan under the Medical Expense Benefit for covered expenses that are incurred for hospitalizations and certain other types of care.

UHS SUBSCRIPTION CERTIFICATE

The previous pages contained only a **SUMMARY** of the services and supplies that are provided at UHS facilities by UHS doctors. Refer to your UHS Subscription Certificate for a complete list of the services available to you at a UHS facility. You can obtain a UHS Subscription Certificate by contacting the Fund Office or UHS.

WHAT TO DO IN CASE OF AN EMERGENCY OR SERIOUS HEALTH PROBLEM

1. **If you have a "life-threatening emergency,"** call 911. Then, you (or someone acting for you) must contact UHS as soon as it is medically possible so that a UHS doctor can supervise the treatment and provide your follow-up care. To contact UHS in an emergency, call

(312) 423-4200 and ask for the Medical Management Department, extension 3231.

If you (or a dependent) need to be hospitalized because of an emergency, you or someone acting for you must contact UHS. If it is not medically possible to contact UHS prior to the admission, UHS must be contacted as soon as possible after your hospitalization begins.

Be sure to read the definition of "emergency" on page 52. **If you get emergency care for a medical problem before calling UHS, and the condition is determined NOT to meet the definition of an emergency, the treatment will be considered Out-of-Plan, and a $500 deductible will apply to the covered expenses incurred for the care provided by the hospital emergency room or emergency treatment center.** In addition, you will pay 20% of the Out-of-Plan hospital expenses over the $500 deductible. Out-of-Plan charges for doctors' services are not covered.

2. **If you develop a serious health problem, call (312) 423-4200.** There is a 24-hour answering service to help you. Please listen to the automated message. When the operator answers, give: your name, ID number, telephone number, your doctor's name if you already have one, and explain your health problem. Either your doctor or a UHS doctor who is on call, will call you back and tell you what to do.

MEDICAL EXPENSE BENEFIT

The Medical Expense Benefit is the self-funded benefit under which the Plan makes payments for:

- In-Plan hospital and other covered medical care not available at a UHS facility but that is arranged by UHS.

  You should call the Fund Office—before the treatment begins—to confirm whether the UHS-arranged treatment will be covered. A referral does not guarantee that the services will be covered. (See "Medical Expense Benefit Covered Expenses" starting on page 22.)

- Out-of-Plan inpatient hospital and skilled nursing facility care, and Out-of-Plan outpatient hospital care for treatment of a medical emergency.

The Medical Expense Benefit is NOT the benefit under which UHS services are covered. UHS provides services to you directly. You do not need to file a claim under this benefit for services you get at UHS. (The UHS services available to you and your family are described in the previous section.)

The following sections explain how your Medical Expense Benefits are paid (also see the Schedule of Benefits starting on page 8).

SPECIAL LIMITATIONS

There are limits on the amount the Plan pays for certain types of treatment during a person's lifetime, or during a calendar year. For example, there is a limit on the amount the Plan pays for home health care during a calendar year. The amount of this limit and the other special limitations that apply are shown on the Schedule of Benefits (see page 8).

***IMPORTANT NOTE ABOUT R&C** – The Plan provides coverage for the reasonable cost of covered health care services. For this reason, covered expenses will only be considered UP TO the reasonable and customary (R&C) charge for the procedure or service provided. This applies to all professional fees, including charges for surgery, anesthesia, diagnostic tests and office services. The amount of an R&C charge is determined by using current statistical data to compare a particular charge with charges made for the same service in the same zip code area for persons of the same age and with similar medical histories or complications. If a particular charge is more than what is considered to be*

R&C, the Plan will not cover any amount over the R&C charge; you will have to pay the amount over the R&C charge. (You should talk to your doctor before paying to see if your doctor will reduce his fee to the R&C amount.)

OUT-OF-PLAN

You (or your dependent) are considered to be "Out-of-Plan" if you receive medical care outside of a UHS facility, and the care is not provided by a UHS doctor or arranged by a UHS doctor. You will also be Out-of-Plan if UHS is not notified immediately of an emergency hospitalization (see page 17, "What to Do in Case of an Emergency or Serious Health Problem").

OUT-OF-PLAN COVERED EXPENSES

Out-of-Plan benefits are limited to covered medical expenses incurred for:

- Hospital and skilled nursing facility charges for inpatient services,
- Hospital emergency room or emergency treatment center charges for outpatient services for treatment of a medical emergency,
- Substance abuse and mental health treatment.

If you go to the outpatient department of a hospital or to an emergency treatment center, the treatment will be considered In-Plan if the medical condition meets the Plan's definition of "emergency" (page 52). If the condition does NOT meet this definition, the treatment is considered Out-of-Plan.

NO BENEFITS WILL BE PAID FOR ANY OTHER OUT-OF-PLAN SERVICES that could have been provided by or through UHS doctors—including inpatient or outpatient doctors' visits and outpatient hospital services (except for emergency room services).

OUT-OF-PLAN DEDUCTIBLES AND PENALTIES

A deductible is the amount of covered expenses incurred by you or any of your dependents that you have to pay out of your own pocket before the Plan will pay its 80% share of the remaining covered expenses.

Deductibles apply only to covered expenses incurred for treatment that is Out-of-Plan—that is, a UHS doctor did not provide, recommend, refer or arrange for the treatment.

The following Out-of-Plan Deductibles apply separately to you and each of your dependents:

- **$500 per Sickness –** Applies to Out-of-Plan inpatient treatment. A separate $500 deductible applies to each separate sickness.
- **$500 per Accident –** Applies to Out-of-Plan inpatient treatment of all injuries caused by the accident. A separate $500 deductible applies to each separate accident.
- **$500 Emergency Room Deductible –** Applies to each visit to a hospital emergency room or emergency treatment center if the visit is for a condition which does not meet the Plan's definition of an "emergency" (see page 52).
- **$100 Hospital Review Noncompliance Deductible –** Applies to expenses incurred for each Out-of-Plan inpatient hospital confinement for which the procedures of the Hospital Review Program are not followed.

Once you have paid any applicable deductible(s), you also pay 20% of your covered hospital (or emergency treatment center) expenses over all applicable deductibles.

If you go Out-of-Plan anyway, there are several ways you can pay less for your care:

1. **PPO HOSPITALS –** The Trustees of your Plan have a contract with BCBSIL. BCBSIL's network of hospitals provide their services at negotiated rates to you and your dependents. If you need additional information, or if you want to find out which hospitals are in the BCBSIL PPO, contact the Fund Office. A list of PPO hospitals is available from the Fund Office free of charge upon request. You can also go to www.bcbsil.com.

2. **HOSPITAL REVIEW PROGRAM –** The Hospital Review Program is administered by a professional Review Organization. Under this Program, you must call the Review Organization for any Out-of-Plan hospitalization. You must make this call regardless of whether the admission is to a PPO hospital or a non-PPO hospital.

FOR OUT-OF-PLAN HOSPITAL REVIEW CALL THE REVIEW ORGANIZATION AT: 1 (800) 367-1934

- ❒ If your non-UHS doctor recommends a non-emergency hospital admission for you or any of your dependents, you or someone acting on your behalf (family member, friend, doctor, the hospital, etc.) must call the Review Organization to provide information about the admission in order to qualify for full Plan benefits.

- ❒ If you or any of your dependents are admitted to a hospital for emergency reasons, the call must be made while you are being admitted or immediately after the admission in order to get full Plan benefits. (*Note: The Plan's definition of "emergency" is on page 52*.)

If you don't follow the procedures of the Hospital Review Program explained above, **an additional $100 deductible** will apply to the hospital expenses incurred for that confinement. This $100 deductible applies in addition to any other deductible, copay, or coinsurance.

You can avoid all of the above Out-of-Plan deductibles and penalties, by staying In-Plan. To stay In-Plan, you must use UHS doctors and go to the UHS core hospital to which a UHS doctor admits you.

MEDICAL EXPENSE BENEFIT COVERED EXPENSES

The Plan pays benefits only for charges that are considered "covered expenses." Actual payment of benefits and amounts of benefits payable depend on the amounts shown on the Schedule of Benefits (starting on page 8) and whether the person is In-Plan or Out-of-Plan.

Covered expenses are the actual reasonable and customary charges incurred by you or a dependent for the services, supplies and types of treatment listed below which are medically necessary and required for care and treatment of your non-occupational injury or sickness.

COVERED EXPENSES FOR INPATIENT HOSPITAL CARE (IN PLAN AND OUT-OF-PLAN) – Including services and supplies provided by a hospital, a skilled nursing facility, or a treatment facility for chemical dependency:

- Room and board in a hospital, skilled nursing facility, or treatment facility for chemical dependency and treatment for mental health up to the semi-private room rate.

- Operating room, fracture room service and other rooms for surgical services.

- Services and supplies such as general nursing care, physical therapy, anesthesia, x-rays and laboratory tests, bandages, casts, splints, braces, trusses, crutches, medicines and drugs.
- Blood, plasma, or other blood derivatives (except for the first three pints during each hospital confinement).
- Clinical laboratory and pathological laboratory examinations, and the services of doctors and for anesthesia administration (including services by certified nurse anesthetists) and interpretation and supervision of x-rays and laboratory and pathology tests.
- Oxygen and oxygen administration.
- X-ray and radioisotope treatments and examinations, electrocardiograms, electroencephalograms, and basal metabolism determination.
- Radiation therapy for proven cases of cancer or specific thyroid or heart conditions.

COVERED EXPENSES FOR OUTPATIENT SURGERY (IN-PLAN ONLY) – If you or your dependent has surgery that doesn't require an overnight stay in a hospital, services and supplies provided for and in connection with surgery in a hospital outpatient department when that surgery is **performed or referred by a UHS doctor**.

COVERED EXPENSES FOR EMERGENCY TREATMENT (IN-PLAN AND OUT-OF-PLAN) – Hospital emergency room/emergency treatment center services and supplies provided for emergency treatment (page 17) of a sickness or injury that meets the definition of an emergency (page 52). The amount the Plan pays depends on whether the person is In-Plan or Out-of-Plan (see the Schedule of Benefits starting on page 8).

COVERED EXPENSES FOR EXTENDED CARE IN A SKILLED NURSING FACILITY (IN-PLAN AND OUT-OF-PLAN) – Services and supplies provided during confinement in a skilled nursing facility when full-time skilled nursing care is needed following a hospital confinement. Plan benefits for skilled nursing care is limited to 30 days per calendar year.

