32BJ SEIU
Stronger Together

www.seiu36.com

It's Open Enrollment Time!

2025
Benefits Guide

You only have until December 2 to enroll in BOLR BMCA Part-Time Benefits for 2025!

OPEN ENROLLMENT FORMS

The forms that you need to complete for enrollment are on the next few pages of this guide and on the **Contacts & Resources** page (https://www.seiu36.com/contacts-resources/) on our website. The forms on the site can be filled out online. You'll just need to print them out to sign them and then mail them to the Fund Office.

You can use the QR code above to go straight to our site. Just open the camera app on your smart phone or tablet and select the rear-facing camera. Point your camera at the code. A notification should pop up. Click it and you will go to our website. Remember to make sure that you are connected to the internet.

See the instructions at the top of each form to help you understand which forms you need to complete and mail back to the Fund Office.

IMPORTANT REMINDER: Please only fill out the forms that apply to you.

And be sure to review the rest of the Guide to help you with your enrollment for coverage in 2025. We have updated the Guide to make it easier to use this year.

Questions? Contact the Fund Office.

NEW PARTICIPANTS/MEMBERS:
If adding dependents to your coverage, you must complete the dependent enrollment form and provide the proper documentation of their dependent status to ensure their enrollment into the Plan.

IMPORTANT INSTRUCTIONS:
Complete this form and return it to the Fund Office if you are adding dependents to your coverage. This form has two sides. **Remember to complete both sides and sign and date on the second page of this form.**

Side A

SEIU LOCAL 32BJ, DISTRICT 36 BOLR BENEFIT FUNDS
DEPENDENT ENROLLMENT FORM

Please complete the information requested on both sides of this form to add your spouse or your dependent child/children to the Plan. For your spouse, natural child/children or stepchild/stepchildren, please attach a copy of the state marriage certificate for your spouse and/or the certified birth certificate naming both parents for your children. For adopted child/children, please supply adoption documentation. Additional documentation such as a Qualified Medical Child Support Order may be required.

Participant/Member's Name				Participant/Member's Social Security Number		
1. Last Name	First Name	Social Security #	Relationship to Participant	Date of Birth	Primary Care Physician Name	Primary Care Physician ID #
Street Address	Apartment #	City	State	Zip Code	Telephone #	
2. Last Name	First Name	Social Security #	Relationship to Participant	Date of Birth	Primary Care Physician Name	Primary Care Physician ID #
Street Address	Apartment #	City	State	Zip Code	Telephone #	
3. Last Name	First Name	Social Security #	Relationship to Participant	Date of Birth	Primary Care Physician Name	Primary Care Physician ID #
Street Address	Apartment #	City	State	Zip Code	Telephone #	

SEIU LOCAL 32BJ, DISTRICT 36 BOLR BENEFIT FUNDS
DEPENDENT ENROLLMENT FORM *continued*

Side B

For each dependent you have named, please let us know whether this dependent has coverage under another group health plan beside your group health plan with SEIU Local 32 BJ, District 36. **Print** yes or no in Column 2. If you wrote yes, please complete columns 3 through 7.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
Name of Covered dependent	Is this dependent covered under another group health plan?	Name of Subscriber or Policyholder	Relationship to Subscriber/ Policyholder	Name of Carrier or Health Plan	Group Number	Participant's Name

Authorization—Important!

I certify that the information on both sides of this form is correct and acknowledge that if I, the Fund participant or my dependents willfully misuse or misrepresent any information about eligibility for any other group health coverage provided either through the course of their own employment or coverage provided from another source (i.e. parent, stepparent or spouse's health coverage), the Fund has the right to terminate benefits for myself and my dependents. Furthermore, should my dependents acquire group health coverage through their own employment, that of a spouse, parent or stepparent, I will immediately notify the Fund Office.

Signature: _____ Date: _____

IMPORTANT INSTRUCTIONS: Only complete this form and return it to the Fund Office if you are waiving Fund coverage for yourself.

