1199SEIU National Benefit Fund for Home Care Employees

Our Benefits
Summary Plan Description of Your Health and Welfare Benefits

1199SEIU National Benefit Fund
for Home Care Employees
330 West 42nd Street
New York, NY 10036-6977
(646) 473-9200
www.1199SEIUBenefits.org

DECEMBER 2012
This booklet serves as both a Summary Plan Description and Plan Document for participants in the 1199SEIU National Benefit Fund for Home Care Employees employed in the metropolitan New York City area and other areas covered by this Fund.

The Home Care Plan (the “Plan”) is administered by the Home Care Plan Board of Trustees (the “Trustees”) of the 1199SEIU National Benefit Fund for Home Care Employees (“NBF-Home Care” or “Fund”), a sub-Fund of the 1199SEIU Benefit and Pension Funds, which has established a separate Home Care Trustee board. No individual or entity, other than the Trustees (including any duly authorized board, committee or designee thereof) has any authority to interpret the provisions of this Plan Document or to make any promises to you about the Plan.

The Home Care Trustees reserve the right to amend, modify, discontinue or terminate all or part of this Plan for any reason and at any time when, in their judgment, it is appropriate to do so. These changes may be made by formal amendments to the Plan and/or any other methods allowed in the Trust Agreement for Trustee actions.

If the Plan is amended or terminated, you and other employees may not receive benefits as described in this Plan Document. This may happen at any time, if the Plan Trustees decide to terminate the Plan or your coverage under the Plan.

In no event will any employee become entitled to any vested or otherwise non-forfeitable rights under the Plan.

The Trustees themselves (or through any duly authorized designee of the Trustees) reserve the complete authority and discretion to construe the terms of the Plan (and any related Plan documents), including, without limitation, the authority to determine the eligibility for, and the amount of, benefits payable under the Plan. These decisions shall be final and binding upon all parties affected by such decisions.

This booklet and any amendments are your source of information on the Plan. You cannot rely on information from co-workers or Union or Employer representatives. If you have any questions about the Plan and how its coverage works, the Fund office staff will be glad to help you. Because telephone conversations and other oral statements can easily be misunderstood, they cannot be relied upon if they are in conflict with what is stated in this Plan Document.
The Fund believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act, which means that this plan can preserve certain basic health coverage that was already in effect when that law was enacted, and may not include certain new consumer protections that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits. Questions regarding the Fund’s status as a grandfathered health plan and which protections apply can be directed to the Fund at (646) 473-9200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
December 1, 2012

Dear 1199SEIU Home Care Member:

The Fund cares about you.

This Summary Plan Description is a guide to your benefits package. You’ll find information about all the benefits covered under the Fund.

The biggest section in the booklet is about health benefits. This booklet will cover the procedures and policies you need to follow. Please remember: If you follow the procedures and policies for getting the most out of your benefits, you will receive comprehensive healthcare at little or no cost to you. Depending on the option you choose, your care may be covered in full when you use doctors, hospitals and other health providers who participate in the Fund’s networks.

It is important that you read the entire booklet so that you know:

• What benefits you are eligible to receive
• What policies and procedures need to be followed to get your benefits; and
• How to use your benefits wisely.

It is the mission of the 1199SEIU National Benefit Fund for Home Care Employees to provide you with the best benefits possible. That’s what the Fund has been doing for 1199SEIU members for over 50 years, and what you can look forward to as an 1199SEIU member.

If you have any questions or concerns about any of your benefits or coverage, call the Member Services Department at (646) 473-9200. Member Services representatives can answer your questions, refer you to another department or take the information and get back to you with an answer.

Enjoy the benefits of your new benefit plan.

The Board of Trustees
NEED HELP WITH THE SUMMARY DESCRIPTION PLAN?

This booklet is a summary of your benefits and the policies and procedures for using these benefits with the 1199SEIU National Benefit Fund for Home Care Employees. If the language is not clear to you, you can get assistance by writing the Fund at:

330 West 42nd Street
New York, NY 10036

Or calling (646) 473-9200.

Office hours for the Fund are 8:00 am to 6:00 pm, Monday through Friday.

¿NECESITA AYUDA CON LA DESCRIPCIÓN ABREVIADA DEL PLAN?

Este folleto es un resumen de sus beneficios y de las políticas y procedimientos para utilizar estos beneficios con el Fondo Nacional de Beneficios de 1199SEIU para los Empleados de Cuidados en el Hogar. Si no entiende bien el texto, puede obtener ayuda escribiendo al Fondo al:

330 West 42nd Street
New York, NY 10036

O llamando al (646) 473-9200.

El horario de oficina para el Fondo es de 8:00 am a 6:00 pm, de lunes a viernes.
你的摘要說明計畫需要幫助嗎？
這本小冊子是關於1199SEIU國家福利基金會給家庭護理雇員使用這些福利的政策和程序之摘要。如果你對該語言是不清楚的，你可以透過寫信至基金會以得到援助：

330 西 42街
紐約，紐約 10036
或請撥打 (646) 473-9200。
基金會的辦公時間是星期一至星期五上午8點至下午6點。

ВАМ ЧТО-ТО НЕПОНЯТНО В КРАТКОМ ОПИСАНИИ ПЛАНА?
Данная брошюра содержит краткое описание и порядок получения льгот, предоставляемых фондом National Benefit Fund for Home Care Employees профсоюза 1199SEIU. Если вам что-то не совсем ясно в этой брошюре, вы можете обратиться за помощью к специалистам Фонда, отправив письмо по адресу:

330 West 42nd Street
New York, NY 10036
или позвонив по телефону: (646) 473-9200.
Офис Фонда открыт с 8:00 до 18:00, с понедельника по пятницу.
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NEED TO KNOW WHAT CERTAIN TERMS MEAN IN THIS BOOKLET?

Refer to the Definitions Section

The Definitions section (pages 121-129) lists the terms used in this booklet and explains how they are defined by the Fund.

Refer to this section if you have any questions about the meaning of specific words or phrases, such as “disabled,” “emergency,” “fiduciary,” etc.

If you have any further questions, please call the Fund’s Member Services Department at (646) 473-9200.
YOUR BENEFIT FUND

The 1199SEIU National Benefit Fund for Home Care Employees is a grandfathered, self-administered, labor-management, Taft-Hartley Trust Fund. Your coverage is provided as a result of a collective bargaining agreement between your employer and your Union – 1199SEIU United Healthcare Workers East (1199SEIU).

**Self-administered** means that the Benefit Fund staff is responsible for the day-to-day administration of the Fund, including processing your claims, answering your questions and performing other administrative operations.

All of the money your employer pays to the Benefit Fund on your behalf goes directly to providing your benefits. The Benefit Fund does not exist to make profits, like an insurance company. It exists only to provide you, other 1199SEIU members and your families with quality healthcare and welfare benefits.

**Labor-management** means that the Benefit Fund is run by an equal number of Trustees appointed by 1199SEIU and by employers who make payments to the Benefit Fund on behalf of their workers.

**Taft-Hartley** is the name of the federal law that allows these labor-management trust funds to be established.

**Grandfathered** under the Patient Protection and Affordable Care Act means that this plan can preserve certain basic health coverage that was already in effect when that law was enacted, and may not include certain new consumer protections that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits. Questions regarding the Fund’s status as a grandfathered health plan and which protections apply can be directed to the Fund at (646) 473-9200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
OVERVIEW OF YOUR BENEFITS

IMPORTANT PHONE NUMBERS

Member Services Department (646) 473-9200
For answers to questions about your benefits or to be referred to another Benefit Fund department.

1199SEIU CareReview (800) 227-9360
For prior approval of hospital stays.

Ambulatory/Outpatient Surgery Pre-Certification Program (636) 473-9200
Program for Behavioral Health (646) 473-7393

Medical Benefits
Members will be asked to decide whether they wish to receive their benefits through the Member Choice Home Care Select Plan or through the Panel Provider Plan. While the benefits provided by the Fund are similar, the co-payments that you may pay will differ.
You can also visit our website at www.1199SEIUBenefits.org for forms, directories and other information. From our website, click on “My Account” and create your own personal information account to check your eligibility, find out whether a claim has been paid, change your address or update other information.

The Benefit Fund has no pre-existing conditions exclusions.

The Benefit Fund believes that it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. Please see page 9 for more details.
OVERVIEW OF YOUR BENEFITS

The following is a quick reference guide that gives you an overview of your benefits. Do not rely on this chart alone. Please read the specific sections for a full explanation of each benefit.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>COVERAGE</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>Hospital Care</td>
<td>• This benefit is for the hospital's charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered, depending on eligibility, as described in Section II.H of this SPD. • Up to 365 days per year • Semi-private room and board • Acute care for Medically Necessary services • Inpatient admissions • Outpatient or ambulatory facilities • Observation care and services • Up to 30 days for inpatient physical rehabilitation.</td>
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<td></td>
<td>Benefits are not provided for care in a nursing home or skilled nursing facility.</td>
<td>Call 1199SEIU CareReview at (800) 227-9360 before going to the hospital or within 48 hours of an emergency admission. Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>• Coverage for a combined total of up to 210 days per lifetime in a Medicare-approved hospice program in a hospice center, hospital, skilled nursing facility or at home.</td>
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<tr>
<td>BENEFIT</td>
<td>COVERAGE</td>
<td>COMMENTS</td>
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<tr>
<td>Emergency Room Visits</td>
<td>- This benefit is for the hospital’s charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered, depending on eligibility, as described in Section II.H of this SPD.</td>
<td>A co-payment may apply if you are not enrolled in the Member Choice Home Care Select Plan and if your visit was for non-emergency services.</td>
</tr>
</tbody>
</table>
|                               | - Use of the Emergency Room must be for an emergency and within 72 hours of an accident or sudden and serious illness
 - Fund pays negotiated or reasonable rate |

**Program for Behavioral Health**

**Mental Health:**
- Outpatient treatment

**Alcohol/Substance Abuse:**
- Medically Necessary services for inpatient detoxification
- Up to 30* days within a 12-month period for inpatient rehabilitation
- Outpatient treatment

Call (646) 473-7393 before getting outpatient treatment for mental health.

Call (646) 473-6900 before getting outpatient treatment for alcohol and substance abuse.

Call 1199SEIU CareReview at (800) 227-9360 for prior approval of inpatient treatment.

Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.

