MEMBER BENEFITS GUIDE
S.E.I.U. LOCAL 704 HEALTH & SECURITY PLAN TRUST

704 – LIBRARY EMPLOYEES

DENTAL / VISION BENEFITS/REIMBURSEMENTS
2026



DANIEL H. COOK
ASSOCIATES INC

1040 Avenue of the Americas, 24th Floor, New York, NY 10018

S.E.I.U. LOCAL 704 HEALTH & SECURITY PLAN TRUST

DENTAL AND VISION BENEFIT INFORMATION

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You and your dependents are eligible for coverage in accordance with the rules and regulations of the SEIU Local 704 Health & Security Plan Trust. Please refer to the Eligibility rules in your benefit booklet and your Plan documents.

Proof of full-time student status must be supplied in writing each semester for all dependents who are over 19 years of age but have not yet turned 25. Members are responsible for notifying the benefit office when a dependent turn 19 and/or enrolls/graduates or is no longer attending school.

*Your plan year is from **January 1st – December 31st.** The mailing address is:*

S.E.I.U LOCAL 704 HEALTH & SECURITY PLAN TRUST
1040 Avenue of the Americas, 24th Floor
New York, NY 10018

All claims must be submitted within 90 days of the date of service. Any questions regarding denied dental or vision claims for late filing should be directed to the S.E.I.U benefits office at (914) 377-6290.

NOTE: Dental claims – ASO (Administrative Services Only) is the primary payor for all dental claims. Once you have submitted your claim to ASO, you should attach a copy of the Explanation of Benefits (EOB) to your dental claim and submit it to DH Cook for secondary processing of your claim.

This guide is for SUMMARY purposes only. Please refer to your official Plan Documents for all plan rules and regulations.

AM I ELIGIBLE?

Participants

The term "Participant" used in this descriptive booklet means:

A) A member working in covered employment shall be eligible for selected Local 704 Plan benefits sixty (60) days after the commencement date of covered employment and must be an active dues paying member of Local 704, Service Employees Internation Union
B) The spouse of an eligible Active Member or
C) The eligible Employee's dependents:
   1) Unmarried child who has attained the age of two weeks but has not attained the age of 19 years. In addition, such child shall be deemed to be a dependent beyond such termination and until he/she reaches his/her 25th birthday on condition that he/she shall continue throughout such extended period to:
      - Be Unmarried and registered as a full-time student working toward a degree at an accredited college or university. Fulltime student is defined as carrying at least 12 credits.
      - Be dependent upon the Eligible Active Employee for support and maintenance, and
      - Have the same permanent residence as the Eligible Active Employee
      - Unmarried child who was handicapped before the age of nineteen years and is dependent upon his parent or legal guardian for support. The Plan may require written proof of such dependence.

HOW DO I ENROLL?

You must enroll for benefits upon hire at S.E.I.U Local 704 Health & Security Plan Trust office.

Once you have received your Daniel H. Cook Associates, Inc. ID Card, you can track your claims at dhclaims.com.

If you have questions about your eligibility, please call Daniel H. Cook Associates, Inc.'s Eligibility Department at (914) 250-0700.

Effective Date of Coverage: A member working in covered employment shall be eligible for selected Local 704 Plan benefits sixty (60) days after the commencement date of covered employment.

Coverage of Dependents: The Trustees shall have the right in their sole discretion to require, whether by marriage certificate, birth certificate or otherwise, proof of eligibility of benefits for any dependent.

WHO IS ADMINISTERING MY BENEFITS?

The benefits of S.E.I.U Local 704 Health & Security Plan Trust are now being administered by Daniel H. Cook Associates, Inc. We have been Welfare Funded third-party administrators for over 45 years, founded in 1977, and have built a strong reputation for putting our clients' needs first.

All of us at Daniel H. Cook Associates, Inc. thank you for the opportunity to serve you and your Welfare Fund!