- **The UHS doctor who has determined the need for the nursing care will authorize the care and make the arrangements.**
- If you have received Plan benefits for the maximum allowable number of days of skilled nursing facility care during a calendar

year, but you still need such care, UHS may, on a case by case basis, authorize additional days of skilled nursing facility care during that calendar year. This authorization will be made only if, without additional skilled nursing facility care, you would need inpatient hospital confinement, and if the Fund's cost for the hospital confinement would be more than the cost of the additional authorized days of skilled nursing facility care

COVERED EXPENSES FOR HOME HEALTH (NURSING) CARE (IN-PLAN ONLY) – The Plan pays up to $10,000 per calendar year for the following services and supplies provided during a course of home health (nursing) care. **The attending UHS doctor will make arrangements** through a home health agency for the home care when he or she considers the care to be the best type of care for you.

- Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.
- Part-time or intermittent home health aide services.
- Medical supplies and the use of medical appliances (this does not include drugs and biologicals other than non-self-administered injectable drugs). Benefits paid for non-self-administered injectable drugs and portable oxygen supply units do not apply to the calendar year maximum benefit for home health care.
- Equipment or services provided on an outpatient basis at a hospital or skilled nursing facility under arrangements made by the home health agency (excluding transportation).

UHS may, on a case by case basis, authorize additional home health care during that calendar year if, without more home health care, you would require inpatient hospital confinement, and if the Fund's cost for the hospital confinement would be more than the cost of the additional authorized days of home health care.

COVERED EXPENSES FOR TREATMENT OF MENTAL/NERVOUS DISORDERS (IN-PLAN AND OUT-OF-PLAN) – including inpatient, outpatient, intensive outpatient, and partial inpatient treatment. Inpatient professional services will be covered if a UHS physician arranges for the care.

COVERED EXPENSES FOR TREATMENT OF CHEMICAL DEPENDENCY (IN-PLAN AND OUT-OF-PLAN) – including inpatient, outpatient, intensive outpatient, and partial inpatient treatment. Inpatient professional services will be covered if a UHS physician arranges the

care. Out-of-Plan treatment for treatment of chemical dependency will only be covered if a physician recommends the care (or if the treatment is for an emergency – see page 52).

COVERED EXPENSES FOR PHYSICAL MEDICINE (IN-PLAN ONLY) – The Plan pays for physical medicine (physical therapy, occupational therapy, cardiac rehabilitation therapy, and restorative therapy after a stroke, a heart attack, trauma or surgery) only if a treatment plan is submitted to the Fund Office by the attending doctor. The Fund Office must approve continued treatment on a monthly basis, based on monthly progress reports showing improvement. The therapy must be arranged by a UHS doctor.

COVERED EXPENSES FOR CHIROPRACTIC TREATMENT (IN-PLAN ONLY) – Services and supplies provided for chiropractic treatment, subject to the $1,000 calendar year maximum benefit. The chiropractic treatment must be referred by a UHS doctor.

COVERED EXPENSES FOR SPEECH THERAPY (IN-PLAN ONLY) – Services and supplies provided for speech therapy caused by a congenital defect, subject to the $2,000 calendar year maximum benefit. Speech therapy must be arranged by a UHS doctor.

COVERED EXPENSES FOR SPECIAL TYPES OF TREATMENT (IN-PLAN ONLY) – Benefits are provided for covered expenses as stated above for the following special types of treatment:

- **Chemotherapy** for cancer, including prescription oral chemotherapy drugs and related supportive drugs, that are prescribed by a UHS Physician or prescribed as part of a course of treatment arranged by a UHS Physician and administered under the supervision of a home health care nurse.

- **Local ambulance** service to the nearest hospital qualified to provide the necessary treatment.

- **Reconstructive surgery** performed primarily to restore or improve bodily functions or to correct damage caused by disease, injury or birth defects.

- **Reconstructive breast surgery** following a mastectomy, including surgery on the non-affected breast to achieve a symmetrical appearance.

- **Cosmetic surgery** for correction of defects caused by disease, injury or birth defects.

- **Corrective surgical procedures** on organs of the body which do not function properly.
- **Vasectomies**, tubal ligations, and other sterilization procedures for employees and dependent spouses.
- **Cornea and bone marrow transplants**.
- **Medically necessary therapeutic abortions** for eligible employees and eligible dependent spouses.
- Rental, up to the purchase price, of **hospital-type equipment**, such as a hospital bed, oxygen equipment, wheelchair, or similar therapeutic equipment.
- **Prosthetic devices** such as artificial eyes and limbs ordered by a UHS doctor to replace a natural eye or lost limb. Only the first such device is covered by the Plan. One replacement device will also be covered if UHS determines the replacement is medically necessary and provides a referral for the replacement.
- **Food and food supplements** administered intravenously that are prescribed by a UHS doctor, provided that this is the only form of food you can have.
- Hearing aids, eye examinations, eye refractions, eyeglasses, contact lenses, dental prosthetic appliances, or any charges made for the fitting of these appliances, when needed because of a **non-occupational injury**.

SPECIAL COVERED EXPENSES FOR HOSPICE CARE (IN-PLAN ONLY)

- The Plan provides a $10,000 lifetime maximum benefit for hospice care if you have a terminal condition. "Terminal" means that your medical prognosis means you have six months or less to live.
- A program of hospice care provides certain types of services and supplies not normally considered covered expenses under the Medical Expense Benefit. For example, hospice aides and non-prescription drugs will be covered. (Long-term inpatient care, surgical operations, or hospital confinements due to medical complications of your terminal condition are not covered under the hospice care program. These types of expenses are considered for payment under the regular benefits and covered expenses of the Medical Expense Benefit.)

- Benefits paid for hospice care will apply to the hospice care lifetime maximum benefit. Once the Plan has paid $10,000 for your hospice care, the Plan will pay no further hospice care benefits. Expenses for any further treatment of your terminal condition will be considered for payment under the regular benefits and covered expenses of the Medical Expense Benefit.

- **Hospice care will be arranged by the attending UHS doctor.**

EXTENSION OF MEDICAL EXPENSE BENEFITS – If you or an eligible family member is totally disabled at the time your coverage terminates, limited benefits will be continued for your covered expenses. This extension will last up to three months if you remain continuously disabled (see page 46).

NOTE ABOUT DEPENDENT CHILDREN OF TWO COVERED EMPLOYEES – If a child is a covered under the Plan as a dependent of both parents, the benefits payable under one of the parent's coverage will be "coordinated" according to the rules described in the "Coordination of Benefits" section which starts on page 38. The Plan benefits payable under both parents' coverages combined will still be subject to any and all Plan maximums shown on the Schedule of Benefits and described in this booklet.

VERIFY COVERAGE IF YOU RECEIVE A UHS REFERRAL – If your UHS doctor refers you or an eligible family member for special services that are not provided at a UHS facility, you should call the Fund Office to confirm whether the treatment will be covered by the Plan—before the treatment begins. While the Plan covers a wide range of non-UHS services provided due to UHS-referrals, a referral does not guarantee that the services will be covered. (See "Medical Expense Benefit Covered Expenses" starting on page 22.)

UNION PHARMACY SERVICE
(Prescription Drug Coverage)

Prescription drug coverage is provided through Union Pharmacy Service (UPS) by an arrangement between the Fund and UHS.

UHS provides Fund participants with a Union Pharmacy Service I.D. card, a copy of the UPS formulary and a list of participating pharmacies.

YOUR CO-PAYS – When you use your Union Pharmacy Service (UPS) card, you can purchase drugs that are on the UPS formulary for a co-pay of $10 for a generic drug or $20 for a brand name drug. (If the discounted price for your drug is less than the co-pay amount, you will only have to pay the discounted price.) You will usually be able to get a month's supply or the prescribed amount for a specific cycle of treatment with each purchase.

UPS FORMULARY – The UPS formulary is a list of covered medications. It includes many, but not all, of the drugs commonly prescribed by physicians. You must pay the full price for non-formulary medications, although your cost for certain drugs may be discounted if you use a participating pharmacy. The formulary may change from time to time.

PARTICIPATING PHARMACIES – You must use a participating pharmacy in order to get benefits for prescription drugs. Participating pharmacies have been selected because they are convenient to the greatest number of participants. One of the participating locations is the pharmacy at the UHS Polk Street facility.

Normally you do not need to file a claim or complete any paperwork when you use a participating Union Pharmacy Service pharmacy. However, if you must purchase a short-term supply of an emergency medication at a non- participating pharmacy, and if it is a medication on the UPS formulary, save the receipt and call the telephone number on the back of your Union Pharmacy Service I.D. card. A customer service representative will assist you in completing a claim for potential reimbursement.

The Union Health Service Main Pharmacy may be contacted at (312) 423-4260 regarding any pricing questions or if you need to compare prices.

For other customer service questions, contact:
Optum Rx
(855) 505-8107

Web Site:

www.unionhealth.org

or

www.optumrx.com

DENTAL INSURANCE

Dental benefits for you and your covered dependents are provided through the BlueCare® Dental DMO Plan 740, a dental plan provided by Blue Cross Blue Shield of Illinois.

The BlueCare Dental program requires you and your dependents to select a participating dental office. You must use this dental office to get your dental care.

You have no co-pays for preventive and diagnostic services. Your co-pay amounts for restorative services are explained in the coverage certificate BlueCare Dental gives to covered participants. Your coverage certificate is a booklet entitled "Your Dental Care Benefit Program."

No dental coverage is provided for services received outside the BlueCare program. However, treatment for non-occupational injury to sound natural teeth may be covered under the medical plan.

For more information or to make a customer service inquiry, call BCBSIL (BlueCare Dental HMO) at 1 (866) 431-1594.

EMERGENCY TREATMENT – If you have an emergency, you can receive emergency care from any provider, not only your Dental Center. You should first attempt to contact your Dental Center or customer service at 1-800-323-7201 and follow the directions you receive. In the event you cannot reach your Dental Center or customer service, you may seek emergency dental treatment from the nearest dentist or Dental Center. Remember, only services for palliative care (for the relief of pain) will be covered.