SEIU LOCAL 32BJ, DISTRICT 36 BOLR WELFARE FUND

1515 Market Street, Suite 1020, Philadelphia, PA 19102

Opt-Out Form—Member

Complete This Form to Opt Out of Fund Coverage

Please use this form if you wish to opt out of your Fund-provided vision or dental coverage for yourself and/or your dependents.

NOTE: If you opt out of coverage for yourself, your dependents will automatically waive their coverage as well.

Please note: This form must be completed yearly if you choose to continue to waive coverage for you and your dependents.

Please return this form to the Fund office. Thank you for your cooperation.

Your Authorization

By signing this form, I am rejecting the Fund-provided vision and dental coverage offered for myself and/or my dependent(s) under the SEIU Local 32BJ, District 36 BOLR Welfare Fund for 2025.

Please list the names and dates of birth of the individual(s) you are disenrolling:

Participant's Name		Date of Birth
Dependent's Name		Date of Birth
Dependent's Name		Date of Birth
Dependent's Name		Date of Birth

Participant Signature	Please Print Name	Date

Special Enrollment Rights

You may enroll for medical coverage during the year if you get married, acquire a new dependent, or lose your other medical coverage. To be eligible for this special enrollment, you must send a written request to the Fund Office within 31 days of the event (or 90 days from the birth of a child).

IMPORTANT INSTRUCTIONS: Only complete this form and return it to the Fund Office if you are waiving Fund coverage for your dependents.

SEIU LOCAL 32BJ, DISTRICT 36 BOLR WELFARE FUND

1515 Market Street, Suite 1020, Philadelphia, PA 19102

Proof of Other Coverage Form—Dependents

Complete This Form to Opt Out of Coverage for Dependents Only

In order to waive coverage for your dependent(s), you must complete this form and provide proof that the dependent(s) has/have coverage elsewhere.

Remember: If you opt out of coverage for yourself, your dependents will automatically waive their coverage as well. This form is for waiving coverage for your dependents only.

Attach a copy of the identification card from your other insurance coverage.

Please return this form to the Fund Office. Thank you for your cooperation.

Dependents' Coverage is Provided Through:

Employer Name or Plan: _____

Your Authorization

By signing this form, I am rejecting the coverage offered for my dependent(s) under the SEIU Local 32BJ, District 36 BOLR Welfare Fund for 2025 and certify that my dependent(s) has(have) the coverage indicated above.

Please list the names and dates of birth of the dependent(s) you are disenrolling:

Dependent's Name: _____ Date of Birth: _____

Dependent's Name: _____ Date of Birth: _____

Dependent's Name: _____ Date of Birth: _____

Participant Signature: _____ Date: _____

Please print name: _____

Special Enrollment Rights

You may enroll for medical coverage during the year if you get married, acquire a new dependent, lose your other medical coverage, or experience another form of a qualified change of status. To be eligible for this special enrollment, you must send a written request along with appropriate documentation to the Fund Office within 31 days of the event (or 90 days from the birth of a child).

IMPORTANT INSTRUCTIONS: You must complete both sides of this form, sign, date, and return it to the Fund Office.

Side A

SEIU LOCAL 32BJ, DISTRICT 36 BOLR BENEFIT FUNDS
DEMOGRAPHIC CENSUS FORM

PLEASE PRINT AND COMPLETE ALL INFORMATION ON BOTH SIDES OF THE FORM. WE MUST HAVE BOTH YOUR DEMOGRAPHIC INFORMATION AND BENEFICIARY INFORMATION COMPLETED, SIGNED, AND DATED. INCOMPLETE INFORMATION COULD CAUSE A DELAY IN PROCESSING YOUR CLAIMS.