PROOF OF FULL-TIME STUDENT

All dependents covered under the S.E.I.U Local 704 Health & Security Plan Trust are entitled to full coverage until they reach the limiting age of 19. After this, dependents can extend their coverage up until age 25 if they are a full-time student at an accredited institution of learning. When the dependent reaches the limiting age of **25**, coverage will end on the last day of their birthday month.

"Full-time student" is defined as carrying at least 12 credits. To continue your dependent coverage as a full-time student under 56 years of age, proof is required **every semester**. Fall semester covers 9/1 to 1/31, and Spring semester covers 2/1 to 8/31. Separate proof is needed for each dependent on your plan.

Please note that if proof of full-time student is not received in a timely fashion, your dependent's coverage will be terminated. Termination of coverage for a post-secondary student not returning to school is 30 days from the last day of enrollment.

Accepted Documentation and Requirements

You may submit the following as proof of being a full-time student:

- Paid Bursar's bill, letter from or Registrar, or similar (see below requirements).
    - All proof must specify the following:
        - Semester/term dates
        - School name
        - Amount of credits
        - Name of student

We **do not** need your grades, schedule, tuition amount, phone number, or student ID number. Feel free to block this information out.

You should submit your proof of enrollment documentation in English. If your document is not in English, you must also provide a translation to English as one of the pages. Failure to provide a translation will result in a rejection of your proof. You may translate the documentation yourself.



Please email your Proof of Full-Time Student to the following Email Address:
Eligibility.dept@dhcook.com

TERMINATION OF COVERAGE

Except as modified by Applicable Law, all benefits covered herein shall terminate for an Eligible Active Member and his/her dependents on the date on which the first of the following occurs:

(1) Your employment ceases;
(2) His/her change to a Job Title not covered by the Plan; or
(3) His/her retirement (except where contributions are made by the employer during retirement); or
(4) The discontinuance of the benefit by the Plan; or
(5) The termination of the plan; or
(6) Upon determination by the Trustees of the Plan Trust that the Eligible Active Member has engaged in fraudulent practices against the Plan. In such event, the termination shall be for such period or periods, including total termination, as may be determined by the Trustees; or,
(7) The employer ceases to make contributions on the Members' behalf for any reason

COBRA – CONTINUING/EXTENDING BENEFITS

Under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) certain individuals are given the option of continuing their group health benefits under specified conditions.

You and your dependents are eligible to continue coverage for up to 18 months when termination is due to a reduction in your hours worked, or upon termination of your employment.

A member who (a) elects continuation coverage as the result of termination of employment and (b) is subsequently determined by Social Security to have been disabled as of the date of termination, is entitled to continue coverage for 29 months instead of 18 months.

Your dependents are eligible to continue their coverage for up to 36 months upon the occurrence of the following events:

a) The spouse and children upon the death of the covered employee.
b) The spouse, upon divorce or legal separation from the employee;

c) The spouse and children of Medicare-eligible employees, when the employee ceases to participate in the plan (dental and vision benefits are not covered by Medicare.)
d) Dependent children when they cease to be a dependent child under the definition in the Plan.

Coverage cannot be continued beyond any of the following dates.

a) The date on which the Welfare Fund ceases to provide any Plan to any member.
b) The date the premium is not paid by the individual.
c) When the individual becomes covered by any other group health plan, except if the other group health plan contains a preexisting condition limitation that applies to the person receiving continuation coverage, or when the individual is entitled to Medicare benefits.
d) In the case of a spouse, when the spouse remarries and becomes covered under another group health plan, except if the other group health plan contains a preexisting condition limitation that applies to the person receiving continuation coverage.

If your coverage terminates, or is about to terminate, you will be provided with a Continuation of Coverage Election Form, which will enable you and your spouse to elect or reject continuation of group health coverage. You are responsible for providing us with current information as to your family status (i.e. separation, divorce or dependent ineligibility for coverage.)