* Effective January 1, 2013, the Benefit Fund will eliminate any restrictions on mental health and substance abuse benefits that are prohibited by the Wellstone-Domenici Mental Health Parity and Addiction Equity Act.
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<tr>
<th>BENEFIT</th>
<th>COVERAGE</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>Surgery</td>
<td>• Inpatient or outpatient (ambulatory) surgery</td>
<td><strong>Call 1199SEIU CareReview at (800) 227-9360 before having non-emergency surgery.</strong></td>
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<tr>
<td></td>
<td>• Benefits based on the Fund’s allowance for the surgical procedure</td>
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<tr>
<td></td>
<td>• Participating surgeons bill the Fund directly and accept the Fund’s payment as payment in full</td>
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<tr>
<td>Anesthesia</td>
<td>• Benefits based on the Fund’s Schedule of Allowances</td>
<td></td>
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<tr>
<td>Maternity Care</td>
<td>• An allowance that includes all prenatal and postnatal visits and delivery charges</td>
<td><strong>Call the Prenatal Care Program at (646) 473-8962 to register for the Prenatal Care Program during the first three months of your pregnancy.</strong></td>
</tr>
<tr>
<td></td>
<td>• Hospital benefit</td>
<td>Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.</td>
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<tr>
<td>BENEFIT</td>
<td>COVERAGE</td>
<td>COMMENTS</td>
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<tr>
<td>Medical Services</td>
<td>• Treatment in a doctor's office</td>
<td>Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.</td>
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<tr>
<td></td>
<td>• Immunizations</td>
<td>Members enrolled in the Member Choice Home Care Select Plan will have no co-payments as long as they use their health center for all of their primary care needs.</td>
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<tr>
<td></td>
<td>• X-rays and laboratory tests</td>
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<tr>
<td></td>
<td>• Dermatology: up to 20 treatments per year</td>
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<tr>
<td></td>
<td>• Chiropractic: up to 12 treatments per year</td>
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<td></td>
<td>• Podiatry: up to 15 treatments per year for routine care</td>
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<td>• Allergy: up to 20 treatments per year, including diagnostic testing</td>
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<td></td>
<td>• Outpatient chemotherapy, radiation therapy and hemodialysis</td>
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<td></td>
<td>• Ambulance Services</td>
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<tr>
<td></td>
<td>• Participating Providers bill the Fund directly and accept the Fund's payment as payment in full</td>
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<td>BENEFIT</td>
<td>COVERAGE</td>
<td>COMMENTS</td>
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<tr>
<td>Medical Services Requiring Prior Authorization</td>
<td>• Home healthcare</td>
<td>Call the Prior Authorization Department at (646) 473-7446 for prior approval for all services except emergency ambulance and radiology tests.</td>
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<td></td>
<td>• Non-emergency ambulance services</td>
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<td></td>
<td>• Durable medical equipment and appliances</td>
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<td></td>
<td>• Medical supplies</td>
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<td></td>
<td>• Specific medications</td>
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<td></td>
<td>• Home infusion services and supplies</td>
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<td></td>
<td>• MRI, MRA, PET and CAT scans and certain nuclear cardiology procedures</td>
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<td></td>
<td>• Ambulatory/outpatient surgery</td>
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<tr>
<td></td>
<td>• Hospice care</td>
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<tr>
<td>Vision Care</td>
<td>• One eye exam every two years</td>
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<td></td>
<td>• One pair of glasses or contact lenses every two years</td>
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<tr>
<td>Hearing Aids</td>
<td>• Once every three years</td>
<td>Co-payments may apply.</td>
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<td></td>
<td>• Call for referrals to a Participating Provider.</td>
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<tr>
<td>BENEFIT</td>
<td>COVERAGE</td>
<td>COMMENTS</td>
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<tr>
<td><strong>Basic Dental Care</strong></td>
<td>• Basic and preventive services through Participating Provider network</td>
<td>If you do not use a participating DentCare provider, you will be responsible for all charges.</td>
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<td></td>
<td>• Initial/periodic oral exams once every 6 months</td>
<td>Call DentCare at (800) 468-0600 to find a provider convenient to you.</td>
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<td>• Bitewing X-rays once every 6 months</td>
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<tr>
<td></td>
<td>• Prophylaxis, scaling and fluoride once every 6 months</td>
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<tr>
<td></td>
<td>• Dental emergencies</td>
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<td></td>
<td>• Minor restorative services</td>
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<td></td>
<td>• Denture adjustments, repairs and relines</td>
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</tr>
<tr>
<td><strong>Major Dental Care</strong></td>
<td>• Major restorative work through Participating Providers</td>
<td>Co-payments apply.</td>
</tr>
<tr>
<td></td>
<td>• Oral surgery</td>
<td>Call DentCare at (800) 468-0600 for additional information.</td>
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<tr>
<td></td>
<td>• Crowns, bridges, dentures and periodontal care once every 60-month period</td>
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</table>
### Prescription Drugs

- **FDA-approved prescription medications**
- **No co-payments if you are enrolled in the Member Choice Home Care Select Plan; no deductible when you use generic drugs and preferred drugs where available.**
- **Co-payments for brand and generic drugs if you are not enrolled in the Member Choice Home Care Select Plan; no deductible when you use generic drugs and preferred drugs where available.**
- **Use Participating Pharmacies**
- **Maintenance drug access program for chronic conditions – The 90-Day Rx Solution**
- **Prior authorization needed for certain medications.**

### COBRA

- **If you lose your eligibility for health benefits under the Fund, you may be able to extend your coverage.**
- **Must notify the Fund within 60 days of a “qualifying event.”**
- **“Qualifying events” determine length of coverage – either 18 or 29 months.**

**MONTHLY PREMIUMS**

- **Monthly premiums are paid directly to the Fund.**

**COMMENTS**

- Please refer to “What Is Not Covered” in Section II. L.
- Call (646) 473-7446 for prior authorization of certain medications.
<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>COVERAGE</th>
<th>COMMENTS</th>
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</thead>
<tbody>
<tr>
<td>Workers’</td>
<td>• For injuries at work or work-related illness</td>
<td>• Must file claim with your employer or you may jeopardize your rights</td>
</tr>
<tr>
<td>Compensation</td>
<td></td>
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</tbody>
</table>
SECTION I – ELIGIBILITY

A. How You Become Eligible
B. Your Health Benefits ID Card
C. Coordinating Your Benefits
D. When Others Are Responsible for Your Illness or Injury
E. When You Are on Workers’ Compensation Leave
F. Losing Eligibility

G. Regaining Eligibility
H. Extending Eligibility
   • Coverage While Disabled
   • Family and Medical Leave
   • Uniformed Services Leave
   • COBRA
I. Resolving Eligibility
WHERE TO CALL
Member Services Department
(646) 473-9200
www.1199SEIUBenefits.org
Call Member Services:
• To check whether you are eligible to receive benefits;
• To request any forms;
• To update the information on your Enrollment Form (address, phone number, etc.);
• To notify the Fund when you change employers;
• To report any errors on your ID card;
• To notify the Fund when you’re on Workers’ Compensation leave, Disability, or FMLA leave; and/or
• To get the answers to any of your questions.

COBRA Department
(646) 473-9200
Call the COBRA Department:
• To apply for COBRA continuation coverage; and/or
• To get more information on COBRA.

PRE-EXISTING EXCLUSIONS
• The Fund has no pre-existing conditions exclusions.

IMPORTANT REMINDERS
• Enroll in the Fund to be eligible for benefits.
• Check the information on your Health Benefits ID card and notify the Fund of any incorrect information immediately.
• Fill out all forms completely and attach all the documents required. Otherwise, your claim may be delayed or your benefits denied.
• Notify the Fund of any change of address, phone number, etc.
• Notify the Fund when you change employers in order for your coverage to continue.
• To protect your benefits, contact the Fund immediately if you are not working due to a Workers’ Compensation leave, Disability or FMLA leave.
• Let the Fund know of any change that will affect your right to COBRA continuation coverage.
SECTION I. A
HOW YOU BECOME ELIGIBLE

To receive benefits under this Fund, you must be a participant at the time services are provided. Participation in the Fund is not the same as Union membership. Your union dues do not pay for your benefits.

YOU BECOME A PLAN PARTICIPANT BY MEETING THESE ELIGIBILITY REQUIREMENTS:

1) You work in a covered job title at a Contributing Employer.
   A “covered job title” is one specified by the collective bargaining agreement among 1199SEIU and the agencies that contribute to the Fund. Because these can change from time to time, you may receive a list of Contributing Employers and/or covered titles by writing to or calling the Fund.

AND

2) You have completed and submitted an 1199SEIU Home Care Enrollment Form.
   To be covered by the benefit plan, you must be enrolled. Make sure to fill out all the information on the Enrollment Form completely and return it to the Fund office.

AND

3) You have become eligible under the “80 hour” rule.
   To become a participant, you must have 80 or more “hours worked” per month for two consecutive calendar months. This two-month period is called the “determination period.” You will then become a participant one calendar month later. This one-month period between the determination period and the date of first eligibility is called the “waiting period.”
   Participation is always counted from the first day of a month. “Hours worked” includes all hours for which you were paid by your employer. This includes hours for which you received sick and vacation pay. Exception: If you are hospitalized on the day your eligibility would otherwise start, eligibility for the hospitalized individual does not begin until their date of discharge.

AND

4) You pay the required weekly premium by authorizing your employer to deduct the cost of the premium from your paycheck. This amount is currently $5 per week.

NOTE: If you are income-eligible for Medicaid or Family Health Plus (FHP), New York State may pay your weekly premium.
EXAMPLES OF THE 80-HOUR RULE

1) Ms. Hernandez began working for an 1199SEIU-covered agency as a home attendant at the end of January 2012. In January, she worked only 21 hours. In February, she worked 240 hours. In March, she worked 260 hours. By March 31, she had completed the “determination period” – two months in a row with 80 or more hours. After a one-month waiting period (April) she will be eligible for benefits on May 1, 2012.

2) Ms. Hernandez began working for an 1199SEIU-covered agency as a home attendant at the end of January 2012. In January, she worked 40 hours. In February, she worked 260 hours. Even though she worked a combined total of 300 hours over two calendar months, she did not complete the “determination period” because she worked only 40 hours in January. If she works at least 80 hours in March, she will be eligible – after a one-month waiting period (April) – for benefits beginning on May 1, 2012.
SECTION I. B
YOUR SPOUSE, DOMESTIC PARTNER OR CHILDREN

The Trustees voted to end coverage through the Fund for spouses/domestic partners effective November 1, 2009.

YOUR CHILDREN

The Trustees voted to end coverage through the Fund for children effective January 1, 2011.
SECTION I. C
YOUR HEALTH BENEFITS ID CARDS

If you are eligible for benefits and have enrolled in the Fund, you will receive a Health Benefits ID card. Call the Fund’s Member Services Department at (646) 473-9200 if you have any problems with your ID card, including:

• You did not receive your card
• Your card is lost or stolen
• Your name is not spelled correctly.

NOTE: If you are no longer eligible for benefits, you may not use your Fund ID card regardless of any expiration date that may appear on the card. If you do, you will be personally responsible for all charges.

Your Health Benefits ID card is for use by you only. To help safeguard your identity, please use the unique ID number that is printed on your card, instead of your Social Security number, when communicating with the Fund. You should not allow anyone else to use your ID card to obtain Fund benefits. If you do, the Fund will deny payment, and you may be personally responsible to the provider for the charges. If the Fund has already paid for these benefits, you will have to reimburse the Fund. The Fund may deny benefits to you and/or may initiate civil or criminal actions against you until you repay the Fund.

If you suspect that someone is using a Health Benefits ID card fraudulently, call the Fund’s Fraud and Abuse Hotline at (646) 473-6148.
SECTION I. D
MAXIMUM BENEFITS

IF YOU WORK FOR MORE THAN ONE CONTRIBUTING EMPLOYER
Your hours from all Contributing Employers are combined to determine your eligibility. However, you can receive no more than the maximum benefit allowed by the Fund’s Schedule of Allowances.

LET THE FUND KNOW OF ANY CHANGES
Your claims will be processed faster – and you will receive your benefits more quickly – if the Fund has up-to-date information about you.