Full Name (Last, First, MI)	Social Security Number	Date of Birth	Marital Status	Gender	Language

Street Address (include Apt # if applicable)	City	State	Zip Code	Primary Physician Name	Physician Adress

Home Phone No. (include area code)	Cell No. (include area code)	Email Address

Name of Employer	Date of Hire	Union Start Date	Job Classification

Dependent Information (Last, First, MI) of each dependent	Social Security No.	Date of Birth	Gender	Relationship to participant (spouse, son, daughter)

Name of Other Insurance Carrier	Name of Insured	Policy/Group No.	Identification number

Insurance Carrier's Address	City	State	Zip Code	Phone No. (include area code)

Signature of Fund Participant	Date	
		☐ Yes, I would accept updates about my benefits via text ☐ No, Don't update me about my benefits via text

Side B

SEIU LOCAL 32BJ, DISTRICT 36 BOLR BENEFIT FUNDS
BENEFICIARY INFORMATION FORM *continued*

Beneficiary- Your beneficiary may be any person or persons you choose to name. However, if you are married, there may be certain benefits payable only to your spouse, unless your spouse consents to a different designation in writing at the time of retirement. This beneficiary designation form will apply to any Death Benefits available from the various Funds. Proceeds are paid to contingent beneficiary(ies) only if there are no surviving primary beneficiary(ies). If multiple primary and contingent beneficiaries are named and no percentage distribution is noted, then any proceeds payable to such beneficiaries will be split equally. Please be sure to complete the form in full, sign and date the form. This form will be invalid unless you sign and date it certifying your designation.

Participant's Name	Social Security Number	Date of Birth	Name of Employer
Participant's Address	**City**	**State**	**Zip Code**

Primary Beneficiary(ies) Information (You can name up to four primary beneficiaries)

Beneficiary's Name	Address	Telephone No.	Relationship to Participant	Social Security No.	Benefit Percentage Must equal 100%

Contingent Beneficiary(ies) Information (Contingent beneficiaries will only receive a benefit if there are no surviving primary beneficiaries)

Beneficiary's Name	Address	Telephone No.	Relationship to Participant	Social Security No.	Benefit Percentage Must equal 100%

Please Print Participant's Name	Participant's Signature	Date

What's Inside

This Enrollment Guide is available in Albanian, Chinese, German, Italian, Polish, and Spanish on our website. Go to the "Documents & Forms" section of the "Contacts & Resources" page (https://www.seiu36.com/contacts-resources/). Please note that the forms are only available in English.

Ky udhëzues regjistrimi është i disponueshëm në gjuhën shqipe në faqen tonë të internetit. Shkoni te seksioni "Dokumentet dhe formularët" të faqes "Kontaktet dhe burimet" (https://www.seiu36.com/contacts-resources/). Ju lutemi vini re se formularët janë të disponueshëm vetëm në anglisht.

本注册指南可在我们的网站上找到中文版。转到"联系人和资源"页面的"文档和表格"部分 (https://www.seiu36.com/contacts-resources/)。 请注意，表格仅提供英文版本。

Dieser Leitfaden zur Einschreibung ist auf unserer Website in deutscher Sprache verfügbar. Gehen Sie zum Abschnitt „Dokumente & Formulare" der Seite „Kontakte & Ressourcen" (https://www.seiu36.com/contacts-resources/). Bitte beachten Sie, dass die Formulare nur auf Englisch verfügbar sind.

Questa guida all'iscrizione è disponibile in italiano sul nostro sito web. Vai alla sezione "Documenti e moduli" della pagina "Contatti e risorse" (https://www.seiu36.com/contacts-resources/). Tieni presente che i moduli sono disponibili solo in inglese.

Niniejszy Przewodnik Rekrutacyjny jest dostępny w języku polskim na naszej stronie internetowej. Przejdź do sekcji „Dokumenty i formularze" na stronie „Kontakty i zasoby" (https://www.seiu36.com/contacts-resources/). Należy pamiętać, że formularze są dostępne wyłącznie w języku angielskim.

Esta Guía de Inscripción está disponible en español en nuestro sitio web. Vaya a la sección "Documentos y formularios" de la página "Contactos y recursos" (https://www.seiu36.com/contacts-resources/). Tenga en cuenta que los formularios solo están disponibles en inglés.

Need a form? Check the front of this Guide–and on our website!

The forms that you need to complete for enrollment are on the first few pages of this guide and on the Contacts & Resources page (https://www.seiu36.com/contacts-resources/) on our website. The forms on the site can be filled out online. You'll just need to print them out to sign them and then mail them to the Fund Office.