Reimbursement for emergency care will be provided as follows:

- Benefits for emergency care received from your Dental Center will be provided according to the Schedule of Dental Services in this Certificate (any Copayment indicated in the Schedule of Dental Services applies).
- Benefits for emergency care received from a dentist or dental office other than your selected Dental Center will be provided up to a maximum amount of $50.00. You will need to obtain a paid receipt and itemized statement of services rendered from the dentist or dental office providing your treatment. Send Claims to: BlueCare Dental HMO, 701 E. 22nd Street, Suite 300, Lombard, IL 60148.

WEEKLY DISABILITY BENEFITS

Weekly disability benefits can give you some income if you become totally disabled and unable to work while you are covered under the Plan.

Weekly benefits are payable only for disabilities that start after you become covered under the Plan.

AMOUNT AND DURATION OF BENEFITS

- The amount of your weekly benefit is shown on the Schedule of Benefits (page 8). Benefits for part of a week of disability are paid at the rate of one-fifth of the weekly benefit for each day of disability (no benefits are payable for Saturday and Sunday).
- Weekly benefits are payable for up to 26 continuous weeks during one period of disability, whether from one or more causes.

DEFINITION OF TOTAL DISABILITY – For the purposes of getting these weekly benefits, you are totally disabled if you are completely prevented from performing any and every duty of your occupation or employment because of a non-occupational accidental bodily injury or sickness. Disabilities due to pregnancy, childbirth, or related medical conditions are treated as a sickness.

WHEN WEEKLY BENEFITS START – Benefits will start on:

- The first day of disability due to an accidental injury;
- For a disability due to sickness, the earliest of the following dates:
  - ❒ If outpatient surgery is performed, on the day of surgery;
  - ❒ If you are hospitalized, on the first day of hospitalization; or
  - ❒ The eighth day.

HOW TO GET YOUR WEEKLY BENEFIT CHECKS – The Local 25 Claim Department must have your Weekly Disability Claim Form before your benefit payments can start. You and your doctor must properly complete and sign the Form. To file a claim for the Weekly Disability Benefit, follow the steps shown below:

1. Call the Local 25 Claim Department at (312) 233-8899 as soon as possible and ask for a Weekly Disability Claim Form.

2. Be prepared to give the Claim Department the following information:

   - ❒ Your name, address, phone number, birth date and Social Security number or alternate ID number.
   - ❒ The location of your employment, the last day you worked, and the date you returned to work (if applicable).

3. When you get the Claim Form:

   - ❒ Check the information that has already been filled in for you to make sure that it is correct. Add any additional required information.
   - ❒ **Sign and date the Claim Form.**
   - ❒ Take the Claim Form to your doctor and have him or her complete the rest of the form. Your doctor must certify on the form the first day of your sickness or injury and the first day that he or she saw you for that sickness or injury. Be sure your doctor signs the Claim Form.

4. After making sure that all required information has been filled in on the Claim Form, mail or fax it back to the Local 25 Claim Department.

5. After the Claim Department gets your correctly completed Claim Form, a benefit check will be mailed to you (usually within a week).

TO CONTINUE GETTING WEEKLY BENEFITS – While you are disabled, your doctor may be required to provide additional information on a Physician's Supplemental Report.

The Claim Department will send you the Report form if you have to send one in. It is your responsibility to make sure your doctor fills in the Form, and sends it back to the Claim Department. Your payments may be temporarily stopped if this Form is not completed and returned to the Claim Department. Your benefits will not begin again until the Claim Department receives the correctly completed Report form.

The Trustees have the right to have a doctor of their choice examine you from time to time to make sure that you still qualify for benefits.

Be sure to notify the Local 25 SEIU Welfare Fund Office Claim Department when you return to work.

EXCLUSIONS AND LIMITATIONS – Weekly Disability Benefits will not be paid for:

1. Any disability for which you are not under the direct and continuing care of a doctor;

2. Any disability caused by an injury, sickness, or disease which happened before you became covered under this Plan;

3. Any disability resulting from accidental bodily injury, sickness or disease sustained while performing any act or duty related to any occupation or employment for compensation or profit; or any disability for which benefits are or would be payable in whole or in part in accordance with the provisions of any Workers' Compensation Act, Occupational Diseases Act, Employers Liability Act or similar law;

4. For any disability arising out of war, declared or undeclared, or any act of hazard of war; or

5. For any disability incurred during or as a result of the commission (or attempted commission) of a felony by the employee.

TAXATION OF WEEKLY BENEFITS – Your Weekly Disability Benefits are subject to Federal Income Tax and may be subject to Social Security Taxes (FICA). Your last employer is responsible for the employer's portion of the FICA tax.

DISMEMBERMENT BENEFITS

If you suffer any of the losses listed below, the Plan will pay you the amount shown for that loss. The loss must happen within 90 days of an accidental injury. This injury must happen while you are covered under the Plan and the loss must result solely from that injury.

DEFINITION OF "LOSS"

- Hands and feet – Actual severance at or above the wrist or ankle joints.
- Eyes – Entire and irrecoverable loss of sight.
- Index fingers – Actual severance at or above metacarpophalangeal joints.

EXCLUSIONS AND LIMITATIONS – This benefit does not cover:

- Any loss that occurs more than 90 days after the accident causing the loss.
- Any disability for which you are not under the direct care of a doctor.
- Any disability caused by war.
- Any disability caused during or as a result of your committing (or attempting to commit) a felony.

PLAN EXCLUSIONS AND LIMITATIONS

Your Plan provides broad health care coverage for you and your family, but there are some limitations and exclusions. Some of the most important exclusions and limitations are listed below.

The Weekly Disability Benefits and the Dismemberment Benefits are also subject to these limitations and exclusions where applicable. (Certain types of services and supplies which are provided in connection with a covered program of hospice care are exempt from these exclusions and limitations—see "Special Covered Expenses for Hospice Care" starting on page 26 for more information.)

The following are not provided by or through UHS, and no Plan payment will be made for or in connection with any of them unless an exception is stated:

1. Any service or supply that is **not medically necessary** for care or treatment of the person (based on the opinion of a professional medical consultant).

2. Any care, treatment, service or supply that is **experimental or investigative** in nature.

3. **Hospital admission for routine check-ups**, diagnosis, or laboratory or other tests made prior to surgery if the tests could have been performed at UHS or at the hospital on an outpatient basis.

4. Any care, treatment, or surgery that is **elective**, including any non-emergency plastic, beautifying or cosmetic surgery on the body (including but not limited to such areas as the eyelids, nose, face, breasts, or abdominal tissue) except as set forth in the "Covered Expenses for Special Types of Treatment" section starting on page 25).

5. **Pre-admission testing** that is not recommended by a UHS doctor.

6. **Pre-admission tests** performed prior to a hospital admission if the admission is cancelled (unless the cancellation is due to circumstances beyond the control of the patient).

7. Reversal or attempted **reversal of vasectomies** or other sterilization procedures.

8. Treatment or surgery for **obesity** or overweight conditions.

9. **Maternity**, pregnancy, or pregnancy-related conditions for any person other than an eligible employee or an eligible dependent spouse.

10. Care or treatment provided for rest, **custodial care**, or special education.

11. Any organ **transplant** other than a cornea or bone marrow transplant.

12. **Prescribed drugs** or biologicals not used in UHS or the hospital, or, if purchased at a retail pharmacy, that are not on the UHS formulary and obtained through a participating pharmacy.

13. **Doctor visits or surgery** not provided by or arranged for by a UHS doctor other than during an emergency (page 52).

14. **Radiation therapy** except for proven cases of cancer or specific thyroid or heart conditions.

15. Treatment of **infertility.**

16. Except as provided through UHS, charges incurred for **hearing aids**, including the fitting or repair of hearing aids, eyeglasses, eye refractions, eyeglasses, contact lenses (except the first pair of contact lenses required following cataract surgery), dental prosthetic appliances or any charges made for the fitting of any of these appliances, unless the service or supply was provided because of a non-occupational injury. Surgical treatment of corns, calluses or the trimming of toenails.

17. Treatment for chronic illness, including tuberculosis, in any institution **other than a licensed hospital**, except as may be provided under a hospice care program to a person with a terminal medical condition.

18. Any charges incurred for services of **technicians** not employed and billed by a covered facility, services of **special nurses** and their board, group nursing services, or services of physicians other than those specifically included as covered expenses.

19. Services or supplies for which payment under the Plan is **specifi-**

cally limited or excluded in any other provision of the Plan or which are specifically limited or excluded on the Schedule of Benefits, unless an exception is specifically stated.

20. Care or treatment of injuries or sicknesses caused by **war** or any act of war (declared or undeclared); any act of international armed conflict; insurrection; or participating in a riot.

21. Care or treatment of, or benefits provided as a result of, any disability resulting from injury, sickness, or disease sustained while the person is performing any act or duty pertaining to **any occupation or employment** for compensation or profit, or for which benefits are or would be payable in whole or in part under any Workers' Compensation Act, Occupational Diseases Act, Employers' Liability Act, or similar law. (Exception: this exclusion does not apply to the Dismemberment Benefit.)

22. Care, treatment, services, or supplies which are provided by reason of the past or present service of a person in the **armed forces** of any government, or which are provided while a person is confined in a hospital operated by the U.S. government or its agency or which are provided under any legislation covering war veterans or merchant seamen, except that the Plan, to the extent required by law, will reimburse a VA hospital for treatment of a non-service-related condition if the treatment would be covered under the Plan if the VA were not involved.

    However, if an eligible family member is a reservist who is called up to active military duty for more than 30 days and continues coverage for himself and/or any of his dependents through COBRA self-payments, this exclusion will not apply to the extent that the Plan is required by law to provide coverage for non-service-related sicknesses and injuries.

The above list is not an all-inclusive list of excluded procedures or services. It is only representative of the types of situations for which limited benefits, or no benefits, are provided. If you want to read the complete and detailed explanation of the types of treatment, services and supplies not covered under the Plan as listed in the Plan Document, contact the Fund Office.

OTHER BENEFIT LIMITATIONS

COORDINATION OF BENEFITS (C.O.B.) WITH OTHER GROUP PLANS

Coordination takes place when you are covered under two or more group plans (including blanket insurance plans, Medicare and this Plan). This usually occurs when both you and your spouse work and are covered under your own plans. You and your spouse may be covered as dependents under the other's plan, and your children may be covered as dependents under both plans. This Plan does not coordinate its benefits with Medicaid.