You must notify the Fund when:
• You move

OR
• You change employers.

Fill out an Enrollment Change Form and send it to the Fund’s Eligibility Department so that your records can be updated.

An English translation certified to be accurate must accompany foreign documents.

All information appearing on your Enrollment Form is for Fund use only and will not be released to any third party, except where necessary for the administration and operation of the Fund, or where otherwise required by law.
SECTION I. E
COORDINATING YOUR BENEFITS

When you are covered by more than one group health plan, the two plans share the cost of your health coverage by “coordinating” benefits.

Here’s how it works:

• One plan is determined to be primary. It makes the first payment on your claim.

• The other plan is secondary. It may pay an additional amount, according to the terms of that plan.

If the Fund is:

• Primary, it will pay your claim in accordance with its Schedule of Allowances and the rules set forth in this Summary Plan Document.

• Secondary, the total amount paid by both plans shall not be more than the Trustees determine as the maximum allowable cost for the Medically Necessary care provided or 100% of the actual expenses, whichever is less. In no event will the Fund pay more than its Schedule of Allowances.

WHEN YOU ARE COVERED AS AN EMPLOYEE BY MORE THAN ONE PLAN

The coverage that has been in place the longest will be your primary insurer. However, if you are enrolled in a Health Maintenance Organization (HMO) or any other paid-in-full plan, you must use the benefits provided by that plan. If the Benefit Fund is the secondary coverage, we will provide only for those benefits that are not provided by the primary plan.

WHEN YOU ARE COVERED BY MORE THAN ONE EMPLOYER PARTICIPATING IN THE BENEFIT FUND

The total amount paid shall not be more than the Trustees determine as the maximum allowable cost for the Medically Necessary care provided or 100% of the actual expenses, whichever is less.
WHEN YOU AND YOUR SPOUSE ARE COVERED BY DIFFERENT PLANS

When you also receive coverage through your spouse’s employer, the Fund will coordinate payment of your benefits with that plan.

For your care:
- The Fund is the primary payer. It makes the first payment on your claim.
- Your spouse’s plan is your secondary payer. It may cover any remaining balance, according to the terms of that plan.

WHEN YOU ARE COVERED BY MEDICARE

The Fund is the primary payer for working members age 65 and over who may be covered by Medicare. You will be eligible for the same coverage as any other working member.

However, you may want to sign up for Medicare Part A and Part B as well. That way, Medicare will become your secondary payer.

This means that after the Fund pays benefits for your covered expenses, you may submit a claim for any unpaid balances to Medicare to be considered.

If you prefer, you may elect to end your coverage under the Fund and elect to have Medicare as your only insurance. However, if you elect this option, the Fund may not provide any benefits that supplement those provided under Medicare.

MEDICARE AND END STAGE RENAL DISEASE (ESRD)

In the case of an individual entitled to Medicare benefits on the basis of end stage renal disease (ESRD), the Fund will be the primary payer of benefits only for the period required by law. Thereafter, the Fund will be secondary to Medicare for the periods prior to your transplant and after your transplant.

To protect your benefits, you must enroll in Medicare Part A and Part B immediately upon becoming entitled to Medicare benefits, and maintain this coverage prior to and after your transplant as required by law until you have verified that the Fund will become your primary insurer.

The Fund will provide reimbursement for 50% of your basic Medicare Part B premium. You may file a claim, along with the required documentation, once each quarter to get this benefit.
SECTION I. F
WHEN OTHERS ARE RESPONSIBLE FOR YOUR ILLNESS OR INJURY

If someone else is responsible for your illness or injury, or is responsible for additional treatment as a result of a malpractice, for example, because of an accident, you may be able to recover money from that person or entity, his or her insurance company, an uninsured motorist fund, no-fault insurance carrier or Workers’ Compensation insurance carrier. Expenses such as disability, hospital, medical, prescription or other services resulting from such an illness or injury or treatment caused by the conduct of a third party are not covered by this Plan.

However, the Plan Administrator recognizes that often the responsibility for injuries or illness or treatment is disputed. Therefore, in certain cases, as a service to you and if you follow the required procedures, the 1199SEIU Benefit Fund may advance benefit payments to you, or on your behalf, before the dispute is resolved.

When another party is responsible for an illness, injury or treatment, the Plan Administrator has rights to recover the full amount it has paid or will pay related to any claims that you may have against any person or entity. This means that by accepting health benefits, you are assigning your rights to the Fund to the extent of the Fund’s payments that have been made, or will be made, on your behalf. The Fund’s right to recover the payment comes before you can recover. Therefore, the Fund has an independent right to bring an action in connection with such an injury or illness or treatment in your name and also has a right to intervene in any such action brought by you. It also means that the Fund has an equitable lien on the proceeds of any verdict or settlement reached in a lawsuit that you bring against someone for causing an illness, injury or treatment, when the Fund has paid for costs arising from that person or entity’s actions. The Fund has a right to be repaid from those proceeds. You must notify the Fund of any accident, injury or treatment for which someone else may be responsible. Further, the Fund must be notified of initiation of any lawsuit arising out of the accident, injury or treatment.

You are required to provide the Fund with any and all information required and to execute and deliver all necessary documents, including a fully completed Accident Questionnaire that the Plan Administrator may require to enforce the Fund’s rights. Once the Fund learns that another party may
be responsible, you must sign an agreement (or a “lien”) affirming the Fund’s rights with respect to benefit payments and claims. Benefit payments are not payable until this agreement is signed and received by the Fund.

If you receive payments from, or on behalf of, the party responsible for an illness or injury, the Fund must be repaid from those payments. You must repay the Fund regardless of whether the total amount of the recovery is less than the actual loss and even if the party does not admit responsibility, itemize the payments or identify payments as medical expenses. You cannot reduce the amount of the Fund’s payments to pay for attorneys’ fees incurred to obtain payments from the responsible party. The Fund’s rights provide the Fund with first priority to any and all recovery in connection with the injury or illness. The Fund has these rights without regard to whether you have been “made whole.”

If you fail or refuse to sign a lien or to comply with these terms, the Plan Administrator may suspend your eligibility for benefits and/or recovery from providers’ money paid to them, until the Fund is fully repaid. In addition, the Plan Administrator may bring a court action against you to enforce the terms of the Plan.

By accepting the Fund’s payments, you are consenting to a constructive trust being placed on the amount owed to the Fund out of any proceeds.

WHEN MOTOR VEHICLE OR NO-FAULT INSURANCE PROVIDES COVERAGE

This provision is expressly intended to avoid the possibility that this Plan will be primary to coverage that is available under motor vehicle or no-fault insurance.

This Plan is secondary to:

• Coverage provided under any “no-fault” provision of any motor vehicle insurance statute or similar statute

AND

• Coverage provided under motor vehicle insurance that provides for health insurance protection, even if you select coverage under the motor vehicle insurance as secondary.

In the event that the Benefit Fund pays benefits that should have been paid by the no-fault insurer, you are obligated to reimburse the Benefit Fund for the amount advanced on your behalf from any monetary recovery from any person or entity responsible for the injury or illness.

WHEN MOTOR VEHICLE OR NO-FAULT INSURANCE DENIES COVERAGE

Before the Fund will provide benefits, you must exhaust all of your benefits under your no-fault insurance.

If the no-fault insurer denies your claim for benefits, you are required to appeal this denial to your no-fault carrier.
You must provide proof to the Fund that you have exhausted the no-fault appeals process before the Fund will consider payment in accordance with its schedule of fees and allowances.
SECTION I. G
WHEN YOU ARE ON WORKERS’ COMPENSATION LEAVE

If you are injured at work or suffer from a work-related illness, you are covered by Workers’ Compensation, which is provided by your employer. This includes coverage for healthcare costs and loss of wages.

You must file a Workers’ Compensation claim with your employer. Otherwise, you will jeopardize your rights to Workers’ Compensation and your benefits from the Fund. If you need help or advice concerning your Workers’ Compensation claim, call the Fund at (646) 473-9200.

In most cases, the Fund will not provide any coverage for a work-related illness or injury.

However, the Fund will:

- Continue to cover you for benefits not related to the job injury or illness while you are receiving Workers’ Compensation benefits, up to a maximum of 26 weeks within a 52-week period

If you can’t go back to work after 26 weeks, your coverage through the Fund will end. However, you can extend your health benefits under COBRA continuation coverage (see pages 36-43).

NOTIFY THE FUND

You need to contact the Fund within 30 days when you’re not working due to a work-related illness or injury. Call the Member Services Department at (646) 473-9200 to find out which forms need to be filed with the Fund.

Here’s why: The Fund determines your eligibility for benefits based on wage reports it receives from your employer. If you haven’t received any wages, then your coverage may be suspended because the Fund does not know that you are out on Workers’ Compensation leave.
SECTION I. H
LOSING ELIGIBILITY

HOW YOU LOSE ELIGIBILITY

You will no longer be eligible for 1199SEIU Benefit Fund benefits if you do not work the required 80 hours for two consecutive calendar months. Eligibility ends immediately after the second consecutive month in which you work fewer than 80 hours. You may be able to extend your coverage. See how you can extend your eligibility for healthcare coverage on page 36.

You may also lose your eligibility if:

• You fail to make the required weekly premium. In this case, your coverage will be terminated retroactive to the last day of the month that you made payment if you do not make the payment within 30 days.

OR

• The Fund is advised by your employer that your employment has been terminated. In this case, your coverage will end on the last day of the month that you were terminated.

NOTE: You must continue to pay the weekly premium to maintain your coverage if you are eligible to receive continued benefits while on disability, FMLA Leave or Workers’ Compensation.
SECTION I. I
REGAINING ELIGIBILITY

HOW YOU REGAIN ELIGIBILITY

You may regain eligibility by again working two consecutive calendar months with 80 or more hours worked per month; that is, by completing the Determination Period again. You will have the same one-month waiting period as any other newly eligible participant.

EXAMPLE OF REGAINING ELIGIBILITY – 80-HOUR RULE

Ms. Ruiz was a participant in the Fund through July, but did not work 80 hours in June or July so her coverage ceased July 31. Beginning in September, she was once again working 80 hours per month. By counting September and October as the Determination Period, and November as the waiting period, she regained her eligibility in December.
SECTION I. J
HOW YOU CAN EXTEND ELIGIBILITY

NOTIFY THE FUND
You need to contact the Fund within 30 days of when you stop working due to a work-related illness or injury. Call the 1199SEIU Benefit Fund’s Member Services Department at (646) 473-9200 to find out which forms need to be filed with the Fund.

Here’s why: The Fund determines your eligibility for benefits based on wage reports it receives from your employer. If you have not received any wages, then your coverage may be suspended because the Fund does not know that you are out on Workers’ Compensation leave.

1. Coverage While Disabled
If you become disabled while you are a participant in this Plan, your eligibility can continue for up to a maximum of 26 weeks from the date you become disabled. “Disabled” means that you are receiving either New York State Disability benefits or payment for lost wages and healthcare costs from Workers’ Compensation. The Fund will not provide coverage for a work-related illness or injury.

You are required to notify the Fund immediately upon becoming disabled, even though you may not yet be receiving any payments under your New York State Disability or Workers’ Compensation coverage. Since the issuance of an “award” by New York State may take some time, you want to avoid termination of coverage while you are waiting.