Each form will tell you the conditions under which you should fill it out. Only complete the forms that apply to you. Tear each completed form on the perforated edge and mail to the Fund Office using the return envelope included in this guide.

REMEMBER: Choose carefully! Once Open Enrollment is over, you will not be able to change your elections until the next Open Enrollment period in the Fall of 2025, for coverage effective January 1, 2026, unless you have a qualified status change.

Open Enrollment Overview

October 2024

In this Guide and the accompanying materials, you will find the information, forms and instructions that you need to enroll for BOLR BMCA Part-Time benefits coverage in 2025.

Open Enrollment is your annual opportunity to review your coverage and make changes to the benefits you elect or the dependents you cover. Outside of Open Enrollment, you are only permitted to make changes if they are the result of a qualified life change (a "qualifying event") as described below. Please review the enclosed materials and consider your and your family's needs before making enrollment decisions. If you want to make changes to your dependent status, return your completed BMCA Part-Time Enrollment form to the Fund Office no later than December 2, 2024.

If you wish to keep the same benefit options and coverage you have now, you don't need to do anything.

Questions?

Should you have any questions, please do not hesitate to contact the Benefit Funds Office. You can contact us at (215) 568-3262, Extension 1400 or (800) 338-9025, Extension 1400 (outside the local calling area). You can also come to the SEIU Local 32 BJ, District 36 Fund Office located at 1515 Market Street, Suite 1020, Philadelphia, PA 19102 to speak to one of our representatives. Make sure to call us first before you come in.

IMPORTANT: Status Change Reminder

You may ONLY add or remove dependents or make any other changes to your benefits coverage outside of Open Enrollment if you experience a qualifying event. A qualifying event means that you or your dependent experiences a life change that affects the administration of your benefits. Examples include getting married, giving birth, or getting divorced. In these cases, you may need to add or remove dependents from your Fund coverage.

For all qualifying events, you must provide documentation of the status change (such as a birth or marriage certificate). **The Fund Office MUST receive the documentation within 31 days of the qualifying event (90 days for the birth of your child).** Please review your Summary Plan Description or contact the Fund Office for more information on qualifying events.

Note: If you have a qualifying event and need to complete a new census/beneficiary form to reflect the status change, please contact the Fund Office.

This document and the materials in your enrollment packet provide a summary description of your SEIU Local 32BJ, District 36 BOLR Welfare Fund benefits and the changes that will be effective January 1, 2025. These materials supplement other descriptions of your Plan benefits. The changes described in these documents and the enclosed materials are effective as of January 1, 2025. The Fund hopes to continue the Plan and the benefits mentioned in these documents and described in your benefits booklet indefinitely, but reserves the right to amend, suspend or terminate the Plan, in whole or in part, at any time and for any reason. Neither receipt of this enrollment packet nor enrollment in any of the benefits offered under the Plan constitutes a contract of employment. Please read these documents carefully and keep this important information with your other benefit materials for future reference.

Basic Facts

Who's Eligible?

You are eligible for the BOLR BMCA Part-Time Plan if you work in covered employment, and your employer is required through a collective bargaining agreement to make contributions on your behalf to the Fund.

If you are eligible to participate in the BOLR BMCA Part-Time Plan, you may also enroll your eligible dependents for dental and vision benefits. Your eligible dependents include:

- Your legal spouse (including same sex spouse)
- Children from birth to age 26
- Stepchildren up to age 26
- Adopted children (from the date of placement in your home) up to age 26
- Children placed for adoption
- Children over age 26 incapable of sustaining employment by reason of mental impairment or physical handicap

Any child for whom you gratuitously assume support will not be considered a dependent.

Enrolling Dependents

You must complete and submit the following information to enroll your dependents into the Plan:

- **Dependent Enrollment Form** (remember to complete both sides)
- **Document Dependent Status**—examples of documentation include:
  - Valid state birth certificate naming both parents for natural or stepchildren under age 26
  - Proof of adoption for a legally adopted child under age 26
  - If required to add your children under age 26 as a result of a Qualified Medical Child Support Order, please provide a copy of the Order
  - Proof of Social Security number
  - If you have a child who must remain on your coverage beyond age 26 by reason of physical or mental impairment as a result of which they are unable to support themselves, the Fund Office requires documentation of their disability on a periodic basis. This information must be provided to the Fund Office no later than 31 days from the date of the child's 26th birthday.