Your election to continue coverage must be completed within 60 days after you receive this Continuation of Coverage Election Form, or your termination date, whichever occurs last. Benefits provided shall be identical to coverage provided for active full-time employees and their dependents who have coverage under the Plan but have not yet terminated their coverage. The cost to continue coverage is paid for by the individual. Within 180 days before the expiration of your continuation of coverage, you shall have a right to convert to a conversion policy if such a policy is part of the group dental/vision plan at the time of your termination and is being offered to other active full-time employees under the plan.

For a complete description of COBRA and questions regarding your right to continue coverage after your termination date, please contact your Fund or Plan Administrator.

HIPAA PRIVACY NOTICE

The Plan shall disclose Protected Health Information (PHI) only to members of the Welfare Fund's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. The Welfare Fund may use or disclose PHI for operations such as auditing, quality improvement, premium or contribution calculations, and managing the plan. Additionally, the Welfare Fund may use or disclose PHI to coordinate your health care services with providers, such as doctors, pharmacies, or hospitals.

The Welfare Fund has implemented reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the Welfare Fund creates, maintains, or transmits on behalf of the Plan. "Electronic Protected Health Information" refers to all Protected Health Information that is transmitted by or maintained in electronic media.

The Welfare Fund will never use your PHI without your explicit written permission for:

- Marketing Purposes
- Sale of your PHI, or
- Fundraising Communications

Dental Plan

The following is an overview of the dental plan available to members:

Benefits	Description
Deductible:	There is no deductible on this plan
Annual Individual Maximum Benefit	**$1,500.00** Per Covered Individual
Orthodontia Lifetime Maximum Benefit	**$3,000.00** lifetime benefit for dependent children only
Implant Maximum	$6,000 Lifetime Implant benefit
Periodontal maximum	$1,200 Periodontal Annual Maximum (separate from the Annual Maximum of $1,500)
Payment Percentage	100% of the allowable charge
Limitations at-a-Glance	Each covered member is entitled to: • **2** Cleanings or Periodontal Maintenance per Calendar Year • **2** Oral Exams with 2 Bitewing X-rays per Calendar Year • **1** Full Mouth X-Ray every 3 years. • **2** Fluorides per Calendar Year to age 19 • **2** Emergency Dental Treatments per Calendar year

Preventative Services

Services	Limitations
Cleaning of teeth (Prophylaxis)	Cleaning of teeth (prophylaxis) is covered twice during each calendar year. If a periodontal (04341 - 04340) scaling and a prophylaxis (01110) are performed on the same date, the plan will only pay for the scaling. Additionally, the plan will not cover a prophylaxis within 30 days of a full-mouth periodontal scaling.
Fluoride Treatment	A fluoride treatment will be covered twice each calendar year for children up to age 19.
Space Maintainers and Fitting	For children only up to age 19.
Emergency Treatment	Emergency visits are covered by the plan even if no actual dental treatment is provided during the same day. No more than two (2) emergency treatments will be covered in any one calendar year.

Diagnostic Services

Services	Limitations
Routine Oral Exams	Oral exams are covered twice per calendar year. The Plan covers oral examinations that may be necessary to diagnose a specific symptom.
X-rays, Laboratory, and Full mouth/Panoramic X-ray	The Plan covers oral examinations, x-rays and laboratory tests that may be necessary to diagnose a specific symptom. The Plan will cover no more than four (2) bitewing X-rays for any one oral examination. However, a full mouth X-ray of all teeth taken as a part of a general examination is covered once in a 3-year month period. Allowances for films or other procedures covered by the Plan include the charge for examination and diagnosis.