Your extended coverage starts as of the award date as determined by your disability or Workers’ Compensation carrier. Coverage may continue throughout the period you receive insurance payments. You are required to notify the Plan when your insurance payments cease. The Fund has the right to conduct an independent medical evaluation.

If you return to work directly from disability status and begin working the hours required for coverage, you will not have to re-establish eligibility. If your disability coverage expires and you cannot return to work, you may be eligible to obtain or purchase COBRA coverage. See pages 39-43 for more information.

EXAMPLE OF EXTENDING ELIGIBILITY THROUGH DISABILITY
Ms. Washington was covered by the Fund when she was seriously injured in an accident in March. She notified her employer, filed for New York State Disability and then notified the Fund office. She had already worked enough hours to ensure that her eligibility would cover her through the end of May. Her 26-week disability extension will continue coverage through a date in November if her condition persists. To maintain eligibility, she would need to supply the Fund office with evidence of her continued disability, such as paycheck stubs.
2. Family and Medical Leave Act

The Family and Medical Leave Act of 1993 (FMLA) provides that the Fund – upon proper notification from your employer – will extend eligibility for you and your dependents for up to 12 weeks, under certain conditions.

You are entitled to an FMLA extension if you experience an FMLA “qualifying event”:

- For the birth of your child and to care for the baby;
- When you adopt a child or become a foster parent;
- To care for your spouse, your child or your parent who has a serious health condition (but not your mother-in-law/father-in-law);
- When you have a serious health condition that keeps you from doing your job; and/or
- When your spouse, son, daughter or parent is a military service member and is on or has been called to active duty in support of a contingency operation in cases of “any qualifying exigency.”

The FMLA defines a serious health condition to include an injury, illness, impairment, or physical or mental condition that involves inpatient hospital care or continuing treatment by a healthcare provider.

If you are eligible for FMLA leave for one of the above qualifying family and medical reasons, you may receive up to twelve (12) work weeks of unpaid leave during a twelve (12) month period. During this leave, you are entitled to receive continued health coverage under the Fund under the same terms and conditions as if you had continued to work.

If you return to work with the required number of hours or more hours in your first full month after your FMLA leave ends, there is no lapse in coverage.

If you need to care for your spouse, son, daughter, parent or “next of kin” who has a serious injury or illness incurred in the line of active duty, you are eligible for up to 26 work weeks of unpaid FMLA leave in a 12-month period. For Armed Forces members, FMLA defines a serious injury or illness as an illness or injury that may render the service member medically unfit to perform his or her military duties.

During this FMLA leave, you are entitled to receive continued health coverage under the Benefit Fund under the same terms and conditions as if you had continued to work.

To be eligible for continued benefit coverage during your FMLA leave, your employer must notify the Fund that you have been approved for FMLA leave.
Your employer – not the Fund – has the sole responsibility for determining whether you are granted leave under FMLA.

FMLA legislation was enacted to provide for temporary leave in situations where an employee intends to return to work when FMLA ends. If you do not return to work, you may owe your employer for the costs that were paid on your behalf over any period of time where coverage was extended solely on the basis of your FMLA leave.

3. Uniformed Services Leave

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), if your coverage under the Fund ends because of your service in the U.S. uniformed services, your medical coverage will be reinstated for you, your spouse and your children when you return to work with your employer without any waiting periods.

If you take a leave of absence under USERRA, healthcare coverage under the Plan will be continued for up to 30 days of active duty. If active duty continues for 31 days or more, coverage may be continued at your election and expense for up to 24 months (or such other period of time required by law). See the section in this booklet on pages 39-43 for a full explanation of the COBRA coverage provisions.

When you are discharged from service in the uniformed services (not less than honorably), your full eligibility will be reinstated on the day you return to work with a Contributing Employer, provided that you return to work within ninety (90) days from the date of discharge if the period of military service was more than one hundred eighty one (181) days, or within fourteen (14) days from the date of discharge if service was more than thirty (30) days but less than one hundred eighty (180) days, or at the beginning of the first full regularly scheduled working period on the first calendar day following discharge if the period of service was less than thirty-one (31) days. If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended for up to two (2) years. Contact the Fund office if you have any questions regarding coverage during a military leave.

The Fund may apply exclusions and/or waiting periods permitted by law, including for any disabilities that the Veterans Administration (VA) has determined to be service related. This includes any injury or illness found by the VA to have been incurred in, or aggravated during, the performance of service in uniformed service.
4. COBRA
Under the federal law commonly known as COBRA, you have the option of extending your group healthcare coverage for a limited period of time in certain instances where group health coverage under the Fund would otherwise end (called a qualifying event). A qualified beneficiary is someone who will lose group health coverage under the Fund because of a qualifying event.

Continuation coverage is available on a self-pay basis. This means that you pay monthly premiums directly to the Fund to continue your group health coverage.

This section summarizes your rights and obligations regarding COBRA continuation coverage. You and your spouse should read it carefully.

For more information, contact the Fund’s COBRA Department at (646) 473-9200.

If you elect to continue your coverage, you will receive the same health coverage that you were receiving right before you lost your coverage. This may include hospital, medical, surgical, dental, vision and prescription coverage.

WHEN AND HOW LONG YOU’RE COVERED

How long you can extend health coverage will depend upon the nature of the qualifying event.

18 MONTHS OF COVERAGE

You may have the right to elect COBRA continuation coverage for a maximum of 18 months if coverage is lost as a result of one of the following qualifying events:

• The number of hours you work is reduced, resulting in a change in your eligibility

OR

• Your employment is terminated for reasons other than gross misconduct on your part.

Being on a Family and Medical Leave of Absence (see page 37) is not a qualifying event for COBRA. If you do not return to work, you will be considered to have left your job, which may lead to a qualifying event.

You may be eligible for COBRA continuation coverage if you lose your Fund coverage because your employer has filed a Title 11 bankruptcy proceeding. Please contact the Plan Administrator if this occurs.
EXTENDED COVERAGE

Disability Extension

If you are determined by the Social Security Administration to be disabled, and you notify the Fund in a timely fashion, you may be entitled to an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability must have started at some time before the 60th day of the initial 18-month continuation period and must last at least until the end of the 18-month period of continuation coverage.

The disability extension is available only if you notify the Fund of the Social Security disability determination within 60 days after the latest of:

- The date of the Social Security disability determination
- The date of the qualifying event
- The date on which the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event

OR

- The date on which the qualified beneficiary is informed, through the furnishing of this SPD, of both the responsibility to provide and the procedures for providing notice of the Social Security Administration’s disability determination but before the end of the first 18 months of COBRA continuation coverage.

Your employer is responsible for notifying the Fund within 30 days if coverage is lost because:

- Your hours or days are reduced
- Your employment terminates
- You become entitled to Medicare
- You die.

INFORMING YOU OF YOUR RIGHTS

After the Fund is notified of your qualifying event, you will receive information on your COBRA rights.

If you decide to elect COBRA coverage, you have to notify the Fund of your decision within 60 days of the date (whichever is later) that:

- You would have lost your Fund coverage, including extensions
- You are notified by the Fund of your right to elect COBRA coverage.

In order for your election to be timely and valid, your election form must be:

- Actually received by the Fund office on or before the 60-day period noted above at:
  PO Box 1036
  Attn: Home Care
  COBRA Department
  New York, NY 10108

OR

- Mailed to the Fund office and postmarked on or before the 60-day period noted above.
If you do not choose COBRA continuation coverage in a timely manner, your group health coverage under the Fund will end as described in Section I. H, and you will lose your right to elect continuation coverage.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you may lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of Continuation Coverage may help you not have such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get Continuation Coverage for the maximum time available to you.

With respect to other health plans, you should also take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying event.

You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

**COST OF COBRA COVERAGE**

You are required to pay the entire cost of COBRA continuation coverage.

**WHEN COBRA COVERAGE ENDS**

Your COBRA continuation coverage may end before the end of the applicable 18- or 29-day coverage period when:

- Your employer ceases to be a Contributing Employer to the Fund, except under circumstances giving rise to a qualifying event for active employees
- The Fund is terminated
- Your premium for your coverage is not paid on time (within any applicable grace period)
- You get coverage under another group health plan that does not include a pre-existing condition clause that applies to you.
- A qualified beneficiary becomes entitled to Medicare
- Coverage had been extended for up to 29 months due to a disability and there has been a final determination that the qualified beneficiary is no longer disabled.
COBRA continuation coverage may also be terminated for any reason the Fund would terminate coverage of a participant not receiving continuation coverage (such as fraud).

If the Social Security Administration (SSA) determines that the individual is no longer disabled, this extended period of COBRA coverage will end as of the last day of the month that begins more than 30 days after the SSA has determined that the individual is no longer disabled. The disabled individual or a family member is required to notify the Fund office within 30 days of any such determination.

You do not have to show that you are insurable to elect this continuation coverage. However, you must be eligible for coverage under the Fund to be eligible for COBRA continuation coverage. The Plan Administrator reserves the right to end your COBRA continuation coverage retroactively if you are found to be ineligible for coverage.

Once your COBRA coverage has stopped for any reason, it can’t be reinstated.

Claims incurred by you will not be paid unless you have elected COBRA coverage and pay the premiums, as required by the Plan Administrator.

This description of your COBRA rights is only a general summary of the law. The law itself must be consulted to determine how the law would apply in any particular circumstance.

If you have any questions about COBRA continuation coverage, please call the Fund at (646) 473-9200.

In order to take advantage of this program, the Fund is required to collect information about you.

YOUR HIPAA RIGHTS

When your Fund coverage ends, a federal law – the Health Insurance Portability and Accountability Act (HIPAA) – protects you if your new health plan excludes pre-existing conditions.

When your Fund coverage ends, under HIPAA you are entitled by law to, and will be provided with, a Certificate of Creditable Coverage. Certificates of Creditable Coverage indicate the period of time in which you were covered under the Fund (including COBRA coverage), as well as certain additional information required by law. The Certificate of Creditable Coverage may be necessary if you become eligible for coverage under another group health plan, or if you buy a health insurance policy within 63 days after your coverage under this Fund ends (including COBRA coverage). The Certificate of Creditable Coverage is necessary because it may reduce any exclusion for pre-existing coverage periods that may apply to you under the new group health plan or health insurance policy.
The Certificate of Creditable Coverage will be provided to you shortly after this Fund knows, or has reason to know, that your coverage (including COBRA coverage) has ended. The Certificate of Creditable Coverage will also be provided once the Fund Office receives a written request, provided that the request is received within two (2) years after the later of the date your coverage under the Fund ended or the date your COBRA coverage ended.

Accordingly, the Fund will provide you with Certificates of Creditable Coverage showing when you were covered by the Fund:

- On your request, within 24 months after your Fund coverage ceases;
- When you are entitled to elect COBRA (see page 39);
- When your coverage terminates, even if you are not entitled to COBRA (see page 41), and
- When your COBRA coverage ceases.

You should retain these Certificates of Creditable Coverage as proof of prior coverage for your new health plan.

For further information, call the Member Services Department of the Fund at (646) 473-9200.