If you choose to remove a dependent from the Plan, you must complete the Opt-Out form and submit proof of other coverage for that dependent to the Fund Office.

Any change you make to your dependent status must be completed and returned to the Fund Office in the enclosed self-addressed stamped envelope by December 2, 2024. If you do not add or drop a dependent during open enrollment, you must wait to do so until you or your dependent experiences a qualifying event.

Qualified Medical Child Support Order (QMCSO)

If you are required to provide child support and healthcare coverage under a Qualified Medical Child Support Order (QMCSO), contact the Fund Office for an explanation of the information required. A QMCSO is any judgment, decree, or order issued by the court requiring you to provide healthcare coverage for a child. For additional information regarding the procedures for administration of QMCSOs, contact the Fund Office.

Dental Benefits

Regular, professional dental care is not only essential to good health, but it also can prevent serious or costly problems. That's why our Dental Plan, provided through Delta Dental, covers a full range of dental services, including diagnostic and preventive care.

Chart of Dental Benefits

Deductible	In Network	Out of Network
Annual Maximum Benefit[1]	$3,000 per person, per year	$3,000 per person, per year
Preventive and Diagnostic Care • Oral exam, cleaning, bitewing X-rays (twice a year); full-mouth X-rays every 36 months • Fluoride treatments up to age 19 (limits apply) • Sealants or space maintainers (age limits apply)	100%	100% (allowed amount)
Basic Restorative • Fillings	100%	100% (allowed amount)
Major Restorative • Repairs of existing crowns • Inlays, onlays, crowns, cast restorations • Bridges and dentures	100%	100% (allowed amount)
Orthodontia (Children only, subject to a lifetime maximum of $4,500, except for medically appropriate orthodontia)	100% $1,000 lifetime maximum	100% (allowed amount)

[1] *Annual maximum for dental is a combined maximum for both in- and out-of-network care. Under the Affordable Care Act (ACA) guidelines, pediatric dental care is not subject to the annual maximums.*

Predetermine Benefits for Treatment Over $300

If your treatment is expected to cost $300 or more, ask your dentist to "predetermine benefits" with Delta Dental before treatment starts (this means evaluating whether the suggested treatment is appropriate and determining how much the Plan will pay for the care). With predetermination, you know exactly how much the Plan will pay—and how much you will pay. That way, you can make financial arrangements before the treatment begins.

To predetermine benefits, your dentist needs to send a claim form to Delta Dental describing the proposed treatment and the estimated charges. Delta Dental will send you a statement showing the services that will be covered and how much the Plan will pay. You can review the treatment plan with your dentist and agree on the services to be performed. After treatment is completed, return the original statement, with dates of services and necessary signatures, to Delta Dental for payment.

Please review your Summary Plan Description for a complete list of dental limitations and exclusions.

Vision Benefits

How the Plan Works

You have the option to receive eye care from a National Vision Administrator (NVA) participating provider or any other eye care specialist. However, you receive maximum benefits when you use a participating eye doctor or optometrist.

- **When you use a participating provider,** you receive maximum benefits because the Plan pays the full cost or a large portion of the cost for most routine services.
- **When you use a non-participating provider,** the Plan will reimburse you for exams, eyeglass frames, and lenses or contact lenses. You pay the full cost when you receive services. Then, you must file a claim to be reimbursed for the Plan's share of the cost.

Under the Vision Plan, you may use your ID card to get eye care services or eyewear. However, you cannot use your card combined with any special offers, such as coupons or special promotions.

What the Plan Pays

When you receive services from an NVA-participating provider, the Plan pays for the cost of an eye exam once every 24 months.

The Plan also pays for one new pair of lenses and frames or contact lenses, up to $120 every 24 months (or every 12 months for children under 19).

When you receive services from a non-participating vision provider, the Plan will pay up to $30 for an eye exam once every 24 months (or every 12 months for children under 19).