Basic Services

Services	Limitations
Removal of teeth (Extractions) and cutting procedures in the mouth (Oral Surgery)	The Plan covers all extractions and/or other necessary oral surgery, including fractures and dislocations. Allowances for extractions and oral surgery procedures include routine post-operative care. The Plan covers oral surgery related to the excision of tumors and/or cysts, which are located on the teeth, gum tissue and the alveolus surrounding the teeth. Claims for extraction of wisdom teeth must be accompanied by x-rays of the area in question.
Endodontics-Root Canal Therapy	The Plan covers root canal and other endodontic treatment. All services provided that are normally associated with root canal therapy are included in the scheduled fee.
Periodontics (Treatment of Gum Disease)	The Plan covers necessary periodontic treatment of the gums and supporting structure of the teeth. The plan will pay for two (2) periodontal scalings per year. Periodontal maintenance and perio-prophy will be counted as preventive care, which is covered twice per year. The Plan will only pay for periodontic maintenance (04190) where the individual has been involved with procedures of periodontal curettage or osseous surgery. (See Preventive Treatment) In the event that the Plan is billed for full-mouth periodontal scaling, full-mouth periodontal curettage and full-mouth periodontal osseous surgery, the plan will not pay for periodontal curettage. supporting x-rays and charting are required. **Osseous surgery will not be covered within five (5) years of the last treatment.**
Anesthesia	A separate charge for general anesthesia is only covered in conjunction with partial and full bone extraction, osseous surgery, fractures or dislocation. A charge for local anesthesia is not covered as it is included within the normal charge for the treatment for which the local is given.
Medication	The Plan covers charges for4 units of injectable antibiotics administered by a dentist or physician during a calendar year.

Fillings and Prosthetic Services and Supplies

Services	Limitations
Fillings	The Plan covers fillings that are necessary to restore the structure of teeth that have been broken down by decay or traumatic injury. This includes all silver (amalgam) and composite fillings. **Fillings involving the same surfaces are not covered within two (2) years of date of service.**
Crowns	Crowns that are necessary to restore the structure of teeth that have been broken down by decay or traumatic injury and cannot be reconstructed by a filling or other material are covered. This includes gold, porcelain and plastic restorations. Gold onlays and inlays are also covered if the tooth cannot be reconstructed by a filling of other material. Crowning of teeth for periodontal support is not covered. **Replacement crowns and onlays or inlays are not covered within (5) years of prior placement.** *See note below.*

Prosthetic Services and Supplies

Services	Limitations
Prosthetics	The Plan covers prosthetic appliances (full denture, partial removable or fixed bridgework). The Plan will not cover the initial placement of appliances involving teeth extracted prior to coverage. However, the Plan will cover dentures or fixed bridges that replace an existing appliance even if the teeth are not extracted while covered, **if the prior appliance is more than (5) years old and cannot be made satisfactory.** Where teeth are being replaced within the same arch, but not within the same quadrant, an allowance for a partial will be made and not for fixing bridgework. The Plan also includes benefits for repairing damaged dentures or adding teeth to existing dentures or rebasing the denture. If the Plan pays for a new denture, it will not also cover the repair or rebasing of an old denture. **Relines are not covered within the first six (6) months from the date of placement, and are not covered more often than once per plan year.** The Plan does not cover precision or semi-precision attachments. **The plan will not cover replacement of prosthetic appliances in less than (5) years for any reason.**

Implants

Services	Limitations
Implants	Implants which are not of an experimental nature are considered a covered service.

Orthodontic Services

Services	Limitations
Orthodontic Treatment for Dependent Children	There is a maximum life-time benefit. For New Members Only: If a new member's dependent child is already in orthodontic treatment on the date they become eligible for orthodontic coverage, the following formula will apply. Twenty-four (24) months will be considered a full case. The plan will subtract the number of months already in treatment from 24 and pay the maintenance allowance for the remaining months.
Orthodontic for Dependent Child	There is a maximum life-time orthodontic benefit of $3,000 per covered member. Payment will be made for active monthly treatment only. **Adult Orthodontia is COVERED**

Benefit Determination

The Plan covers treatment performed while covered. Treatment will be considered to have been performed for the listed procedure as follows:

A. Dentures, full or partial – when impression is taken for the appliance.
B. Fixed bridgework, crowns and gold restorations – when the tooth is first prepared.
C. Root canal therapy – when tooth is opened.
D. Orthodontics – when the first appliance is installed.