PRIVACY OF PROTECTED HEALTH INFORMATION

HIPAA also imposes certain confidentiality and security obligations on the Fund with respect to medical records and other individually identifiable health information used or disclosed by the Fund. HIPAA also gives you rights with respect to your health information, including certain rights to receive copies of the health information that the Fund maintains about you, and knowing how your health information may be used. A complete description of how the Fund uses your health information, and your other rights under HIPAA's privacy rules is available in the Fund’s “Notice of Privacy Practices,” which is distributed to all named participants. Anyone may request an additional copy of this Notice by contacting the Fund office.
SECTION I. K
HOW TO RESOLVE QUESTIONS CONCERNING ELIGIBILITY FOR BENEFITS

Sometimes questions arise about an 1199SEIU Home Care worker’s eligibility for benefits. Most eligibility disputes involve underreporting of hours by employers or misinterpretation. Hours are reported to the Fund office according to the date of a paycheck rather than the dates that work was actually performed. Often the Fund office can make adjustments upon presentation of evidence from either an employer (agency) payroll office or upon examination of paycheck stubs presented by the member.

The Fund has no independent means of discovering agency reporting errors; it depends upon notification from you that an error was made. If incorrect hours have affected your eligibility, an explanation with photocopies of paycheck stubs in the problem month – as well as the prior month and the subsequent month – should be sent to:

Eligibility Department
1199SEIU National Benefit Fund for Home Care Employees
330 West 42nd Street
NewYork, NY 10036

The Fund has sole authority and discretion to resolve all eligibility questions.
SECTION II – YOUR HEALTH BENEFITS

A. Participating Providers
   • Member Choice Home Care Select Network
   • Panel Providers

B. Using Your Benefits Wisely
   • 1199SEIU CareReview
   • Ambulatory/Outpatient Surgery Pre-Certification
   • Program for Behavioral Health
   • Emergency Rooms Are for Emergencies
   • Care Management
   • Prenatal Care Program
   • Wellness and Disease Management Programs

C. Inpatient Hospital Care and Hospice Care

D. Emergency Room Visits

E. Program for Behavioral Health
   (Mental Health and Alcohol/Substance Abuse)

F. Surgery & Anesthesia
   • Ambulatory Surgery

G. Maternity Care
   • Prenatal Care Program

H. Medical Services
   • Doctor Visits
   • Lab and X-Ray
   • What Is Not Covered

I. Services Requiring Prior Authorization

J. Vision Care

K. Dental Care

L. Prescription Drugs
HEALTH BENEFIT RESOURCE GUIDE

HOW TO REACH THE FUND

You can visit our website at www.1199SEIUBenefits.org for forms, directories and other information. From our website, you can also click on “My Account” to access information about your eligibility and claims history, and to make simple updates to your information.

WHERE TO CALL

Member Services Department
(646) 473-9200
www.1199SEIUBenefits.org

Call Member Services if you have any questions about your benefits, the programs or services offered by the Fund, or any procedures that need to be followed. The staff will either give you the information you need or refer you to someone who can provide you with the necessary information.

You can also call for:

- A list of Participating Providers or Home Care Select Networks in your area
- A list of Member Choice Network hospitals
- A list of Participating Pharmacies

AND/OR

- A list of preferred drugs, also known as a Preferred Drug List (PDL).

For Ambulatory/Outpatient Surgery Pre-Certification Program

Call the 1199SEIU CareReview Program at (800) 227-9360 to pre-certify your surgery if your surgery is going to be performed in the outpatient department of a hospital or in a doctor’s office.

For Prior Authorization
(646) 473-7446

Call for Prior Authorization if:

- You have questions about the treatment your doctor is recommending
- You require home care or home intravenous (IV) services
- You require certain diagnostic tests
- You need prior authorization for certain medications.
HEALTH BENEFIT RESOURCE GUIDE

For Inpatient Hospital Stays (including Behavioral Health)
1199SEIU CareReview Program
(800) 227-9360

Call the 1199SEIU CareReview Program:
• To pre-certify your hospital stay before going to the hospital for non-emergency care;
• To notify the Fund within two business days of an emergency admission; and/or
• For prior approval of inpatient mental health or alcohol/substance abuse treatment.

For the Prenatal Program
(646) 473-8962
Call to register with the Fund’s Prenatal Care Program.

For the Program for Behavioral Health (Mental Health and Alcohol/Substance Abuse)
(646) 473-6900
Call to get help with a mental health or alcohol/substance abuse problem.

For the Dental Program
(800) 468-0600
Call to select a participating DentCare dentist.

You can also visit our website at www.1199SEIUBenefits.org for forms, directories and other information.

QUALITY CARE ASSESSMENT

Your 1199SEIU Benefit Fund is concerned about the quality of the care you receive. If our medical advisor has questions about your claims, the Benefit Fund may send it to an independent specialist to review. In some cases, the Benefit Fund may require that you be examined by a specialist chosen by the Benefit Fund. There is no cost to you for this consultation.
SECTION II. A
PARTICIPATING PROVIDERS

GETTING THE CARE YOU NEED

In addition to the Member Choice Home Care Select Network, the Fund contracts with thousands of doctors, hospitals, labs, diagnostic facilities, pharmacies, medical equipment suppliers, and other healthcare professionals that provide comprehensive healthcare services. In addition, the Fund has designated certain laboratory facilities as “exclusive” (including Member Choice hospital-based labs) and certain radiology facilities as “preferred.” You must use these providers to avoid out-of-pocket expense and to help control costs.

“Participating Providers” are independent practitioners who accept the Fund’s payment as payment in full for most services (see shaded box), subject to co-payments as described in this section.

You can choose any doctor, hospital or other healthcare provider that you want for your care.

Some services, such as psychiatric care, require that you pay a share of the cost.

THE FUND PAYS FOR YOUR BENEFITS, YOUR DOCTORS PROVIDE YOUR CARE

You make the decision about which physician or healthcare provider you and your family use.

The Fund’s Participating Providers are independent practitioners that do not provide services as agents or employees of the Fund. The Fund does not provide medical care. It pays for benefits.

The Fund reviews providers’ practice patterns and credentials. However, the Fund is not responsible for the decisions and actions of individual providers.
MEMBER CHOICE HOME CARE
SELECT (MCHCS) ACCESS TO
COMPREHENSIVE CARE

Through MCHCS, you choose one health center – your “medical home” – for all of your primary care, and access the Fund’s panel of Participating Providers and hospitals for all other service.

You can choose from more than 100 health centers that are conveniently located near your work or your home throughout New York City. You can receive comprehensive care at no cost to you for medical care or prescriptions as long as you use your selected health center for all of your primary care needs. And, there are no claim forms to file. If you use a provider for primary care that is not affiliated with your health center, then you will have to pay a co-payment.

With MCHCS, your primary care doctor coordinates your healthcare needs with specialists, diagnostic facilities and other healthcare services provided in the same hospital network.

HOW TO JOIN

To join MCHCS:
1. Call the Fund at (646) 473-9200 for the list of health centers, or visit the Fund’s website at www.1199SEIUBenefits.org.
2. Complete a Plan Election Form during designated open enrollment periods and select the center that you would like to use.
3. Choose a primary care doctor.
4. Send your form to the Fund.

Special Rules:

You can change from MCHCS to the Panel Provider Plan at any time.

Once you choose a center, you can only change that center during open enrollment once per year unless the following criteria are met:

- You have moved and now live too far from the chosen center based upon the judgment of the Plan Administrator.
- A medical condition exists that is better served in another center. All requests will be considered based upon medical need and will be evaluated by the Fund’s Care Management Department.

NOTE: If you do not submit a Plan Election Form, you will be eligible to use Participating Providers only, but not MCHCS.
HOW IT WORKS

You should go to see your primary care doctor for regular checkups, vaccinations and other preventive care and whenever you are sick.

If you have a special medical problem, talk to your primary care doctor. Your doctor can determine whether you need to be referred to a specialist.

If you receive a referral to a specialist, make sure the provider is also participating in your Member Choice Home Care Select Network or a Panel Provider.

You do not need a referral in order to obtain access to obstetrical or gynecological care from a healthcare professional who specializes in obstetrics or gynecology.

Be sure to show your Health Benefits ID card whenever you require services through this program.

PANEL PROVIDERS

There are thousands of doctors, hospitals and other healthcare providers participating in the Fund’s Panel program. These providers:

• Accept the Fund’s payment as payment in full for most services;
• Are conveniently located near where you work or where you live;
• Are licensed physicians and, in almost all cases, board-certified or board-eligible in their area of specialty; and
• Are affiliated with highly regarded institutions throughout the area.

If your Panel doctor needs to refer you to a specialist or another healthcare provider, make sure that provider is also on the Fund’s panel of Participating Providers.

This is important because if the specialist is a Non-Participating Provider, you cannot be sure that the specialist will accept the Fund’s allowances as payment in full. You may face a high out-of-pocket cost when using Non-Participating Providers.

For the names of Panel doctors and other healthcare providers in your area, call the Fund at (646) 473-9200.

PREFERRED LABORATORY, RADIOLOGY (X-RAY) FACILITIES AND DURABLE MEDICAL EQUIPMENT (DME) VENDORS

The Fund has designated certain labs (including Member Choice hospital-based labs), certain radiology facilities and certain DME vendors as preferred. You must use these providers to avoid out-of-pocket costs. If your doctor wants you to have lab or radiology tests, please contact the Fund or visit our website at www.1199SEIUBenefits.org for the listing and locations of these laboratory and radiology facilities.
WHEN YOU USE
NON-PARTICIPATING PROVIDERS

You can go to any doctor or hospital you choose. However, if you use a Non-Participating (or Non-Panel) Provider, you may be billed whatever the provider normally charges. You would then have to pay any cost over the Fund’s allowance.
SECTION II. B
USING YOUR BENEFITS WISELY

In order to avoid out-of-pocket costs, you must comply with the following:

1199SEIU CARE REVIEW PROGRAM
(800) 227-9360

If you need to go to the hospital, you must contact the 1199SEIU CareReview Program:

• To pre-certify your hospital stay before going to the hospital for non-emergency care
• To pre-certify your hospital stay within two business days of an emergency admission
• For prior approval of inpatient mental health or alcohol/substance abuse treatment
• To pre-certify your acute inpatient physical rehabilitation
• To pre-certify certain outpatient or ambulatory surgical procedures.

PROTECT YOUR BENEFITS

If you use an emergency room for non-emergency care

The cost of non-emergency treatment in an emergency room is much higher than non-emergency treatment in your doctor’s office clinic or through the use of an urgent care center that may be conveniently located near where you live. These centers are generally open seven hours per week and have extended hours. You will be responsible for the difference between some of the Fund’s payments and the actual cost of the care you receive in the emergency room – resulting in a high out-of-pocket cost to you.

Questions?

If you have any questions, call the Fund’s Member Services Department at (646) 473-9200. The staff can help you understand what procedures you need to follow in order to protect your benefits.
EXCLUSIVE LABORATORY
AND PREFERRED RADIOLOGY
(X-RAY) FACILITIES
If your doctor wants you to have lab or radiology tests, contact the Fund or visit our website at www.1199SEIUBenefits.org for the listing and locations of these laboratory and radiology facilities.

PROGRAM FOR
BEHAVIORAL HEALTH
Mental Health and
Alcohol/Substance Abuse
The Fund has a special program to help you get behavioral healthcare. All calls and treatment information are kept strictly confidential.