The Plan also pays up to $60 for lenses and up to $60 for frames, or up to $120 for contact lenses, once every 24 months for children and adults.

Expenses Not Covered (Please note that this is only a partial listing.)

The Vision Plan does not cover:

- Fundus photography;
- Medical or surgical treatment of the eyes;
- Services or materials provided as a result of Worker's Compensation Law or obtained by any governmental agency or program; or,
- Plain or prescription sunglasses.

Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance

Today, life insurance is more than a "peace of mind benefit"—it is one of life's necessities.

Life insurance is designed to offer protection to your family, or anyone who counts on your income, if you die. Accidental Death and Dismemberment (AD&D) insurance pays a benefit to you if you suffer an accidental loss of a limb or your eyesight, and pays a benefit to your beneficiary(ies) if you die as the result of a covered accident.

Dependents are not eligible for life and AD&D insurance coverage.

Employee Only Benefit	
Death, Natural	$25,000
Death, Accident	$25,000 (in addition to above)
Dismemberment Benefits	Specific amount determined by loss

This life insurance benefit is generally only payable if you die while in active covered employment.

Any AD&D benefit payable as a result of your accidental death is equal to the amount of your life insurance and is paid in addition to your life insurance benefit.

The amount of AD&D benefit depends on the type of accidental loss. See your Summary Plan Description, or call the Fund Office for details.

Exclusions and certain limitations may apply. See your Summary Plan Description for a complete list of exclusions and limitations.

Don't Forget—Your Beneficiary

To make sure any benefits are paid to the person you want, you must name your beneficiary—and keep your beneficiary designations up to date as your life changes. If you are newly eligible, or have changes in your dependent status, complete a Demographic Census/Beneficiary Information form. Contact the Fund Office if you need a new form. Return the form to the Fund Office.

Disability Benefits

If you are a part-time employee and your employer makes an additional contribution to the Fund for disability benefits, you are eligible for disability benefits. Disability benefits provide you and your family with a supplemental weekly payment if you become disabled and cannot work due to a non-work-related illness or injury.

The specific time allowance for disability is determined by the diagnosis and established disability guidelines. However, no disability can exceed the maximum benefit of 26 weeks. For disability benefits to be considered, you must complete a disability claim form, and you must provide documentation from a legally qualified doctor certifying that you are disabled and unable to perform your normal work duties. Please note: MHC providers can also certify disability.

If you're eligible, you'll receive a weekly benefit equal to a percentage of your regular pay, up to a weekly maximum, while you are disabled and remain under the direct regular care of a legally qualified doctor or your care is being managed by an MHC Mental Health/Substance Use provider.

Your disability claim begins on the fourth working day after you visit your doctor as a result of your disability. Disability benefits will not be paid for any period in which you missed work before you visited your doctor.

Disability forms must be submitted on time. If you are out of work on a continuing disability that exceeds a month, you must submit continuation forms ("blue forms") on a regular basis--usually once a month. See the form for more information about timing and deadlines. Contact the Fund Office to get a form.

For more information about disability benefits, see your Summary Plan Description, or call the Fund Office at 215-568-3262 or 800-338-9025 outside the local calling area.

** If your employer is required to make an additional contribution for disability benefits.*

Please note: Some employers may still be under the flat rate benefit allowance, based on their contract requirements. If you are eligible under the flat rate weekly benefit for part-time employees who work less than 30 hours a week, the rate will be $130 per week.

"Legally qualified physician" includes Medical Doctors (MD), Doctors of Osteopathy (DO), Doctors of Dental Surgery (DDS), Doctors of Dental Medicine (DMD), or Doctors of Podiatric Medicine (DPM).

Any claim for disability must be filed with the Fund Office within 60 days from the initial date of your disability. Be sure that all sections are completed and signed by you , your employer and your attending physician before submitting to the Fund Office.

Important Notices

SEIU Local 32 BJ, District 36 BOLR Welfare Fund ("the Fund") is required to provide the following important notices to you. Please review them carefully so you understand your rights and responsibilities.