Preauthorization of Benefits

For members who would like to know what their estimated out of pocket costs will be, you may send in for a preauthorization request. This is voluntary and not mandatory. You should submit to the Plan within 20 days following the examination for services or treatment. Such Treatment Plan should include appropriate x-rays, and a description of services to be furnished. The pre-authorization request shall be submitted on official claim forms.

When sending in Preauthorization of Benefits, follow the steps below.

A regular dental claim form is used for the preauthorization of benefits. The covered Employee fills out the Member and Patient section(s) of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

Daniel H. Cook Associates, Inc.
1040 Avenue of the Americas, 24th Floor
New York, NY 10018

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

Dental Plan Limitations and Exclusions Applicable to the Dental Plan

"Covered Dental Charges" shall in no event be deemed to include expenses incurred for the service, supplies or treatment:

A. Unless such services, supplies or treatment were prescribed as necessary by a dentist or physician.
B. In a Veteran's Administration Hospital, or which in the absence of coverage, would have been furnished without cost, or are furnished under conditions where the covered individual has no legal obligations to pay, or if the expenses are reimbursable by a local or other governmental agency.
C. Covered under any group program or union, employer or association program to the extent that more than 100% recovery by the participant would be made for any charges for which benefits are provided hereunder.
D. Covered under the U.S. Social Security Act (Title XVIII) as amended from time to time.
E. If they were incurred on account of:
    (1) war, declared or undeclared, included armed aggression;
    (2) Services, supplies or treatment received from a dental or medical department maintained by an employer, a mutual benefit association, labor union, Welfare Fund or similar type of group;
    (3) Loss or theft of dentures or bridgework;
    (4) Dentistry for cosmetic purposes, inclusive of orthodontia, including alteration or extraction and replacement of sound teeth for the purpose of changing appearance;
    (5) Bodily injury arising out of and in the course of employment by any employer, or disease or defect with respect to which benefits are payable under any Workmen's Compensation or Occupational Disease Act or Law.
F. There are time restrictions indicated in the plan document for certain procedures. All members are expected to adhere to these time restrictions.
G. Crowning of teeth for periodontal support is not covered.
H. Temporary services are not covered expenses.

Common Claim Problems

- Incomplete information regarding whether you or your spouse has other group insurance coverage, and if so, name or group, name of insurance company, address, policy number, etc.
- If there is other group coverage, send a copy of the benefit payment record furnished by the other plan.
- Incomplete information regarding dates of birth or age.

Claim Processing

Examination – The Welfare Fund, at its own expense, shall have the right and opportunity to examine any member information as often as it may reasonably require during the review and processing of the claim.

S.E.I.U LOCAL 704 HEALTH & SECURITY PLAN TRUSTPPO Network

Providers who have agreed to accept the plans fee schedule as payment in full will submit your claims directly to us and we will pay them directly. If you choose a non-participating dentist, you will be responsible for any amount billed over the plan amount for the services provided. If a provider would like to join the network, they can contact the plan to request and accept the fee schedule.

Coordination of Benefits

For dental claims, **ASO Administrators is your primary plan payor**. Once you receive your EOB (Explanation of Benefits) from ASO, please submit that along with your claim to Daniel H. Cook Associates for secondary benefit payment processing.

If you and your spouse each have coverage, your dependent children will be considered primary by the plan of the person whose **month and day of birth** occur earlier in the calendar year.

When you submit claims for members of the family who are primary through another carrier, a copy of the primary plan's payment must accompany the claim.

The Plan will only pay amounts up to the actual charge and is not responsible for charges in excess of the plans fee schedule.

Vision Plan

The following is an overview of the vision plan available to members:

Raymond Opticians is a participating provider: You may obtain services directly from Raymond Opticians by visiting https://raymondopticians.com/appointments/

You also have the option to go out of network and the plan will reimburse up to the amounts listed below.