Remember to call 1199SEIU CareReview before going to the hospital for inpatient care.

Effective January 1, 2013, the Fund will eliminate any restrictions on mental health and substance abuse benefits that are prohibited by the Wellstone-Domenici Mental Health Parity and Addiction Equity Act.

EMERGENCY ROOMS
ARE FOR EMERGENCIES
A hospital emergency room should be used only in case of a legitimate medical emergency. To be considered an emergency, your emergency room visit must occur within 72 hours of an injury or the onset of a sudden and serious illness.

The Plan Administrator reserves the sole discretion to determine whether a legitimate emergency existed and benefits will only be provided in the event such a determination has been made.

CARE MANAGEMENT PROGRAM
This is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services required to meet a member’s health needs.

If you require ongoing medical treatment from a catastrophic or severe illness/injury, including after-hospital care, the Care Management (CM) staff may consult with the doctor or hospital during the planning of Medically Necessary and appropriate care. CM aims to coordinate your care under the terms of our Plan to ensure utilization of covered services by Participating Providers to minimize out-of-pocket costs. Information related to CM is strictly confidential.

UTILIZATION REVIEW
Utilization Review is a process for evaluating the medical necessity, appropriateness, and efficiency of health care services provided to you. This will ensure that requested services are the most appropriate for the illness or injury and are provided at the most cost-effective level of care.
The review process can be:

- Prior Authorization (or prospective) – review before services are provided
- Concurrent – review as services are being provided
- Retrospective – review after services have been rendered.

THE PREGNANT CARE PROGRAM – HAVING A HEALTHY BABY

Complications can occur during your pregnancy that could lead to premature birth, low birth weight, birth defects or possibly even infant death.

With regular prenatal care, which includes the visits to your doctor and medical care you receive while pregnant, complications can be detected early and treated to reduce the risk of harming your baby.

Through the Prenatal Program, you can get important information, take part in practical workshops and receive supportive advice. You’ll also learn about making healthy choices and get tips on what to expect during your pregnancy and when caring for your baby.

Call (646) 473-9200 to register for the Fund's Prenatal Care Program.

PREFERRED LABORATORY FACILITIES

The Fund has contracted with certain free-standing labs in addition to Member Choice hospital-based labs. You must use these providers to avoid out-of-pocket costs. If you require lab work, make sure that your doctor sends your lab samples to an exclusive lab. If you need to have your lab work performed outside of your doctor’s office, take your referral slip from your doctor to a Patient Care (Drawing) Center from one of the preferred labs. Contact the Fund or visit our website at www.1199SEIUBenefits.org for a listing and locations of these facilities.

PREFERRED RADIOLOGY (X-RAY) FACILITIES

Prior authorization is required for certain radiological tests, such as MRI, MRA, PET scans, CAT scans and certain Nuclear Cardiology procedures. If your doctor prescribes one of these tests, you or your doctor must call (888) 910-1199 for prior approval.

The Fund has entered into an agreement with a preferred network of radiology facilities. Call (888) 910-1199 for a referral to a preferred radiology facility. All radiological tests must be performed by a radiologist or a non-radiology provider within the specialty for your particular test.
PREFERRED DURABLE MEDICAL EQUIPMENT (DME) VENDORS

The Plan covers rental of standard durable medical and surgical equipment such as braces, hospital beds and wheelchairs. By using these vendors, you will avoid out-of-pocket costs. Call for prior authorization at (646) 473-9200.

See Section II. I for Services Requiring Prior Authorization. Other benefits may also require prior authorization. Please refer to the sections describing those specific benefits for more information.
### SECTION II. C

**HOSPITAL CARE AND HOSPICE CARE**

<table>
<thead>
<tr>
<th><strong>BENEFIT BRIEF</strong></th>
<th><strong>Observation Care and Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Care</strong></td>
<td><strong>Call the 1199SEIU CareReview Program before going to the hospital or within two days of an emergency admission to avoid out-of-pocket costs.</strong></td>
</tr>
<tr>
<td>This benefit is for the hospital’s charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered, depending on eligibility, as described in Section II.H of this SPD.</td>
<td><strong>Inpatient and Outpatient Hospice Care</strong></td>
</tr>
<tr>
<td>• Up to 365 days per year.</td>
<td>• Coverage for a combined total of up to 210 days per lifetime in a Medicare-approved Hospice Program in a hospice center, hospital, skilled nursing facility or at home.</td>
</tr>
<tr>
<td>• Acute care that is Medically Necessary.</td>
<td>• Life expectancy is estimated to be six months or less.</td>
</tr>
<tr>
<td>• Semi-private room and board.</td>
<td><strong>Hospice Care</strong></td>
</tr>
<tr>
<td>• Up to 30 days per year for inpatient physical rehabilitation in an acute care facility. Benefits are not provided for care in a sub-acute nursing home or skilled nursing facility.</td>
<td></td>
</tr>
</tbody>
</table>
PLEASE NOTE:
Hospital benefits will not be provided for any hospitalization that began prior to the date of your eligibility.

WHEN YOU NEED TO GO TO THE HOSPITAL
You are covered for acute inpatient hospital care for up to 365 days during a calendar year in a semi-private room in a hospital if Medically Necessary to treat your medical condition.

If you need hospital care:
- Call the 1199SEIU CareReview Program at (800) 227-9360; and
- Show your Health Benefits ID Card when you get to the hospital.

Even though you are covered for up to 365 days per year, most people do not have to stay in the hospital for more than a few days.

The Fund reviews hospital admissions. Based on this review, the Plan Administrator determines the number of days the Fund will pay for a given admission based on the diagnoses when you are admitted and discharged. Your doctor may consult with the Fund’s Medical Advisor or 1199SEIU CareReview if your doctor feels a longer hospital stay is needed.

If you choose a private room, you will have to pay the difference between the charges for a private room and the average charges for a semi-private room.

CARE COVERED
Inpatient hospital benefits cover reasonable payments billed by the hospital for the Medically Necessary care customarily provided to patients with your medical condition. These may include:
- Room and board, including special diets
- Use of operating and cystoscopic rooms and equipment
- Lab work that is needed for the diagnosis and treatment of the condition for which you are in the hospital, including pre-admission testing within seven days of the admission
- X-rays that are needed for the diagnosis and treatment of the condition for which you are in the hospital, including pre-admission testing within seven days of admission
- Use of cardiographic equipment
- Basal metabolic examinations
- Use of physiotherapeutic and X-ray therapy equipment
- Oxygen and use of equipment for administering oxygen
- A fee for administration of blood for each hospital stay
- Recovery room charges for care immediately following an operation.

Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.
INPATIENT ACUTE REHABILITATION
You are covered for up to 30 days per calendar year in a non-governmental hospital for Medically Necessary acute inpatient treatment. Benefits are not provided for care in a nursing home or skilled nursing facility (SNF).
Your doctor must provide the Fund with a detailed written treatment plan. This plan must be reviewed and approved by the Fund’s Medical Advisor before the Fund will agree to provide benefits for any rehabilitation care.

ELECTIVE/SCHEDULED ADMISSIONS
Before you go to the hospital, remember to call the 1199SEIU CareReview Program.

OUTPATIENT OBSERVATION CARE AND SERVICES
Observation care benefits cover Medically Necessary services before a decision can be made regarding whether a patient will require further inpatient treatment or if they are able to be discharged from the hospital. Generally, observation services are for a period of less than 48 hours.

HOSPITAL CARE OUTSIDE OF THE COUNTRY
The Fund will reimburse the member directly for Medically Necessary services rendered outside of the country. The member must provide proof of payment, an itemized bill and other pertinent information, which may include a copy of the member’s passport or airline tickets and a certified translation, if requested by the Fund.

WHAT IS NOT COVERED
The Fund will not pay for:

- Custodial care or sub-acute care in a hospital or any other institution
- Care or service in a nursing home, skilled nursing facility, rest home or convalescent home
- Hospitalization covered under federal, state or other laws except where otherwise required by law
- Rest cures
- Blood for transfusions
- Admissions for cosmetic services
- Personal or comfort items
- Private rooms
- Services related to a claim filed under Workers’ Compensation
- Services that in the judgment of the Plan Administrator are not Medically Necessary
- Services that are not pre-approved in accordance with the terms of the Plan
- All general exclusions listed in Section VII. D.

Some benefits may require prior authorization. Please refer to the sections describing those specific benefits for more information.
PAYMENT TO A HOSPITAL
The Fund has negotiated rates with many hospitals in the New York area. These are called “Participating Hospitals.”
When you go to a Participating Hospital for Medically Necessary care, the Fund will pay the hospital directly for all services. You will have no out-of-pocket costs.
If you go to a hospital that is not a Participating Hospital for an elective admission, the Fund will pay only what it determines is the Schedule of Allowances at a comparable Participating Hospital for the services provided. You may be responsible for large out-of-pocket costs for the balance of the hospital bill and/or for other services.

HOSPICE CARE
Hospice care is a type of care and a philosophy of care that focuses on bridging comfort and relief of symptoms to patients nearing the end of life. The Fund pays for inpatient and outpatient charges made by a Hospice Care Agency, which may include but are not limited to:
• Room and board and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management
• Services and supplies furnished to you on an outpatient basis
• Part-time or intermittent nursing care by a RN or LPN for up to eight hours a day
• Part-time or intermittent home health aide services to care for you for up to eight hours a day
• Physical and occupational therapy
• Consultation or case management services by a physician
• Psychological counseling.

LIMITATIONS
Unless specified above, not covered under this benefit are charges for:
• Daily room and board charges over the semi-private room rate
• Bereavement counseling
• Funeral arrangements
• Pastoral counseling
• Financial or legal counseling, including estate planning and the drafting of a will
• Homemaker or caretaker services. These are services that are not solely related to your care. These include, but are not limited to, sitter or companion services, transportation or maintenance of your residence.
• Respite care. This is care furnished during a period of time when your family or usual caretaker cannot attend to your needs.
SECTION II. D
EMERGENCY ROOM VISITS

BENEFIT BRIEF
Emergency Room Visits
This benefit is for the hospital’s charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered as described in Section II.H of this SPD.

- Use of the emergency room visit must be within 72 hours of an accident or sudden and serious illness to be considered emergent care.
- The Fund pays negotiated rate at Participating Hospitals or reasonable charge at Non-Participating Hospitals.
- Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan and use the emergency room for non-emergent care.

The Fund has negotiated emergency room rates with many hospitals in the New York area (“Participating ER Providers”). If you go to the emergency room of a Participating ER Provider, you will have no out-of-pocket costs.

EMERGENCY ROOMS ARE FOR EMERGENCIES
A hospital emergency room should be used only in the case of a legitimate medical emergency. To be considered an emergency, your emergency room visit must meet the definition of emergency (see page 124) and must occur within 72 hours of an injury or the onset of a sudden and serious illness.

- Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan and use the emergency room for non-emergent care.

When you go to the emergency room:
- Show your Health Benefits ID card. The Fund will pay the hospital directly.
- Call 1199SEIU CareReview at (800) 227-9360 within two business days if you are admitted.