HIPAA Special Enrollment Rights

If you are declining enrollment in the health insurance plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends and provide supporting documentation. In addition, if you have a new dependent as a result of marriage, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the health insurance plan, provided that you request enrollment within 31 days after the marriage, adoption, or placement for adoption. If you have a new dependent as a result of birth, you may be able to enroll yourself and your dependents in the health insurance plan, provided that you request enrollment within 90 days after the birth.

The Fund will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days from the date of the Medicaid/CHIP eligibility change to request enrollment in Fund coverage. Note that this 60-day extension applies **only** to enrollment opportunities due to Medicaid/CHIP eligibility changes.

Enrollment materials must be completed and all proof of dependent status provided to the Plan within 31, 60 or 90 days of the request for Special Enrollment. If you are unable to complete the enrollment materials and provide proof of dependent status within the time frame (for example, if additional time is needed to obtain a birth certificate for a newborn), the deadline may be extended.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), you and your eligible dependents may continue medical coverage for up to 18 months if coverage ends because:

- You terminate employment for any reason (other than gross misconduct), or
- You have a reduction in work hours.

COBRA also allows for your eligible dependents to continue their medical coverage for up to 36 months if coverage would otherwise end because:

- You die,
- You and your spouse divorce or legally separate,
- You become eligible for Medicare, or
- Your dependents are no longer eligible for coverage under the medical plan.

You and your dependents generally may elect to continue coverage anytime within the first 60 days after coverage ends or 60 days from the date the notice is received, whichever is later. Continued coverage takes effect on the first of the month following the date of the event that caused coverage to end, as long as you pay the necessary premium. You may only continue the coverage that was in effect one day prior to the event. However, you may make changes to your elections each year during the annual open enrollment period. If the medical plan changes, those changes will also apply to coverage under COBRA.

To receive coverage under COBRA, you and/or your eligible dependents are required to make a timely election and make monthly premium payments.

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. In the case of a plan participant who is receiving benefits in connection with a mastectomy, coverage will be provided in a manner determined in consultation with the attending physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of mastectomy, including lymphedema

Breast reconstruction benefits are subject to deductibles and coinsurance limitations that are consistent with those established for other benefits under the plan.

HIPAA Privacy Notice Reminder

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the SEIU Local 32 BJ, District 36 BOLR Welfare Plan (the "Plan") to periodically send a reminder to participants about the availability of the Plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI. You may also obtain a copy of the Privacy Notice by contacting the Fund Office at 215-568-3262, Extension 1400 or 800-338-9025, Extension 1400 (outside the local calling area).

Medicaid and the Children's Health Insurance Program (CHIP)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial **877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866-444-EBSA (3272)**.

The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

PENNSYLVANIA	**Medicaid and CHIP**
Medicaid Website	https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Medicaid Phone	800-692-7462
CHIP Website	https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone	800-986-KIDS (5437)
NEW JERSEY	**Medicaid and CHIP**
Medicaid Website	http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone	800-356-1561
CHIP Premium Assistance Phone	609-631-2392
CHIP Website	http://www.njfamilycare.org/index.html
CHIP Phone	800-701-0710 (TTY: 711)
NEW YORK	**Medicaid**
Medicaid Website	https://www.health.ny.gov/health_care/medicaid/
Medicaid Phone	800-541-2831
DELAWARE	**Medicaid and CHIP**
Medicaid Website	http://dhss.delaware.gov/dhss/dmma/medicaid.html
Medicaid Phone	302-571-4900 or 866-843-7212
CHIP Website	http://dhss.delaware.gov/dhss/dmma/dhcp.html
CHIP Phone	302-571-4900 or 866-843-7212
MARYLAND	**Medicaid and CHIP**
Medicaid Website	https://health.maryland.gov/mmcp/Pages/home.aspx
Medicaid Phone	855-642-8572
CHIP Website	https://mmcp.health.maryland.gov/chp/pages/home.aspx
CHIP Phone	855-642-8572 (TTY 711)

To see if your state has a premium assistance program, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

Notes

www.seiu36.com

October 2024

Union Bug