Benefits for vision are available to you and your eligible dependents once every other year. If you use your own vision provider, you will be reimbursed as follows:

Benefits	Description	
Benefit Overview	Eye exams are allowed once per calendar year Glasses/contacts are covered **once per individual every other plan year**. The Plan will pay for glasses or contacts but not both.	
Payment Type	Reimbursement	
Payment Percentage	100% of the allowable charge	
Allowance Per Service	**REIMBURSEMENT**	**AMOUNT**
	Optical Exam	$25.00
	EYEWEAR	
	1ST PAIR	
	Lenses & Frames- Single Vision	$60.00
	Lenses & Frames- Bifocal	$70.00
	Lenses Only- Single Vision	$30.00
	Lenses Only- Bifocal	$40.00
	Lenses Only-Sunglasses	$40.00
	Frames Only	$30.00
	FOR EMPLOYEE ONLY	
	Prescription Sunglasses	$63.00
	Contact Lenses	$70.00
	Progressive (one pair only)	$140.00

Covered Services

1. **Eye Examination:** Check of principal visual functions, ability, and condition of vision. If a medical diagnosis exists, the claim should be filled with your medical carrier.
2. **Glasses/Contacts:** Covered if a visual deficiency exists.

Please note: Services or supplies beyond which are listed may require having to pay the provider the difference.

How-to File a Vision Claim

Submit Vision claim for out-of-net network providers. Vision form can be found on the D. H. Cook website. Please navigate to www.dhcook.com → Client Center → Member & Administrative Services, then use the "What is your group…" drop-down to find S.E.I.U Local 704 Health & Security Plan Trust.

REIMBURSMENT BENEFITS OVERVIEW

The Fund will reimburse Eligible member, spouse, and dependents up to a maximum of the allowances as outlined below. These amounts are subject to change.

The following is an outline of the amounts you are entitled to. Please note that payments will be pro-rated for those who have not been active members for a full 12 months.

Reminder: You may only submit your reimbursement request for the year beginning December 1st through March 31st. Any claims received by DH Cook after March 31st, will be denied for late filing.

Prescription Drugs: The fund will reimburse the eligible member, spouse, and dependents up to **$20 per prescription for a maximum of $200** (90-day prescriptions will be counted as 3 separate co-pays. You must submit either a printout from your pharmacist for the above dates or original receipts. All must have your name, date, prescription number and cost. It is preferred that you submit the drug store printout.

Medical Deductible: Please **submit the original** statement from your Medical Insurance Provider stating the amount of your deductible for the year. You are only able to submit **ONE** (the highest). Only one deductible can be submitted per family for a reimbursement **up to $100**. Medical deductible is accumulated when a member or dependent visits a physician who does not accept one of the medical plans and therefore does not accept a co-payment. **This is for members who currently pay towards their medical insurance offered by the City of Yonkers.**

Doctor Co-Payments: The fund will reimburse eligible members and dependents up to **$30 per visit for a total of 20 visits per year** for services performed. You must submit a doctor's receipt or form from your Medical Insurance Provider. (All receipts must include name and date of service along with the amount of the co-pay for the eligible member or dependent. **(We will not accept cancelled checks)**

Premium Reimbursements: The Fund will reimburse members who pay towards their medical insurance coverage offered by the City of Yonkers a **maximum reimbursement of $250 per member**. **You must submit copies of your TWO latest consecutive payroll stubs**.

Reminders

1. Any copay (prescription or doctor) that is paid with a flex spending account is **NOT** eligible for reimbursement.
2. Keep copies of all paperwork submitted as well as the date submitted.



Mail Completed Claim Form To:

Daniel H. Cook Associates, Inc.

1040 Avenue of the Americas,
24th Floor

New York, NY 10018



Email Completed Claim Form To:

intake@dhcook.com

Questions? You can call our Customer Service Department at (914) 250 – 0700.

STEP ONE

Type in www.dhclaims.com in your preferred web browser and hit enter.