- When benefits are coordinated, one plan pays its normal benefits first and the other plan pays its benefits based on the amount that is not paid by the first plan. C.O.B. also helps to insure that duplicate benefits are not paid by the plans.
- If another plan pays benefits first on expenses incurred by you or a family member, this Plan's benefit payment, added to the benefits paid by the other plan, will not be more than this Plan's normal benefit.
- The Fund has the right to recover the cost of benefits provided for you or your family if that cost has also been paid by another person or company.
- If this Plan is secondary to a plan that has rules which must be followed in order to get the maximum reimbursement under that plan, this Plan will coordinate its benefits as if those rules or procedures had been followed even if they were not. For example, if the plan requires you to use certain providers, assesses a utilization review penalty for non-compliance or requires you to follow other procedures, that penalty, whether in dollars or other reduction in benefits, shall not be reimbursable by this Plan.
- If this Plan is secondary to a plan that determines its benefits on the basis of negotiated fees, any amounts in excess of such negotiated fees are not reimbursable by this Plan, except when this Plan and another plan have negotiated fee arrangements with the same provider, in which case this Plan may make reimbursement up to the lower of the two negotiated fees.

- This Plan does not coordinate benefits with Medicaid.

ORDER OF BENEFIT DETERMINATION

1. Normally, the plan covering the person (for whom benefits are claimed) as an employee pays first, and the plan covering the person (for whom benefits are claimed) as a dependent pays second.

2. If a person who has COBRA Coverage is also covered under another plan as an employee, retiree or dependent, the COBRA Coverage is secondary.

3. Order of benefit determination for **dependent children**:

   a. ***When both parents have health care coverage for their children, and the parents are not separated or divorced***, the plan of the parent whose birthday comes earlier in the year is the primary plan. (For example, if your birthday is in May and your spouse's birthday is in March, your spouse's plan is primary and this Plan is secondary.) However, if the other plan does not have this rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan determines the order of benefits.

   b. ***When the parents are separated or divorced***, benefits are payable according to any existing court decree. If there is no court decree stating who is responsible for a child's health care, the plan covering the parent with custody pays first and the plan covering the other parent pays second. If the parent with custody has remarried, the stepparent's plan pays before the plan covering the parent without custody.

   c. ***If the child is covered under this plan and another plan***, the plan covering the child as an employee will be primary over the plan covering the child as a dependent. A plan covering the child as a spouse will be primary over a plan covering the child as a child.

4. ***If a husband and wife are both covered as employees under this Plan***, the Plan will coordinate benefits on the claims filed for the husband, wife and any covered dependent child(ren). However, the total benefits paid under both coverages together will not exceed any of the maximum benefits or other limitations shown on the Schedule of Benefits.

If the above rules still do not clearly show which plan should pay first, the plan that has covered the person for whom the claim is filed for the longest period of time will pay first, the plan that has covered the person for the next longest period of time will pay second, and so on.

COORDINATION OF BENEFITS (C.O.B.) WITH MEDICARE

This Plan coordinates with Medicare. If an eligible family member is eligible for Medicare for reasons other than being age 65 or older (for example, totally disabled individuals and End Stage Renal Disease beneficiaries), this Plan will usually pay benefits first and Medicare will pay second unless the law allows otherwise.

ELIGIBLE EMPLOYEES WORKING AFTER AGE 65 – If, after you become age 65, you continue to work for a contributing employer who has 20 or more employees, you get the same Plan benefits as employees under age 65, as long as you meet the regular eligibility requirements. This means that this Plan will usually pay benefits first and Medicare will pay second. If your dependent spouse is age 65 or older and eligible for Medicare while you are still working and eligible (regardless of your age), this Plan will usually pay its normal benefits for your spouse before Medicare pays (if your spouse has his own plan, that plan will pay first, this Plan will pay second, and Medicare will pay last).

If you continue to work for a contributing employer after you or your spouse is age 65 and eligible for Medicare, and if your employer has fewer than 20 employees, Medicare will pay its benefits first and this Plan will pay second, unless it is legally required to pay first.

If you have any questions about C.O.B., contact the Fund Office. If you want information about enrollment in Medicare, contact your local Social Security office.

SUBROGATION

The Trustees have adopted a policy requiring a third person who has caused you to incur medical expenses to reimburse the Fund for the medical expenses that it pays on your behalf. If bills are sent to the Claim Department for payment of expenses that someone else may be legally responsible for, or if you have a claim for Weekly Disability Benefits and someone else may be responsible for your loss of income, you will get a letter asking you to sign a subrogation agreement before your claim is processed. The subrogation agreement gives the Plan the right to recover any amounts it pays on the claim, including the right to sue the responsible party in your name. (This is a brief summary of a detailed

legal provision. If you want more information about subrogation, contact the Fund Office.)

By accepting benefits paid by the Plan, you agree to repay the Plan if you recover anything from a third party.

ELIGIBILITY

EMPLOYEE COVERAGE

If you are an "employee," and if you meet the "Initial Eligibility" requirements, you will be eligible for Plan 1 benefits.

DEFINITION OF "EMPLOYEE" – You meet this Plan's definition of an employee if you are one of the following:

- You are an employee of an employer who is required to make contributions to the Fund for you under the terms of a collective bargaining agreement.
- You are an employee of the Welfare Fund. (Your eligibility begins immediately and will continue as long as you remain a Fund employee.)
- You are an employee of the Union, and the Union makes contributions to the Plan on your behalf.

INITIAL ELIGIBILITY REQUIREMENTS – If you are an employee as stated in the first bullet of the above definition, you will be eligible for Plan 1 benefits on the first day of the month following the date that your employer has made contributions of 1,200 hours or more for you over a ten-consecutive-month period. You must average 120 hours (or more) each month for ten consecutive months, and have at least one hour in each of these ten months.

WHEN YOUR COVERAGE STARTS – Your coverage will start on the date that you meet the initial eligibility requirements.

DEPENDENT COVERAGE

Your dependents will be eligible for Plan 1 benefits if you are eligible for benefits and if they meet the definition of a dependent (see the definition starting on page 51).

WHEN DEPENDENT COVERAGE STARTS – Normally, coverage for your dependents will start on the same date that your employee coverage starts. Or, if you get one or more dependents after you become covered, their coverage will start on the date they become your dependents.

To complete the enrollment of a dependent, you must give the Fund Office copies of any of the following applicable documents:

- Birth certificate
- Marriage certificate
- Divorce decree

You must also notify the Fund Office when a dependent no longer meets the definition of a dependent (for example if you get divorced or your child becomes age 26).

CONTINUING COVERAGE

In general, you and your dependents will continue to be covered under the Plan as long as you average 120 hours a month over a ten-consecutive-month period. Each month, your hours for the previous ten months are totaled. If they add up to 1,200 or more, your coverage will continue for one month. (See "Termination of Coverage" below for the rules that govern when coverage terminates for you and your dependents.)

TERMINATION OF COVERAGE

Your coverage for Plan benefits will end on the first to occur of the following dates:

1. If, on the first day of any month, you fail to have at least 1,200 hours in the ten preceding months, coverage for you and your dependents will terminate on the that date, unless an on-time election and self-payment for COBRA Coverage is made by you or on your behalf.

2. If you do not work any hours during a two-month period, coverage for you and your dependents will terminate on the first day of the month immediately following this two-month period (e.g. the first day of the third month), unless an on-time election and self-payment for COBRA Coverage is made by you or on your behalf.

3. If your employment with a contributing employer ends and you are not re-employed with a contributing employer within two months of the date your employment ended, coverage for you and your dependents will terminate on the 16th calendar day following the date your employment ended, unless an on-time election and self-

payment for COBRA Coverage is made by you or on your behalf.

4. Your dependent spouse's coverage will terminate on the date of your divorce or legal separation, unless a correct and on-time election and self-payment for COBRA Coverage is made by the spouse or on the spouse's behalf.

5. Your dependent child's coverage will terminate on the date the child ceases to meet the Plan's definition of a dependent, unless a correct and on-time election and self-payment for COBRA Coverage is made by or on behalf of the child.

6. If the Plan is terminated by the Trustees, all benefit coverage for you and your dependents will terminate on the date the Plan is terminated. Benefits will be paid for covered expenses incurred before the Plan termination date if the Plan's assets are more than its liabilities, but benefit payments will be limited to the funds available for such purposes.

REINSTATEMENT OF COVERAGE

1. If your coverage terminates because you do not meet the "Continuing Coverage" requirements, and if you do not elect to continue coverage by making correct and on-time self-payments for COBRA Coverage, you must satisfy the "Continuing Coverage" requirements of 1,200 or more hours in a ten-month period before you will again be covered under the Plan.

2. If your coverage terminates because you do not meet the "Continuing Coverage" requirements, and if you remain ineligible for *two consecutive months*, and if you *DO NOT* maintain coverage by making correct and on-time self-payments for COBRA Coverage, your regular coverage under the Plan will be reinstated on the first day of the month following the date that your employer has made contributions of 1,200 hours or more for you over a ten-month period.

3. If your coverage terminates because you do not meet the "Continuing Coverage" requirements, and if you remain ineligible for *two consecutive months* and if you maintain coverage by making correct and on-time self-payments for COBRA Coverage, your regular coverage under the Plan will be reinstated on the first day of the month following any month during which you work a minimum of 120 hours for a contributing employer. To maintain your regular cover-

age after reinstatement, you must satisfy the "Continuing Coverage" requirements. This rule will not apply if your COBRA Coverage has been terminated for any reason before the date your coverage would be reinstated.

Note: You do not earn "credited hours" or "hours" by making self-payments for COBRA Coverage except when you qualify for reinstatement under rule No. 3 above. If you qualify for reinstatement under rule No. 3 above, you will be credited with 120 hours for each month for which you made a COBRA self-payment, for up to but not to exceed a total of nine months.

MILITARY LEAVE

If you leave employment with a contributing employer to enter active duty in the uniformed services of the United States, your eligibility will be frozen during your active duty. After your release from active duty under circumstances entitling you to re-employment under federal law, your eligibility and accumulated credited hours will be reinstated on the date you return to work with a contributing employer, provided your return to work is within the time prescribed by federal law.