If you go to the emergency room in a hospital with which the Fund does not have an emergency room contract, you may incur out-of-pocket costs. If you have any questions about a bill for emergency room treatment, call the Member Services Department at (646) 473-9200.
NON-EMERGENCY TREATMENT CAN BE COSTLY TO YOU

The cost of non-emergency treatment in an emergency room is much higher than non-emergency treatment in your doctor’s office, a clinic or through the use of an urgent care center that may be conveniently located near where you live. These centers are generally open seven days per week and have extended hours. For non-emergency treatment, you will be responsible for the difference between some of the Fund’s payments and the actual cost of the care you receive in the emergency room – resulting in a high out-of-pocket cost to you.

CALL YOUR DOCTOR FIRST

If you are not sure whether you need to go to the emergency room:

• Call your doctor first.

• Your doctor may be able to recommend treatment over the phone, have you go to the office, or go to the hospital.

• If your doctor’s office is closed, call your doctor’s emergency (after hours) number.

• If you do not have a primary care doctor or cannot reach your doctor, call (646) 473-9200 during normal working hours for a referral to a Participating Provider or call the 24-hour Nurse Helpline at (866) 935-1199.

Some benefits may require prior authorization. Please refer to the sections describing those specific benefits for more information.
 SECTION II. E
PROGRAM FOR BEHAVIORAL HEALTH:
MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE

BENEFIT BRIEF

Inpatient Mental Health
• Medically Necessary services

Inpatient Alcohol/Substance Abuse
• Medically Necessary services for inpatient detoxification
• Up to 30 days within a 12-month period for inpatient rehabilitation

Outpatient Mental Health and Alcohol/Substance Abuse
• Outpatient visits
• Co-payments may apply for inpatient care if you are not enrolled in the Member Choice Home Care Select Plan.

Many professionals, rehabilitation programs and institutions participate in the Fund’s program to provide you with ongoing treatment at no out-of-pocket cost to you. Co-payments may apply.

MENTAL HEALTH BENEFITS
• Outpatient Care
• Outpatient visits
• Co-payments may apply

• Inpatient Care
• Medically Necessary mental health admissions in a non-governmental hospital

Co-payments may apply for inpatient care if you are not enrolled in the Member Choice Home Care Select Plan.

GET THE HELP YOU NEED

The Fund offers a Member Assistance Program to help you receive confidential treatment for alcohol, substance abuse or mental health problems.

If you need help for a mental health issue, call (646) 473-6900.

YOUR RIGHTS
UNDER THE MENTAL HEALTH PARITY ACT

Effective January 1, 2013, the Fund will eliminate any restriction on mental health and substance abuse benefits that are prohibited by the Wellstone-Domenici Mental Health Parity and Addiction Equity Act.*
ALCOHOL/SUBSTANCE ABUSE BENEFITS

When Medically Necessary, you are covered for diagnosis and treatment of:

• Alcoholism

OR

• Substance abuse.

Outpatient Care

• Outpatient visits

Inpatient Care

• Medically Necessary services for inpatient detoxification

• Up to 30 days within a 12-month period* for inpatient rehabilitation services

* Effective January 1, 2013, the Fund will eliminate any restrictions on mental health and substance abuse benefits that are prohibited by the Wellstone-Domenici Mental Health Parity and Addiction Equity Act.

IF YOU NEED TO GO TO THE HOSPITAL

If you need to go to the hospital, you must call (800) 227-9360:

• Before going to the hospital if it’s not an emergency

OR

• Within two business days of an emergency admission.

If you need hospital care, you must call 1199SEIU CareReview at (800) 227-9360. The staff will authorize your hospital stay and may refer you to the Fund for additional follow-up.

In the case of an emergency admission, you or a member of your family must call 1199SEIU CareReview within two business days.

Some benefits may require prior authorization. Please refer to the sections describing those specific benefits for more information.
SECTION II. F
SURGERY AND ANESTHESIA

BENEFIT BRIEF

Surgery and Anesthesia
- Inpatient or outpatient (ambulatory) surgery
- Anesthesia

Benefits are paid according to the Fund’s Schedule of Allowances.

SURGERY
You are covered for surgery when performed:
- By a licensed physician or surgeon
- In an accredited hospital, ambulatory surgery center or office-based surgery suite.

If you need to go to the hospital, call 1199SEIU CareReview at (800) 227-9360 before your hospital stay. See Section II. B for more information.

ASSISTANT SURGEON
The Fund will pay 20 percent of its allowance for your surgery for an assistant surgeon if:
- No surgical residents were available AND
- The assistant surgeon was Medically Necessary, as determined by the Plan Administrator.

YOUR BENEFIT IS DETERMINED BY THE TYPE OF SURGERY YOU NEED

The Fund can only pay up to a certain amount for each type of surgical procedure. Your benefit is the Fund’s allowance for your type of surgery, or the doctor’s charge, whichever is less.

If you need two or more related operations at the same time, the total Fund allowance for all your procedures will be determined based upon the Benefit Fund’s allowance and its claims processing rules for multiple or related operations.

You can find out how much the Fund can pay for your surgery by:
- Writing to the Fund’s Prior Authorization Department; or
- Visiting the Plan Administrator’s offices during normal working hours to examine a listing of the Schedule of Allowances.

If you use a Non-Participating doctor, you could face high out-of-pocket costs. You or your doctor must file a claim with the Fund within 90 days from the date of your treatment.

For the names of participating surgeons in your area, call the Fund’s Member Services Department at (646) 473-9200.
ANESTHESIA

The amount of reimbursement for anesthesia under the Schedule of Allowances varies depending upon:
- The type of anesthesia provided; and
- The length of time anesthesia is given.

Coverage includes:
- Supplies
- Use of anesthesia equipment
- Anesthesiologist charges.
  Payment for local anesthesia is normally included in the Fund’s surgical allowance.

AMBULATORY SURGERY

You no longer need to stay in the hospital for many surgical procedures that can be safely performed in the outpatient center of a hospital, surgical center or Ambulatory Care center. If your procedure can be safely performed in one of these settings, you must have it performed on an outpatient or ambulatory basis.

The Fund pays for:
- Operating room charges
- Ancillary hospital or ambulatory surgical center charges.

You must call 1199SEIU CareReview at (800) 227-9360 before having outpatient or ambulatory surgery.

YOUR RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER ACT OF 1998

The Fund complies with federal law related to mastectomies. If a member has a mastectomy and then chooses to have breast reconstruction, the Fund (in consultation with the patient and doctor) will provide coverage based upon the Fund’s Schedule of Allowances 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
- Prostheses
- Treatment of physical complications of the mastectomy (including lymphedemas).
WHAT IS NOT COVERED

The Fund will not pay surgical or anesthesia benefits if your surgery was:

- Covered by Workers’ Compensation (see Section I. H)
- Performed primarily for cosmetic purposes, except when needed to correct gross disfigurement resulting from surgery, an illness or an accident that occurred while you were covered by the Fund
- Related to infertility treatment including, but not limited to in vitro fertilization, artificial insemination, and reversal of sterilization
- Not Medically Necessary in the judgment of the Plan Administrator
- Services of a type usually performed by a dentist, except certain oral surgical procedures
- Services by an assistant to the Surgeon performing the operation unless Medically Necessary in the opinion of the Plan Administrator
- All general exclusions listed in Section VII. D, pages 107-108.

Some benefits may require prior authorization. Please refer to the sections describing those specific benefits for more information.
SECTION II. G
MATERNITY CARE

BENEFIT BRIEF

Maternity Care
- An allowance which includes all prenatal and postnatal visits and delivery charges
- Hospital Benefit Program

Benefits are paid according to the Fund’s Schedule of Allowances. Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.

MATERNITY BENEFITS

Your maternity benefit includes:
- An allowance for all prenatal and postnatal visits and delivery charges
- Anesthesia allowance
- A hospital benefit.

YOUR RIGHTS UNDER THE NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT OF 1996

The Fund complies with federal law in that:
- A mother is allowed to stay in the hospital for at least 48 hours after delivery (or 96 hours after Caesarean section) and
- A provider is not required to obtain authorization from the Plan for prescribing these minimum lengths of stay.

However, the mother and her provider still may decide that the mother may be discharged before 48 (or 96) hours.
THE PRENATAL CARE PROGRAM

Having a Healthy Baby

With regular prenatal care, complications that may occur during your pregnancy can be detected early and treated to reduce the risk of harming your baby. Prenatal care includes the visits to your doctor and medical care you receive while you are pregnant.

Participating in the Prenatal Care Program

1. Register with the Fund within the first three months of the pregnancy by calling (646) 473-9200 or register online at www.1199SEIUBenefits.org.

2. Ask your doctor to participate in the program. If you do not have a doctor, the Fund can help you find an obstetrician who participates in this program.

Some benefits may require prior authorization. Please refer to the sections describing those specific benefits for more information.
SECTION II. H
MEDICAL SERVICES

BENEFIT BRIEF

Medical Services

- Treatment in a doctor’s office, clinic, hospital or your home
- Dermatology: up to 20 treatments per year
- Chiropractic: up to 12 visits per year
- Podiatry: up to 15 treatments per year for routine care
- Allergy: up to 20 treatments per year, including diagnostic testing
- Physical/Occupational/Speech Therapy: up to 25 visits per discipline per year
- X-rays and laboratory tests
- Outpatient chemotherapy, radiation therapy and hemodialysis
- Ambulance services
- Some co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan
- Members enrolled in the Member Choice Home Select Plan will have no co-payments as long as they use their health center for all of their primary care needs.

Benefits are paid according to the Fund’s Schedule of Allowances.

NOTE: Behavioral health benefits are only provided as described in Section II. E.

PARTICIPATING PROVIDERS

Doctors, labs and other health professionals that are part of the Fund’s Member Choice Home Care Select Plan and Participating Provider Plan accept the Fund’s allowance as payment in full. For more information, see page 48.

If you use a Non-Participating provider, you could face high out-of-pocket costs. You may have to pay the difference between the Fund’s allowance and your doctor’s charges.

DOCTOR VISITS

You are covered for medical services provided in a doctor’s office, clinic, hospital or at home.

A licensed medical provider must provide your care. Specialists must be board-certified or board-eligible in their area of specialty.
MAKING SURE YOU GET THE CARE YOU NEED

Subject to applicable co-payments, the Fund will pay its allowance for the following services up to the maximums indicated below:

- **Dermatology**: up to 20 treatments per year
- **Chiropractic**: up to 12 treatments per year
- **Podiatry**: up to 15 treatments per year for routine care
- **Allergy**: up to 20 treatments per year, including diagnostic testing.
- **Physical/Occupational/Speech Therapy**: up to 25 visits per discipline per year

If it is determined by the Plan Administrator that additional treatment is Medically Necessary and in compliance with the Fund’s clinical guidelines, policies, protocols and procedures, the Fund may provide benefits for additional treatment. To be covered, these treatments must be approved in advance by the Plan Administrator.

PREVENTIVE CARE

Regular medical checkups help to keep you healthy. Benefits are provided for preventive care services, including:

- **Periodic checkups**
  Through regular exams, your doctor can detect any problems early, when they are more easily treated.

X-RAY AND LABORATORY SERVICES

Benefits are provided for X-rays and lab services needed for your medical condition when performed:

- In your doctor’s office (for a limited number of routine tests only)
- By an outside laboratory
- By a hospital outpatient department.