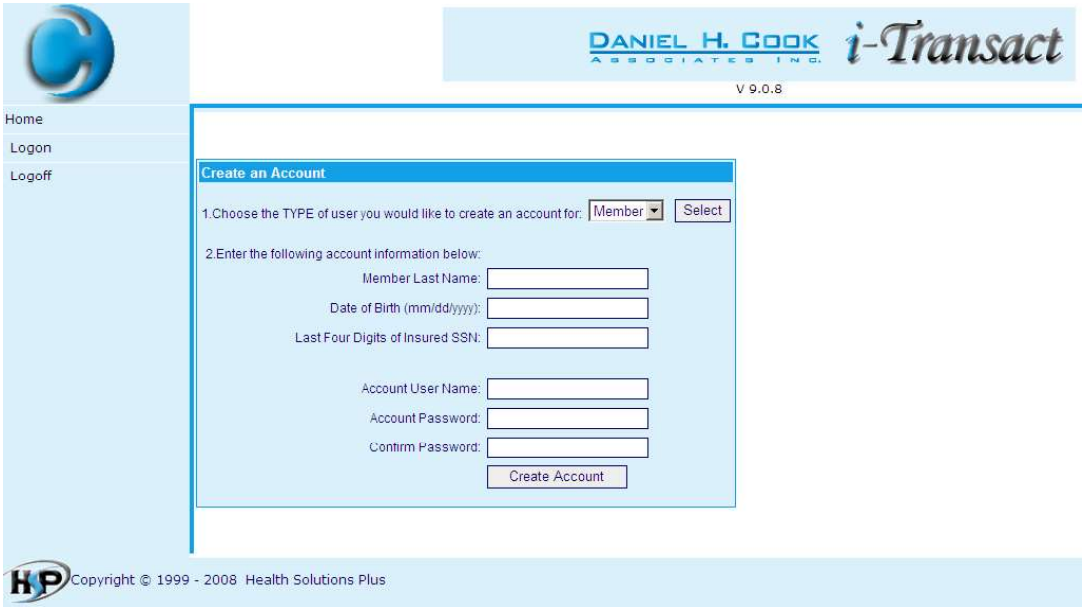
STEP TWO

You should see the web page below. Click "Logon" to gain access to the website. For **first-time users,** click on "Click here to create a new user" to create an account. If you **already have an account**, proceed to enter your username and password, and click "Logon."



STEP THREE (FIRST-TIME USERS)

For **first-time users**, be sure to complete all fields on the "Create an Account" page. Keep in mind, each person covered needs to create their own account. Date of birth is what differentiates each member of the family. We recommend you choose an account username and password that is easy to remember. Click "create account."



STEP FOUR (FIRST-TIME USERS)

After logging on for the first time, you need to set your preferences. You can leave these as is or modify and then click “continue.”



STEP FIVE

Click on the links on the left-hand menu bar to gain access to different parts of the website. After selecting a link, please follow the directions located on the top of each page.



View Member Info – Allows members to view their personal and contact information. This link has been disabled.

My Plan – Displays an abridged version of the member’s benefits.

Check Utilizations –Allows the member to view $ or units used as of given date.

Find Providers – Members can search for providers based on their Network and area.

Claim Status – Allows members to view the status of their claims

Request Id Card – Allows the member to print a temporary ID Card.