You are also entitled to make self-payments for continued coverage for up to 24 months, regardless of any coverage provided by the military or government. The payment amounts, rules and provisions for continued coverage during military leave are very similar to COBRA coverage. This Plan will pay primary benefits before the military/government pays except for service-related disabilities.

(More information about the re-employment rights of persons returning to work from the uniformed services of the United States is available from the Veterans' Employment and Training Administration of the United States Department of Labor.)

LIMITED EXTENSION OF COVERAGE

If an eligible family member is totally disabled at the time his coverage terminates, limited benefits will be continued for up to three months if he stays continuously totally disabled.

Benefits will be payable only for expenses incurred for treatment of the injury or sickness that caused the total disability. Benefits will be payable only to the extent that benefits would have been payable if his coverage had not terminated.

For purposes of receiving an extension of benefits, "totally disabled" means:

- That you are prevented from engaging in your regular or customary occupation and are not performing any work of any kind for compensation or profit; and
- That a dependent is prevented from engaging in substantially all of the normal activities of a person of the same age and sex in good health.

The total disability must be caused by a non-occupational injury or sickness.

The extension of benefits will end on the earlier of:

- The date the person is no longer disabled.
- 11:59 p.m. on the last day of the three-month extension of disability benefits.

Please notify the Fund Office if you or any of your eligible family members are totally disabled when coverage terminates. You will be required to submit a physician's statement certifying the person's total disability.

COBRA COVERAGE

You and your covered dependents have the right to make self-payments for continued health care coverage if you lose coverage because of certain "qualifying events." This coverage is called "COBRA Coverage" (or "Continuation Coverage"). The following is a brief outline of the rules governing COBRA Coverage.

QUALIFYING EVENTS – A "qualifying event" is any of the following events which would cause loss of Plan coverage for you and/or any of your dependents:

- Your loss of employment or reduction of hours;
- Your death;
- Your divorce/legal separation from your spouse; or
- Your dependent child's ceasing to meet the Plan's definition of a dependent.

COBRA Coverage may not be elected for anyone who was not covered under the Plan on the day before the qualifying event.

MAXIMUM COVERAGE PERIODS

- **18-MONTH MAXIMUM COVERAGE PERIOD –** If your coverage is going to terminate because of reduced hours or loss of employment, you can make COBRA Coverage self-payments for yourself and your dependents for up to 18 months after your coverage would otherwise terminate. If you don't elect to make the self-payments and you have dependent coverage, your spouse is entitled to make a separate election to self-pay for up to 18 months of COBRA Coverage for herself and/or any dependent children.
- **29-MONTH MAXIMUM COVERAGE PERIOD –** If you or a covered dependent are disabled (as defined by the Social Security Administration for the purpose of Social Security disability benefits) on the date of one of the qualifying events listed above, or if you or a covered dependent become so disabled within 60 days after an 18-month COBRA period starts, the maximum coverage period will be 29 months for all members of your family who were covered under the Plan on the day before the qualifying event. The COBRA self-payment is higher for the extra 11 months of coverage. Also,

you must notify the Fund Office within 60 days of such a determination by the Social Security Administration and within the initial 18-month period, and within 30 days of the date Social Security determines that the person is no longer disabled.

- **36-MONTH MAXIMUM COVERAGE PERIOD FOR DEPENDENTS –** If your spouse and/or children are going to lose coverage due to ***your death or divorce or legal separation***, your spouse can elect to make COBRA Coverage self-payments for coverage for herself and/or any children for up to 36 months after coverage would otherwise terminate.

  If your child is going to lose coverage due to loss of dependent status (such as when the child reaches age 26), the child can make COBRA Coverage self-payments for a maximum of 36 months after his coverage would otherwise terminate due to the loss of dependent status.

MULTIPLE QUALIFYING EVENTS – If your dependents are covered under an 18-month COBRA period due to termination of your employment or a reduction in your hours, their COBRA Coverage period may be extended if a second qualifying event happens during that 18-month period. The second qualifying event must be one of the following: your death, a child's failure to meet the definition of a dependent, or your divorce or legal separation from your spouse.

If any of these events occur, your spouse and children (or child) are entitled to elect COBRA Coverage for up to a maximum of 36 months minus the number of months of COBRA Coverage already received under the 18-month continuation.

Only a person (spouse or child) who was your covered dependent on the day before the occurrence of the first qualifying event (termination of your employment or a reduction in your hours) is entitled to make an election for this extended coverage when a second qualifying event occurs except as follows: if a child is born to you (employee), adopted by you or placed with you for adoption during the first 18-month continuation period, that child will have the same election rights when a second qualifying event occurs as those of a person who was your dependent on the day before the first qualifying event.

COBRA COVERAGE BENEFITS – If a person was covered under Plan 1 on the day before a qualifying event occurred, he can elect to make self-payments for one of the following options:

- Plan 1 Medical Benefits only, or

- Plan 1 Medical Benefits plus Dental Insurance. Remember that dental coverage is provided through BlueCare Dental.

NOTIFICATION RESPONSIBILITIES – If you get divorced or legally separated, or if a dependent child loses dependent status, **you must notify the Fund Office in writing within 60 days of the date of the divorce, separation or loss of dependent status or within 60 days after coverage would terminate** due to such an event, whichever date is later.

Your employer must notify the Fund Office within 30 days of any other qualifying events that could cause loss of coverage. However, to make sure that you are sent notice of your election rights as soon as possible, you or a dependent should also notify the Fund Office any time any type of qualifying event occurs. If the Fund Office isn't notified of such an event within the time allowed, the affected dependent(s) won't be entitled to elect COBRA Coverage. (To make sure you are sent a COBRA notice as soon as possible, you should notify the Fund Office when any type of qualifying event occurs.)

The important thing to remember is to contact the Fund Office whenever you or any of your dependents will lose your coverage under the Plan.

COBRA COVERAGE SELF-PAYMENT PROCEDURE – When the Fund Office is notified of a qualifying event, the following rules and procedures apply:

1. The Fund Office will send you (employee, spouse or child) an Election Notice explaining your right to elect COBRA Coverage. An Election Form will also be sent. The Election Form states the benefit options that can be elected and the amount of the monthly payment for each option.

2. If you or your dependent(s) want to make COBRA Coverage self-payments, the Election Form must be filled in, signed, and returned to the Fund Office. The Form must be delivered in person or mailed (postmarked) to the Fund Office within 60 days after the Election Notice is sent to you and/or your dependent(s) or within 60 days after coverage terminates, whichever is later. (A postage meter imprint is not a postmark and is not evidence of the mailing date.)

3. If you are electing COBRA Coverage, you have 45 days after the

Election Form is returned to make the initial payment for coverage provided between the termination date and the date the payment is made. (If you wait 45 days to make your first payment, however, the payment for the current month may also be due during that period.) All following monthly payments are due by the first day of each month. A monthly payment is considered on time if it is received by the Fund Office within 30 days of the due date.

WHEN COBRA COVERAGE ENDS – Your COBRA Coverage will terminate at the end of the allowable maximum coverage period, or before the end of the allowable maximum coverage period when:

1. The Fund no longer provides group health coverage;

2. If you become entitled to Medicare after your COBRA Coverage election date;

3. A correct and on-time payment is not made to the Fund (late payments may not be made up);

4. You have been receiving extended COBRA Coverage for up to an additional eleven months due to your or another family member's disability, and the Social Security Administration has determined that you or your family member is no longer disabled; or

5. You becomes covered under another group health plan after your COBRA Coverage election date, unless the other group health plan excludes or limits benefits for a pre-existing medical condition.

For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

DEFINITIONS

The term "you" or "your" means the employee this booklet was given to.

BCBSIL – An abbreviation for Blue Cross Blue Shield of Illinois.

CHEMICAL DEPENDENCY – The abuse of, addiction to, or dependency on the use of drugs, narcotics, alcohol, or any other chemical (except nicotine).

CHILD – See "Dependent" below.

DEPENDENT

1. A dependent is your legal spouse (if you and your spouse divorce or legally separate, your spouse is not a dependent as of the date of divorce or legal separation); and

2. A dependent is your child (see "Definition of Child" below):

   - ❒ Who is less than 26 years old;
   - ❒ Who is age 26 or older and who is incapable of self-sustaining employment because of mental retardation or physical handicap (hereafter called a "handicap" or "handicapped"). The child must be a "child" as defined below and must have become handicapped before becoming age 26. He must remain handicapped, be incapable of supporting himself, and be dependent on you for the major portion of his support. At your expense, you must furnish the Fund Office with proof of the child's handicap within 31 days before the child becomes age 26, and from time to time in the future if the Fund Office requests it.

     Definition of Child - Under this Plan, "child" means:

     a. **Any legitimate child** born of a valid marriage of yours; and

     b. **Any natural child of yours who is not a legitimate child** born of a valid marriage, provided you submit satisfactory proof of your parenthood, such as a birth certificate, voluntary acknowledgement of paternity, etc.; and

     c. **Any child legally adopted** by you or placed in your home for the purpose of adoption; and

     d. Any child determined by the Trustees to be an "alternate

recipient" under the terms of a **Qualified Medical Child Support Order** (contact the Fund Office to obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determination procedures); and

e. **Any stepchild** (meaning any child of your current spouse who was born to your spouse or who was legally adopted by your spouse before your marriage to that spouse); and

f. Any foster child, meaning a child who is placed with you by an authorized placement agency or by judgment, decree, or other order of a court of competent jurisdiction.

Spouses or children who are eligible for Plan benefits as employees will be considered dependents. They will also not be considered dependents if they are full-time active members of the military or armed forces of any country (except if they are covered under COBRA Coverage elected due to a military call-up—see page 37). However, the Plan's "Coordination of Benefits" provisions will apply to the benefits payable for such persons.

A child who becomes covered under another group plan as an employee is not considered a dependent under this Plan.

DOCTOR - A legally qualified physician or surgeon who is a Medical Doctor (M.D.) or a Doctor of Osteopathy (D.O.). With respect to services provided by a practitioner whose license limits the scope of his practice, such as a Doctor of Dentistry (D.D.S.), such individual shall be considered a doctor but only for services rendered within the scope of such individual's license and to the extent that benefits are specifically provided under this Plan.

