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It's Enrollment Time!

2026

New Hire Benefits Guide

**You have 20 days to enroll
in BOLR Part-Time and
Weekend Worker Benefits
for 2026!**

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 2026. 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.**

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

Side A

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 2026.

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; or 60 days if you lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or you become eligible for a state's premium assistance program under Medicaid or CHIP).



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 2026 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; or 60 days if you lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or you become eligible for a state's premium assistance program under Medicaid or CHIP).



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

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

Side A

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 Address				
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							

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

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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.

Open Enrollment Overview

2026

In this guide and the accompanying materials, you will find the information, forms, and instructions that you need to enroll for benefits coverage in 2026. Please review the enclosed materials carefully, and consider your family's needs before enrolling in coverage.

You must return your completed forms (included in the front of this book) to the Fund Office no later than 20 days after you receive this enrollment packet.

What You Need to Do Now

After you've read this guide:

1. Complete both sides of your **Demographic Census/Beneficiary Form**. If adding dependents to the plans, complete the Dependent Enrollment form. Proper documentation must be provided in order to enroll dependents.
2. Review this Guide carefully. Consider which benefit options are best for you and your family.
3. Complete, sign, and date the applicable forms in the front of this Guide. Read the purple boxes to determine which forms you must complete.
4. If you are waiving coverage:
 - Complete and sign the **Proof of Other Coverage Form**; and
 - Return all necessary forms in the enclosed reply envelope.
5. Complete the enclosed **Social Security Data Match** form, and supply a copy of your Social Security card. If adding dependents to the plan, you must also provide copies of their Social Security cards.

Note: If your forms are incomplete, they will be returned to you. If any of your forms are returned, you must complete the missing information and return the forms to the Fund Office within 72 hours.

**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.

IMPORTANT: Status Change Reminder

Your benefit decisions will remain in effect for the rest of this year. You may change your Medical, Dental, or Vision elections during the year only if you have a change in status. Qualified changes in status are:

- A change in your marital status (such as marriage, divorce, or annulment);
- A change in the number of your dependents (such as birth, legal adoption of your child, placement of a child with you for adoption, or death of a dependent);
- Certain changes in employment status that affect benefits eligibility for you, your spouse, or children, such as: termination of employment, a strike or lockout, the start of or return from an unpaid leave of absence, a change in worksite, or a change in work schedule (for example, between full-time and part-time work or a decrease or increase in hours);
- Your child is no longer eligible for coverage;
- Entitlement to Medicare or Medicaid (applies only to the person entitled to Medicare or Medicaid);
- Change to comply with a state domestic relations order pertaining to coverage of your dependent child;
- Your, your spouse's, or child's eligibility for COBRA coverage;
- A significant increase in the cost of coverage or a significant reduction in the benefit coverage under your or your spouse's healthcare plan;
- The addition, elimination, or significant curtailment of a coverage option;
- A change in your spouse's or child's coverage during another employer's annual enrollment period when the other plan has a different period of coverage; or
- A change in dependent care providers or costs if the providers are not relatives of the employee (applies only for Dependent Care Reimbursement Account).

You must notify the Fund Office in writing of your request for a change in coverage within 31 days of the change in status (the deadline is 90 days for adding a newborn child; or 60 days if you lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or you become eligible for a state's premium assistance program under Medicaid or CHIP), and you must provide proof of the event.

REMEMBER: Choose carefully! You have 20 days to enroll. You will not be able to change your elections until the next Open Enrollment period in 2026, for coverage effective January 1, 2027, unless you have a qualified status change.

Questions? Call the Fund Office at 215-568-3262 ext. 1400 or at 800-338-9025 ext. 1400.

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, 2026. 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, 2026. 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 Part-Time and Weekend Worker 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 Part-Time and Weekend Worker Plan, you may also enroll your eligible dependents for medical, 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.

REMEMBER: You have 20-days to enroll yourself and your dependents. If we don't receive your enrollment forms within the specified time, you will have to wait until our next open enrollment unless there is a qualifying status change.

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.

Who Pays for Benefits

Your benefit plan and the required contributions are established by a collective bargaining agreement. Your employer makes monthly contributions on your behalf to the Fund, which pays for all or part of your health and welfare benefits. You pay a portion of the cost of the healthcare services you receive through deductibles, copayments, and/or coinsurance.

Changing Your Benefits

Your benefit elections are effective from the date you enroll until December 31, 2026. You will not be able to change your 2026 Dental or Vision elections during the year unless you experience one of the qualified changes in status described on pages 2 and 3.

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 Benefit¹	\$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.

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. For children under 19, the plan pays for an eye exam once every 12 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.

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.

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.

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.

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

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.

Short-Term Disability Benefits

Short-term 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 a short-term disability is determined by the diagnosis and established disability guidelines. However, no short-term disability can exceed the maximum benefit of 26 weeks due to illness. For short-term disability benefits to be considered, you must complete a short-term 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.

Part-time and weekend employees are eligible for a benefit of \$30 per week (or per weekend) for illness or injury while you are disabled and remain under the direct, regular care of a legally qualified doctor.

The form for your short-term disability claim must be filed in a timely manner. See the form for more information about timing and deadlines. Contact the Fund Office to get a form. You will only receive eligibility credit while you are receiving short-term disability benefits.

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

For more information about short-term 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.

“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 short-term 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.

If you are out of work on a continuing disability that exceeds a month, it will be necessary for you to complete continuation forms “blue forms” on a regular basis, typically monthly.

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 (or 60 days if you lose Medicaid or Children’s Health Insurance Program (CHIP) coverage because you are no longer eligible, or you become eligible for a state’s premium assistance program under Medicaid or CHIP).

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
- Prosthesis 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 January 31, 2026. 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

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights	
You have the right to:	• Get a copy of your health and claims records • Correct your health and claims records • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Get a copy of this privacy notice • Choose someone to act for you • File a complaint if you believe your privacy rights have been violated
Your Choices	
You have some choices in the way that we use and share information as we:	• Answer coverage questions from your family and friends • Provide disaster relief • Market our services and sell your information
Our Uses and Disclosures	
We may use and share your information as we:	• Help manage the health care treatment you receive • Run our organization • Pay for your health services • Administer your health plan • Help with public health and safety issues • Do research • Comply with the law • Respond to organ and tissue donation requests and work with a medical examiner or funeral director • Address workers' compensation, law enforcement, and other government requests • Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information below.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

- Contact you for fundraising efforts
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

October 2018

Tyema Sanchez
Privacy Officer
215-568-3262, Extension 1400

Continuation Coverage Rights Under COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Fund Office.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

www.seiu36.com