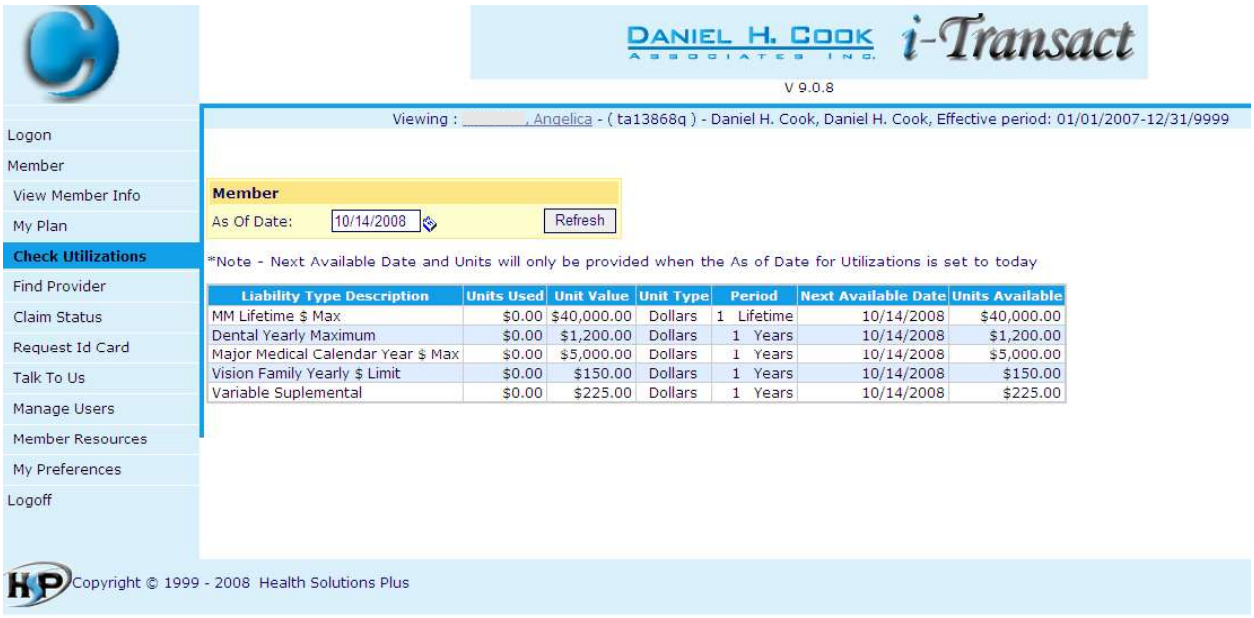
Manage Users – Allows the member to create, update or remove user accounts

Member Resources – Provides members with pertinent information concerning their benefit plan, Forms, and tips on choosing a provider and ways to expedite the handling and processing of their claims.

Talk To Us – This is a messaging center where members can leave questions concerning claims and benefits.

CHECK UTILIZATIONS

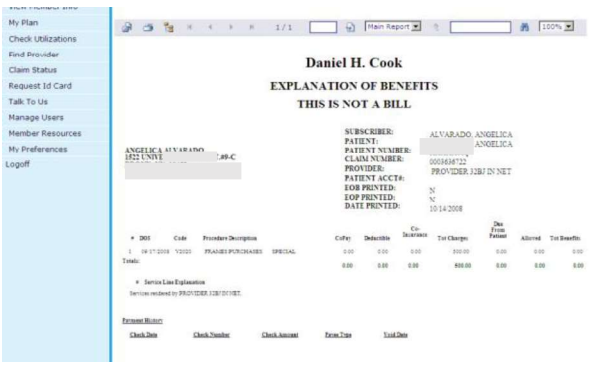
Allows the member to view the amount ($) and units used for the given “as of date.” Below is an example of the check utilizations page:



VIEW CLAIM STATUS

On this page, the member can view all claims for the date range selected. Click on desired “claim number” and an EOB will be shown with more detailed information. This EOB can be printed or saved in different formats, like PDF or as a word document.





FILL OUT A CLAIM FORM

Your Dental and Vision Claim Forms can be found on the Daniel H. Cook Associates, Inc. website. Please navigate to www.dhcook.com → Client Center → Member & Administrative Services, then use the "What is your group…" drop-down to find S.E.I.U Local 704 Health & Security Plan Trust.

Remember to fill out all relevant fields, some of which need to be completed by your provider, and to attach a copy of the provider's bill showing itemized services, fees, and date.

CLAIM FORMS SHOULD BE SENT TO:

Mail Completed Form To:

Daniel H. Cook Associates, Inc.

1040 Avenue of the Americas,
24th Floor

New York, NY 10018

Email Completed Form To:

intake@dhcook.com

Questions? You can call our Customer Service Department at (914) 250 – 0700.