ELIGIBLE FAMILY MEMBER - You or any of your dependents, provided you have met the eligibility requirements and the dependent meets the definition of a dependent.

EMERGENCY

1. A medical condition which, if immediate medical attention is not provided, can reasonably be expected to lead to death, serious dysfunction of any bodily organ or part or other serious medical consequences. These conditions must be severe, sudden in onset and involve one or more of the major organ systems of the body, such as the cardiovascular, metabolic, respiratory, nervous, gastrointestinal or urinary system. In no event will a condition be considered an

emergency if the first treatment by a doctor is provided more than 24 hours after the onset of the symptoms.

2. If symptoms exist which reasonably may have been interpreted as an emergency under the above definition, that condition will be considered an emergency, even if the final diagnosis is of another condition. For example, severe chest pain that creates a suspicion of heart attack and for which cardiac tests are done will be considered an emergency even if the final diagnosis indicates that it was not actually a heart attack.

3. In addition to medical conditions that are emergencies as defined above, there are some conditions that result from accidents which appear to be serious and so threatening to a body part that emergency room treatment is indicated. These conditions will be considered emergencies, even though they do not meet the above definition.

4. In addition, being taken for treatment to the nearest hospital or trauma center by police, fire department or ambulance, when such transportation is made under circumstances over which the person has no control, will be considered an emergency.

HOSPITAL – An institution that meets at least one of the following definitions:

1. It is a licensed hospital primarily engaged in providing facilities for medical and surgical diagnosis, treatment and care of injured and sick persons under the supervision of licensed doctors and with 24-hour-a-day services by registered graduate nurses, or

2. It is a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, or

3. It is a hospital, a psychiatric hospital, or a tuberculosis hospital that is eligible to receive payments from Medicare.

IN-PLAN – An eligible family member is considered to be "In-Plan" if he receives his medical care at a UHS facility or if medical care received outside of a UHS facility is performed or arranged by a UHS doctor.

If you or any of your eligible family members require hospital care, your UHS doctor will admit you to a UHS-affiliated hospital.

PLAN – Plan 1 of the health and welfare Plan of Benefits provided for you and your family by the Local 25 S.E.I.U. Welfare Fund.

REASONABLE AND CUSTOMARY (R&C) CHARGE – The maximum allowable charge that can be considered a covered expense under this Plan. The amount of an R&C charge is determined by comparing a particular charge with charges made for similar services and supplies in the same locality to persons of similar age, sex, circumstances and medical condition. If a particular charge is more than what is considered to be R&C, any amount over the R&C charge will not be recognized by the Plan as a covered expense and you will have to pay the difference.

SPOUSE – See "Dependent" starting on page 51.

UHS – An abbreviation for Union Health Service. The Trustees of your Welfare Fund have made arrangements with UHS to provide you and your family with a full range of medical care, provided at the facilities listed on page 6.

UPS – An abbreviation for Union Pharmacy Service, the provider of your prescription drug insurance program. See pages 28-29 for more information.

GENERAL PLAN PROVISIONS

GENERAL INFORMATION ABOUT PLAN 1

This booklet includes a summary of your Plan 1 eligibility rules and the benefits provided for you and your dependents under the Local 25 S.E.I.U. Welfare Fund. In addition, information about Plan administration, funding, collecting benefits, and other important information is provided in the section entitled "Information About Your Plan" which starts on page 73. The information in this booklet summarizes the main features of your Plan of Benefits as stated in the Plan Document.

The Plan Document is the formal written description of your Plan of Benefits which the law requires the Trustees of your Plan to have. Plan Documents are written in legal-type language and may be difficult to understand; therefore, the Trustees provide you with this easy-to-read "summary" of the Plan Document.

The Plan Document and the Trust Agreement, copies of which you can get from the Fund Office, contain a detailed description of the rules, regulations, benefits, and provisions of your Plan. If any discrepancy exists between this book and the Plan documents, the provisions of the Plan documents will govern. Only the full Board of Trustees is authorized to interpret the Plan described in this book. Its interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious. No agent, representative, officer, or other person from the union or an employer has the authority to speak for the Trustees or to act contrary to the written terms of the governing Plan documents. If you have questions about eligibility or claims, only the Fund Manager is authorized to answer the questions for the Trustees. Matters that are not clear, or which need interpreting, will be referred to the Trustees.

TRUSTEE AUTHORITY AND RIGHT

Under the Plan of Benefits and the Trust Agreement creating the Welfare Fund, the Trustees or persons acting for them, such as a Claim Appeals Committee, have sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement and any other regulations, procedures or adminis-

trative rules adopted by the Trustees. Decisions of the Trustees (or, where appropriate, decisions of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the parties to the Trust that such decision is to be upheld unless it is determined to be arbitrary or capricious.

All benefits under the Plan are subject to the Trustees' authority under the Trust Agreement to change them. The Trustees have the authority to increase, decrease or change benefits, eligibility rules, or other provisions of the Plan of Benefits as they may determine to be in the best interests of Plan participants and beneficiaries.

Benefits under this Plan will be paid only when the Board of Trustees or persons delegated by them decide, in their sole discretion, that the participant or beneficiary is entitled to benefits.

The Plan is maintained for the exclusive benefit of the Plan's participants and their eligible dependents. All rights and benefits granted you under the Plan are legally enforceable.

DISCONTINUANCE OF PLAN

This Plan of Benefits may be discontinued or terminated at any time by the Trustees under certain circumstances, for example, if future collective bargaining agreements do not require employer contributions to the Plan. If the Plan is terminated, benefits for covered expenses incurred before the termination date fixed by the Trustees will be paid on behalf of eligible family members as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets. If there are any assets remaining after the payment of all Plan liabilities, those assets will be used for purposes determined by the Trustees in accordance with the Trust Agreement.

CIRCUMSTANCES UNDER WHICH BENEFITS MAY BE DENIED

The Trustees, or their representatives, are authorized to deny payment of benefits for incurred expenses. In addition to failure to meet the eligibility requirements for coverage, the reasons for denial of benefits, in whole or in part, may include one or more of the following:

1. The person who incurred the expenses was not covered on the date the expenses were incurred.

2. No payment, or a reduced payment, was made because some or all of the expenses were applied against a particular deductible, or the person who incurred the expenses was Out-of-Plan (see "Out-of-Plan" starting on page 20).

3. The bills for the expenses were not sent to the Claim Department within the Plan time limits (one year from the date of service).

4. The expenses that were denied are not covered under the Plan, or the expenses were not actually incurred.

5. The person who incurred the expenses had already received the maximum benefit allowed for that type of expense during a stated period of time.

6. A third party was responsible for paying the expenses and you (or the person who incurred the expenses) did not sign the necessary documents that would permit the Plan to process the claim and recover payment from the third party or his insurance company (see "Subrogation" starting on page 40).

7. The Plan of Benefits was discontinued or terminated (see "Discontinuance of Plan" starting on page 56).

In addition, future benefit payments may be reduced or temporarily suspended in order for the Plan to recover an overpayment of benefits previously paid to you or on your behalf in error.

HOW TO FILE CLAIMS

1. All medical bills should be sent to BCBSIL at the address on your BCBSIL I.D. card (and on the inside front cover of this booklet).

2. To apply for weekly benefits if you are sick or injured, fill out an application form and mail or bring it to the Claim Department at the Local 25 S.E.I.U. Fund Office (see "How to Get Your Weekly Benefit Checks" on page 31).

3. It is your responsibility to furnish any information needed to approve your application (claim) for benefits. You should furnish a current mailing address so your benefit checks will reach you.

Call or visit the Local 25 S.E.I.U. Fund Office whenever you have questions about the Plan or your benefit rights.

CLAIM REVIEW PROCEDURE

When you file a claim for benefits, be sure to follow the proper claim filing procedures. You must file your claim within ONE YEAR after it is incurred.

CLAIM PROCESSING TIME LIMITS – In general, UHS processes doctor bills and the Fund Office processes all other claims, including hospital bills. (Hospital bills are sent to BCBSIL at the address on your I.D. card, but the explanation of benefits is issued by the Fund Office.) For ease of explanation, when used in the following explanation, the term "claims office" can apply to UHS or the Fund Office, depending on which office is responsible for the claim.

The amount of time the applicable claims office can take to process a claim depends on the type of claim. A claim can fall into one of the following categories:

- A claim is "post-service" if you have already received the treatment or supply for which payment is now being requested.
- A "disability claim" is a claim for Weekly Disability Benefits.
- A "pre-service claim" is a request for preauthorization of a type of treatment or supply that requires approval in advance of obtaining medical care.
- An "urgent care claim" is a pre-service claim where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life, health, or ability to regain maximum function, or that could subject you to severe pain that cannot be adequately managed without the proposed treatment.
- A "concurrent care claim" is a request to extend a course of treatment beyond the period of time or number of treatments previously approved.

If all the information needed to process your claim is provided to the Fund Office, your claim will be processed as soon as possible. However, the processing time needed will not exceed the time frames allowed by law, which are as follows:

- Post-service claims – within 30 days.
- Disability claims – within 45 days.
- Pre-service claims – within 15 days.

- Urgent care claims **–** within 72 hours.
- Concurrent care claims - within 24 hours if the concurrent care is urgent and if the request for the extension is made within 24 hours prior to the end of the already authorized treatment. If the concurrent care is not urgent, then the pre-service time limits apply.

You may have an authorized representative act on your behalf, although the Trustees may verify that the person has been so authorized. However, in connection with an urgent care claim, the Plan will recognize a health care professional with knowledge of your medical condition as your representative.

When Additional Information Is Needed – If additional information is needed from you, your doctor or the medical provider, the necessary information or material will be requested in writing. The request for additional information will be sent within the normal time limits shown above, except that the additional information needed to decide an urgent care claim will be requested within 24 hours.

It is your responsibility to see that the missing information is provided to the Fund Office. The normal processing period will be extended by the time it takes you to provide the information, and the limit will start to run once the claims office has received a response to its request. If you do not provide the missing information within 48 hours for an urgent care claim or 45 days for any other claim, the Fund Office will make a decision on your claim without it, and your claim could be denied as a result.

Plan Extension – The normal time periods may be extended if the claims office determines that an extension is necessary due to matters beyond its control (but not including situations where it needs to request additional information from you or the provider). You will be notified prior to the expiration of the normal approval/denial time period if an extension is needed. If an extension is needed, it will not exceed:

- Post-service claims – 15 days.
- Pre-service claims – 15 days.
- Disability claims – 30 days (a second 30-day extension may be needed in special circumstances).

CLAIM DENIALS – If all or a part of your claim is denied after the claims office has received a completed claim form and all other necessary information from you, you will be sent a written notice giving you the reasons for the denial. The notice will include reference to the Plan

provisions on which the denial was based and an explanation of the claim appeal procedure. If applicable, it will give a description of any additional material or information necessary for you to perfect the claim, and the reason such information is necessary. The notice will provide a description of the appeal procedures and the applicable time limits for following those procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA. If the Plan relied upon an internal rule, guideline, protocol or similar criterion to make its decision, the denial notice will state that the Plan will provide you with the specific internal rule, guideline, protocol or criterion used upon request free of charge. If the decision was based on medical necessity or if the treatment was deemed experimental, the notification will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request. For urgent care claims, a description of the Plan's expedited review process will be provided.

CLAIM APPEAL PROCEDURE

Concurrent Care Claims – If you have a concurrent care claim and the claims office terminates or reduces a previously approved period of treatment, you will have the right to appeal that termination or reduction. You will be given advance notice of the termination or reduction and allowed to appeal the determination before the termination or reduction. The rule allowing the treatment to continue pending an appeal does not apply if your benefits terminate because you have lost eligibility under the Plan or if the termination or reduction is the result of a Plan amendment.

Doctor Bills – If you disagree with the denial of payment of a doctor's bill, write to UHS within 180 days of the denial requesting a review to determine whether the denial was proper. Send your request for review, along with the reasons why you believe that the denied claim for payment or services should have been paid, to:

Union Health Service
1634 West Polk Street
Chicago, Illinois 60612

You can orally request a review of a denied urgent care claim by calling UHS at (312) 423-4200.

All Other Claims, Including Hospital Bills – If you want the Appeals Committee of the Board of Trustees to review your claim after a denial of benefits, write to the Board of Trustees at:

Appeals Committee Board of Trustees
Local 25 S.E.I.U. Welfare Fund
111 East Wacker Drive, 17th Floor
Chicago, Illinois 60601-4200

Attach any additional information that you think will help a favorable decision to be made on your claim. Your letter should be submitted within 180 days after the date the denial was mailed to you.

You can orally request a review of a denied urgent care claim by calling the claims office at (312) 233-8899.

FULL AND FAIR REVIEW – UHS or the Appeals Committee (as applicable) will conduct a full and fair review of all the material submitted with your claim, the action taken by the claims office, the additional information you have provided, and the reasons you believe the claim should be paid. The review will be conducted by an appropriate named fiduciary who is neither the party who made the initial adverse determination, nor the subordinate of such party. It will not afford deference to the initial adverse benefit determination, and will take into account all comments, documents, records and other information submitted by you, without regard to whether such information was previously submitted or relied upon in the initial determination.

You have the right, upon request and free of charge, to have copies of all documents, records and other information relevant to your claim for benefits.

The Plan will not preclude an authorized representative (including a health care provider) from acting on your behalf, although UHS or the Appeals Committee will verify that the person has been so authorized. However, in connection with an urgent care claim, the Plan will recognize a health care professional with knowledge of your medical condition as your representative.

With respect to a review of any determination based on a medical judgment, UHS or the Appeals Committee must consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment.

You and/or your representative can also make a personal appearance before the Appeals Committee. If you and/or your representative do so, it

must be done at your own expense.

NOTIFICATION FOLLOWING REVIEW – If your appeal is for an urgent care claim, you will be notified of UHS' or the Appeals Committee's decision about your appeal as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of your request for review. In the case of pre-service claims, you will be notified no later than 30 days after receipt of your request for review.

A review and determination for disability and post-service claims will be made no later than the date of the meeting of the Appeals Committee that immediately follows the Plan's receipt of a request for review. The Committee generally meets on a quarterly basis. If your request for review has been received by the Committee at least 30 days before its next scheduled meeting, a decision on your request for review will normally be made at the next quarterly meeting. If your request for review is not received by the Committee at least 30 days before the next quarterly meeting date, the decision may be delayed one additional quarter. In addition, in unusual circumstances, the decision may be delayed until the third meeting of the Committee after it has received your request for review. If such circumstances require such a delay, you will be informed.

After a decision has been made on a disability or post-service claim, you will be informed in writing of the decision, normally within five calendar days of the review. When you receive the decision on your appeal, it will contain the reasons for the decision and specific references to the particular Plan provisions upon which the decision was based. It will also contain a statement explaining that you are 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; a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures; and a statement of your right to bring an action under section 502(a) of ERISA. If applicable, you will also be informed that the specific internal rule, guideline, protocol or similar criterion relied on to make the decision will be provided to you free of charge upon request. If the decision was based on a medical judgment, you will receive an explanation of that determination or a statement that such explanation will be provided free of charge upon request.

If the Plan fails to make timely decisions or otherwise fails to comply with the applicable federal regulations, you may go to court to enforce your rights.

For services provided at or by UHS, the Consumer Services Division of

the Department of Insurance may be contacted at 122 S. Michigan Avenue, 19th Floor, Chicago, Illinois 60603 or at 320 W. Washington, Springfield, Illinois 62767.

FILING TIME LIMIT

No benefits will be paid for any claim filing more than two years after the date the claim was incurred. Any lawsuit for a claim for benefits must be filed within two years after the date the appeal was denied. Any lawsuit must be filed in the U.S. District Court for the Northern District of Illinois.

WORKERS' COMPENSATION NOT AFFECTED

This Plan does not take the place of or affect any requirement for coverage under any Workers' Compensation Law or Occupational Diseases Law or similar law.

LENGTH OF MATERNITY HOSPITALIZATIONS

A covered person and her newborn infant are entitled to at least 48 hours of inpatient hospital care following a normal delivery and at least 96 hours of inpatient hospital care following a Caesarean section. Further, the Plan will not require the provider (hospital or doctor) to obtain authorization from the Plan for prescribing a length of stay not in excess of these periods. (The attending provider may, however, after consulting with the mother, discharge the mother and newborn earlier than 48 hours following a vaginal delivery or 96 hours following a Cesarean section.) The Plan will provide benefits for the covered medical expenses incurred by an eligible female employee or dependent spouse during the prescribed time periods, subject to the applicable exclusions, deductibles, co-payment percentages payable and maximum benefits and limitations shown on the applicable Schedule of Benefits. The noncompliance deductible when the Hospital Review Program is not followed will not apply to hospitalizations not lasting longer than 48 hours for a vaginal delivery and 96 hours for a cesarean section.

PRIVACY POLICY

The following is effective April 14, 2003.

The Local 25 S.E.I.U. Welfare Fund ("Welfare Fund") exists for one purpose: to provide health and welfare benefits to participants in the Welfare Fund and to their eligible dependents. In the course of pro- vid-

ing welfare benefits, the Welfare Fund receives and maintains information that constitutes "protected health information" as defined in Federal privacy rules. This notice describes the Welfare Fund's policies that protect you from the unnecessary disclosure of your health information and give you certain rights regarding your health information.

In this Notice, "you" means any person whose health information is received by the Welfare Fund. This Notice applies to you whether you are the Plan participant or an eligible dependent. Privacy rights can be exercised either by you or your Personal Representative (defined below). For a minor child, the parent is the Personal Representative.

CIRCUMSTANCES IN WHICH THE WELFARE FUND USES OR DISCLOSES HEALTH INFORMATION

To Process and Pay Your Claims. The Welfare Fund may use or disclose your health information to process and pay your benefit claims. Claim processing includes all aspects of the process including, for example:

- Determining benefit eligibility or Plan coverage.
- Reviewing health care services for medical necessity and reasonableness of charges and duration of hospital stays.
- Providing information regarding your coverage or health care treatment to another health plan to coordinate payment of benefits.
- Processing claim appeals.
- Telephoning you or in your absence, a member of your household (to the extent permitted by law) to obtain information needed to process your claim.
- Answering questions from you or a member of your household (to the extent permitted by law) regarding your benefit claim that is pending or has already been processed.

To Collect Contributions for Coverage. The Welfare Fund may use or disclose your health information in the process of collecting any payments, such as the cost of COBRA coverage (or the charge for dependent coverage).

For Administrative Purposes. The Welfare Fund may use or disclose health information for its own operations. Some examples are:

- Quality assessment and improvement activities.

- Activities designed to improve health or reduce health care costs.
- Underwriting, premium rating or related functions to create, renew or replace Plan benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses.
- General administrative activities of the Welfare Fund, including customer service and resolution of internal grievances.

To Provide You with Health-Related Information. The Welfare Fund may use and disclose your health information to tell you about or recommend possible treatment options or alternatives, or to advise you of health-related benefits and services that may be of interest to you.

When Legally Required. The Welfare Fund will disclose your health information when it is required to do so by any Federal, state or local law. Examples include:

- When the Welfare Fund receives an order, issued by a court or a state agency, to disclose your health information.
- When the Welfare Fund receives a subpoena or a discovery request in a lawsuit or a workers' compensation case. In the case of a subpoena or discovery request that has not been issued under a court order, the party requesting the information should notify you of the request so that you will have an opportunity to obtain a court order protecting your health information.

To Conduct Health Oversight Activities. The Welfare Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensing or disciplinary action.

For Law Enforcement Purposes. As permitted or required by state law, the Welfare Fund may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, reporting a crime in an emergency or if the Fund has reason to believe that your death was the result of criminal conduct.

For Specified Government Functions. In certain circumstances, Federal regulations require the Welfare Fund to use or disclose your health information to facilitate specified government functions, for example

those related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

In the Event of a Serious Threat to Health or Safety. The Welfare Fund may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Welfare Fund, in good faith, believes that disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

PERSONS WHO WILL USE YOUR HEALTH INFORMATION – Claims adjusters and other employees in the Fund Office will use your health information to process your benefit claims. The Fund Manager and other supervisory personnel may use your health information for claim payment, training and administrative purposes, among others. The Board of Trustees, in its capacity as administrator of the Welfare Fund, may have access to your health information for appeals or other administrative or supervisory purposes.

RELEASING HEALTH INFORMATION WITH YOUR AUTHORIZATION – The categories above ("Circumstances in Which the Welfare Fund Uses or Discloses Health Information") describe when the Welfare Fund will use or disclose your health information without your authorization. Other than as stated above, the Welfare Fund will not disclose your health information, except with your written authorization. The following rules apply to authorizations to release health information:

- Authorizations will be in writing, signed by you or your Personal Representative.
- You or your Personal Representative will receive a copy of the authorization form.
- Authorizations have an expiration date that is stated on the authorization form.
- You or your Personal Representative can revoke the authorization at any time. The revocation must be in writing, delivered to the Welfare Fund at the address given below.
- The Welfare Fund will not release psychotherapy notes unless required by law.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION – You have the following rights regarding your health information that the Welfare Fund maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. The Welfare Fund is not required to agree to your request but the Welfare Fund will ordinarily honor any request that the Fund communicate only with you (that is, refrain from disclosing information to other members of your household). If you wish to make a request for restrictions, please contact the Welfare Fund's Privacy Officer.

Right to Receive Confidential Communications. You have the right to request that the Welfare Fund communicate with you in a certain way. The Welfare Fund is not required to honor such requests but the Welfare Fund will do so if it can be done without interfering with the Welfare Fund's normal operations, or if you believe that the disclosure of your health information could endanger you. If you wish to receive confidential communications, please make your request in writing to the Welfare Fund's Privacy Officer. Here are some examples of requests for confidential communications:

- A request that the Fund communicate only with you (that is, refrain from disclosing information to other members of your household). The Welfare Fund will routinely grant this request.
- A request that the Welfare Fund only communicate with you at a certain telephone number or send written communications to a P.O. box instead of your home.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Welfare Fund's Privacy Officer. If you request a copy of your health information, the Welfare Fund will charge you $0.25 per page for copying, plus actual mailing costs.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Welfare Fund amend the records. That request may be made as long as the information is maintained by the Welfare Fund. A request for an amendment of records must be made in writing to the Welfare Fund's Privacy Officer. The Welfare Fund may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Wel-

fare Fund, if the health information you are requesting to amend is not part of the Welfare Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Welfare Fund determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to request a list of certain disclosures of your health information that the Welfare Fund is required to keep a record of under the Federal privacy rules, such as disclosures for public purposes, disclosures authorized by law or disclosures that are not in accordance with the Welfare Fund's privacy policies or applicable law. The request must be made in writing to the Welfare Fund's Privacy Officer. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. The Welfare Fund will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests will be subject to a reasonable cost-based fee. The Welfare Fund will inform you in advance of the fee, if applicable.

Right to a Copy of this Notice. You have a right to request and receive a copy of this Notice at any time, even if you have received this Notice previously. To obtain a copy, please contact the Welfare Fund's Privacy Officer or any employee at the Fund Office.

YOUR PERSONAL REPRESENTATIVE – If you are of legal age, you can exercise the privacy rights explained in this Notice. Your rights can also be exercised by your Personal Representative. A Personal Representative is:

- The parent of a minor child.
- The person designated in Health Care Power of Attorney (limited to the rights stated in the Power of Attorney).
- The legal guardian of a mentally incompetent adult.
- The administrator or executor of your estate, or your next of kin.

OBLIGATIONS OF THE WELFARE FUND – The Welfare Fund is required by law to maintain the privacy of your health information as described in this Notice and to provide to you this Notice of the Welfare Fund's duties and privacy practices. The Welfare Fund is required to conform to the terms of this Notice. The Welfare Fund reserves the right to change the terms of this Notice at any time. If that happens, the Welfare Fund will revise the Notice and will provide you with a copy of the revised Notice within 60 days of the change. You have the right to sub-

mit any complaints regarding privacy issues to the Welfare Fund's Privacy Officer. If you believe that your privacy rights have been violated, you have the right to report any violations to the Secretary of the Department of Health and Human Services. The Welfare Fund encourages you to express any concerns you may have regarding the privacy of your information. Neither the Welfare Fund, your employer or your Union are permitted to retaliate against you in any way for filing a complaint.

CONTACT PERSON – The Local 25 S.E.I.U. Welfare Fund has designated Bozenna Urbanska as its Privacy Officer. She is the contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at Local 25 S.E.I.U. Welfare Fund, 111 East Wacker Drive, 17th Floor, Chicago, IL 60601, 312-233-8801.

AMENDMENTS – The Board of Trustees reserve the right to change this Privacy Policy Statement at any time.

YOUR RIGHTS UNDER ERISA

As a participant in the Local 25 S.E.I.U. Welfare 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

- Examine, without charge, at the Fund Manager's office and at other specified locations, such as worksites and union halls, all 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 Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Fund Manager, 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.
- 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.
- You should be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing

coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date if you should become covered under another plan.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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 Plan participants and beneficiaries. No one, including your employer, your union, 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 a copy of Plan documents or the latest annual report from the Plan 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 because of reasons beyond the control of the 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 you believe that Plan fiduciaries misuse the Plan's money, or if you believe 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 have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. If you have any questions about your Plan, you should contact the Fund Manager.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about this statement or about your rights under

ERISA, or if you need assistance in obtaining documents from the Fund Manager, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory 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. You may also find answers to your questions and a list of EBSA field offices at the website of the EBSA at www.dol.gov/ebsa.

HOW TO READ OR GET PLAN MATERIAL

You can read the material listed in the previous section by making an appointment at the Fund Office during normal business hours. This same information can be made available for your examination at certain locations other than the Fund Office. The Fund Office will inform you of these locations and tell you how to make an appointment to examine this material at these locations. Also, copies of the material will be mailed to you if you send a written request to the Fund Office. There may be a small charge for copying some of the material. Before requesting material, call the Fund Office to find out the cost. If a charge is made, your check must be attached to your written request for the material. The Fund Office address and phone number are shown on the inside front cover.

INFORMATION ABOUT YOUR PLAN

The following provides you with some names, addresses, telephone numbers and other data that identifies your Plan and the people who are responsible for its operation.

NAME OF FUND – Local 25 S.E.I.U. Welfare Fund.

IDENTIFICATION NUMBERS – EIN: 36-2857218, PN: 501.

LAST DAY OF THE PLAN YEAR – September 30.

ADMINISTRATION AND FUNDING – Your Welfare Plan results from collective bargaining between certain associations, employers and the Building Service Division of Local No. 1, Service Employees International Union (formerly Local 25).

The Welfare Plan is administered by a Board of Trustees, made up of Trustees representing participating employers and trustees representing the Union. The Trustees authorize benefit payments, resolve questions, and make rules to assure the Plan is fair to all. Their actions are in accordance with the collective bargaining agreements and the legal documents that describe the Plan in detail. A Fund Manager employed by the Welfare Fund assists the Trustees in the daily operations of the Fund.

The Plan provides medical, surgical and weekly disability benefits on a self-funded basis. Certain medical, pharmacy and vision services are provided through a contract with UHS. Dental benefits are provided to participants through an insurance contract between the Trustees and Blue Cross Blue Shield of Illinois.

The Plan is funded by contributions from participating employers. A copy of a list of participating employers is available from the Fund Office upon written request. Under certain circumstances, self-contributions (self-payments) are permitted (see "COBRA Coverage Self-Payment Procedure," page 49). The Fund may also receive refunds or fees from its prescription benefit manager.

Contributions to the Fund are at fixed rates based on hours or months of employment, as described in the collective bargaining agreement, a copy of which may be obtained from the Fund Office upon written request. The money goes into a trust fund that is managed by the Board of Trustees. Trust Fund assets, including investment earnings, are used to pay benefits and administrative expenses, and to pay the cost of contracts between suppliers of services and the Board of Trustees.

PLAN ADMINISTRATOR/PLAN SPONSOR

The Board of Trustees of the Local 25 S.E.I.U. Welfare Fund.

FUND ADDRESS AND TELEPHONE NUMBER

111 East Wacker Drive, 17th Floor
Chicago, Illinois 60601-5305
(312) 233-8888

AGENT FOR SERVICE OF LEGAL PROCESS

The Fund Manager, James M. McArdle, is the agent for service of legal process against the Plan. Service of legal process may also be made upon any Plan Trustee.

Address all correspondence to:
Board of Trustees
c/o Local 25 S.E.I.U. Welfare Fund
111 East Wacker Drive
17th Floor
Chicago, Illinois 60601-4200

WELFARE FUND TRUSTEES

For the Union

Mr. Thomas Balanoff
President
Service Employees Local No. 1
111 East Wacker Drive
17th Floor
Chicago, IL 60601-4200

Ms. Laura Garza
Service Employees Local No. 1
111 East Wacker Drive
17th Floor
Chicago, IL 60601-4200

Mr. Kenneth E. Munz
Service Employees Local No. 1
111 East Wacker Drive
17th Floor
Chicago, IL 60601-4200

For Participating Employers

Mr. Stanley J. Gaynor
c/o Local 25 SEIU Welfare Fund
111 East Wacker Drive
17th Floor
Chicago, IL 60601-4200

Ms. Krystal W. Kurinsky
Senior Vice President
MB Real Estate
181 West Madison, Suite 3125
Chicago, IL 60602

Mr. Dean L. Johnson
General Manager
Golub Realty Services
435 N. Michigan Avenue, Suite 1231
Chicago, IL 60611

The Plan is subject to change.

You will be advised in writing if a material change is made after the printing of this booklet and before the printing of a new booklet.

Any changes are typically described in a Summary of Material Modifications (SMM). Those SMMs which amend, change or improve the Plan of Benefits are generally published in a one-page flyer in a self-mailing format. You should read the SMMs, and then keep them with this booklet. If you have any questions about an SMM, or about this Plan 1, please call the Fund Office.

FUND PROFESSIONALS

Fund Counsel

Asher, Gittler & D'Alba, Ltd.
200 West Jackson Blvd
Suite 1900
Chicago, IL 60606

Fund Consultant

TFBC, LLC
Two Mid America Plaza
Suite 800
Oakbrook Terrace, IL 60181

Auditor

Bansley & Kiener, LLP
8745 West Higgins Road
Suite 200
Chicago, IL 60631

Investment Manager

Amalgatrust
30 N. LaSalle Street
38th Floor
Chicago, IL 60602