In order to avoid out-of-pocket costs, contact the Fund or visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org) for the listing and locations of Participating Providers.

PREFERRED LABORATORY FACILITIES

The Fund has contracted with certain free-standing labs in addition to Member Choice hospital-based labs. You must use these providers to avoid out-of-pocket costs. If you require lab work:

- Make sure that your doctor sends your lab samples to an exclusive lab
- If you need to have your lab work performed outside of your doctor’s office, take your referral slip from your doctor to a Patient Care (Drawing) Center from one of the preferred labs.

Contact the Fund or visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org) for the listing and locations of these facilities.
PREFERRED RADIOLOGY (X-RAY) FACILITIES

Prior authorization is required for certain radiological tests, such as MRI, MRA, PET scans and CAT scans. If your doctor prescribes one of these tests, you or your doctor must call (888) 910-1199 for prior approval.

The Benefit Fund has entered into an agreement with a preferred network of radiology facilities. By using these facilities, you will avoid out-of-pocket costs. Call (888) 910-1199 for a referral to a preferred radiology facility. All radiological tests must be performed by a radiologist or a non-radiology provider within the specialty for your particular test.

CHOOSE A PRIMARY CARE DOCTOR FOR COMPREHENSIVE CARE

A primary care doctor is an internist, family physician, obstetrician/gynecologist or pediatrician who coordinates your care. There are thousands of primary care physicians in the Fund’s Participating Provider Plan. Your primary care doctor gets to know you and your medical history, sees you when you are sick, and provides regular checkups and immunizations. This way, he or she is aware of your overall health and minor problems can be detected before they become serious illnesses.

If you have a chronic condition, such as diabetes, hypertension or heart disease, your primary care doctor can oversee your care and help you manage your condition.

HOSPICE CARE

You are covered for a combined total of up to 210 days in a Medicare-approved Hospice Program in a hospice center, hospital, skilled nursing facility or at home. See Section II. C for details.

AMBULANCE SERVICES

You are covered for emergency transportation to and services at the closest hospital where you can be treated in the case of an accident or the onset of a sudden and serious illness.

You are also covered for transportation between hospitals if you need specialized care that the first hospital cannot provide.

WHAT IS NOT COVERED

The Fund does not cover:

- Experimental, unproven or non-FDA-approved treatments, procedures, facilities, equipment, drugs, devices or supplies
- Treatment that is cosmetic in nature
- Treatment that is custodial in nature
- Infertility treatment including, but not limited to, in vitro fertilization, artificial insemination and reversal of sterilization
- Laboratory tests that are not FDA-approved
- Venipuncture
- Treatment for illness or injury covered by Workers’ Compensation or the Veterans Administration
• Acupuncture when administered by anyone other than a licensed medical physician
• Private physicians when care is given in a governmental or municipal hospital
• Charges in excess of the Fund’s Schedule of Allowances
• Employment or return-to-work physicals
• Treatments determined to be medically unnecessary by the Plan Administrator
• Habilitation therapies to the extent there is other coverage available from either a government agency or program or through a special organization
• Charges related to refractions when performed by an ophthalmologist
• All general exclusions listed in Section VII. D.

Some benefits may require prior authorization. Please refer to the sections describing those specific benefits for more information.
SECTION II. I
SERVICES REQUIRING PRIOR AUTHORIZATION

BENEFIT BRIEF
Services Requiring Prior Authorization
- Home Health Care
- Non-Emergency Ambulance Services
- Durable Medical Equipment and Appliances
- Medical Supplies
- Specific Medications
- Home Infusion Services and Supplies
- Certain Diagnostic and Radiologic Tests
- Ambulatory Surgery

Prior approval required from the Prior Authorization Department, except emergency ambulance.

WHAT IS COVERED
To be covered, services must be:
- Ordered by your physician
- Medically Necessary to treat your condition
- In compliance with the Benefit Fund’s clinical guidelines, policies, protocols and procedures
- Approved in advance by the Fund’s Prior Authorization Department.

PRIOR APPROVAL NEEDED
Call the Prior Authorization Department at (646) 473-9200. The Fund’s professional staff will:
- Review your medical records
- Determine if the service or supply will be covered by the Plan as Medically Necessary for your condition and appropriate for your treatment
- Contact you if there are any Participating Providers who can provide the course of treatment or equipment you need.

Participating Providers accept the Fund’s payment as payment in full.

If you do not get approval from the Prior Authorization Department before starting the service or using the supplies, you are not covered for these benefits.

Doctors and health professionals that are part of the Fund’s Participating Provider Plan accept the Fund’s allowance as payment-in-full, subject to co-payments where applicable.

If you use a Non-Participating Provider, you could face high out-of-pocket costs. You have to pay the difference between the Fund’s allowance and your provider’s charges.
HOME HEALTH CARE
Home health care services will be covered if they are authorized by the Fund in advance, Medically Necessary and in compliance with the Fund’s protocols. Benefits are payable in accordance with the Fund’s Schedule of Allowances up to the maximum benefits available.

This includes a combined total of up to 60 visits per calendar year for:

• Intermittent Skilled Nursing Care
• Intermittent Non-Skilled Care
• Physical, occupational, or speech therapy.

Coverage may be provided for Private Duty Skilled Nursing Care for up to an additional 120 hours per calendar year, which is authorized by the Fund in advance, Medically Necessary and in compliance with the Fund’s protocols.

DURABLE MEDICAL EQUIPMENT
The Plan covers rental of standard durable medical and surgical equipment (braces, hospital beds, wheelchairs).

Equipment may be bought only if:

• It is cheaper than the expected long-term rental cost, or
• A rental is not available.

MEDICAL SUPPLIES
The Plan covers services and supplies medically needed to treat your illness and which are approved by the Federal Drug Administration, such as:

• Prosthesis
• Blood and blood processing
• Dressings
• Catheters
• Oxygen.

SPECIFIC MEDICATIONS
You must get prior approval before benefits can be provided for certain prescriptions. The Plan Administrator will periodically publish an updated listing of drugs that require prior authorization.

For a listing of these drugs, contact the Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

NOTE: You may have to pay the entire cost of the prescription if you don’t get prior approval from the Fund.
AMBULATORY/OUTPATIENT SURGERY
You must get prior approval for hospital and surgery. See Section II.B.

HOME INFUSION SERVICES AND SUPPLIES
If your doctor prescribes home infusion therapy, contact the Fund in advance of the services being delivered. If the intravenous administration of medication is medically appropriate for your condition and the prescription medication is a covered benefit, the Fund will coordinate the services and supplies with your doctor and the home infusion company. Some commonly prescribed home infusion therapies include antibiotics, steroids, hydration and clotting factors.

CERTAIN DIAGNOSTIC TESTS
Prior authorization is required for certain radiological tests, such as MRI, MRA, PET scans, CAT scans and certain nuclear cardiology procedures. If your doctor prescribes one of these tests, you or your doctor must call (888) 910-1199 for prior approval. The Benefit Fund has entered into an agreement with a preferred network of radiology facilities.

By using these facilities, you will avoid out-of-pocket costs. Call (888) 910-1199 for a referral to a preferred radiology facility. All radiological tests must be performed by a radiologist or a non-radiology provider within the specialty of your particular test.

Some benefits may require prior authorization. Please refer to the sections describing those specific benefits for more information.
SECTION II. J
VISION CARE AND HEARING AIDS

BENEFIT BRIEF

Vision Care
- One eye exam every two years
- One pair of glasses or contact lenses every two years

Hearing Aids
- Once every three years
- Call for referrals
- Co-payments when using participating providers may apply

VISION CARE
- One eye exam every two years
- One pair of glasses or contact lenses every two years

Benefits are paid according to the Fund’s Schedule of Allowances.

YOUR COVERAGE
This vision benefit is not to be confused with medical treatment for diseases of the eye. You are covered for:

- One eye exam every two years
- One pair of glasses or contact lenses every two years

WHAT IS NOT COVERED
The Fund does not cover
- Non-prescription sunglasses
- Scratch resistant and/or ultraviolet treatment
- Visual training
- All general exclusions listed in Section VII.D.

HEARING AIDS
- Hearing aids are covered once every three years. Call Member Services for a referral to a Participating Provider. Co-payments may apply when using Participating Providers.
- If you use a Non-Participating Provider, you can be billed whatever the provider normally charges. You may have to pay any cost over the Benefit Fund’s allowance.

You may have an out-of-pocket cost if you select frames, lenses or other services that are not included in the Fund’s program with your provider.

If you use a participating optometrist or optician, and you incur a large out-of-pocket cost, call the Fund before you pay for your exam, glasses or contact lenses.

If you use a Non-Participating Provider, you’ll be reimbursed up to the Fund’s allowance.
SECTION II. K
DENTAL BENEFITS

BENEFIT BRIEF
Dental benefits are provided by DentCare (formerly Healthplex). For questions regarding dental benefits call DentCare at (800) 468-0600.

- No charge for basic and preventive services
- Co-payments for major restorative services

All dental work must be done by a participating general dentist or specialist in the DentCare network. Cleanings may be performed by a licensed dental hygienist supervised by a licensed dentist.

YOUR PRIMARY CARE DENTAL PROVIDER
You will need to pick a primary care general dentist who will be responsible for coordinating your dental care, including any referrals to dental specialists. Primary care dentists are listed in your DentCare provider directory. Call DentCare at (800) 468-0600 to select a primary care dentist. Then call your dentist to make an appointment.

BASIC AND PREVENTIVE CARE
You are covered in full for:

- Examinations twice per year
- Prophylaxis (cleaning) twice per year
- One complete set of diagnostic
- X-rays in a three-year period
- X-rays needed to diagnose a specific disease or injury.

MAJOR RESTORATIVE CARE
There is a co-payment for major services including:

- Periodontics (treatment of gum diseases)
- Endodontics (treatment of the inner part of the tooth)
- Removable prosthetics (dentures)
- Crown and bridgework, including replacement of any existing denture, bridgework, crown or gold restoration once every five (5) years.

IN CASE OF EMERGENCY
In case of an emergency, please contact your primary care dentist. If you cannot reach your primary care dentist and you have an emergency, call DentCare at (800) 468-0600 for the name of a provider in your area.
GETTING YOUR BENEFITS
When Using a Participating Dentist
Participating dentists receive payment directly from DentCare. They have agreed to accept the Fund’s allowance as payment in full for many services. You will have to pay a co-payment directly to the dentist for some services. If you have to pay a co-payment, it is due at the time services are provided.

WHEN USING A NON-PARTICIPATING DENTIST
If you use a non-participating dentist, you or your dentist will not be reimbursed unless the services are for emergency care while outside the DentCare service area. To receive a benefit for out-of-area emergency care, you will need to pay the bill yourself and send a completed claim form to DentCare for reimbursement. You have to pay any charges not covered by DentCare.

WHAT IS NOT COVERED
Benefits are not provided for:
- Services provided by a dentist not affiliated with DentCare (unless an emergency)
- Services, supplies or appliances that are not Medically Necessary in the judgment of DentCare
- Services, supplies or appliances incurred in connection with implants and periodontal splinting that do not meet the Benefit Fund’s clinical guidelines and approved protocols
- Temporary crowns, restorations, dentures or fixed bridgework, night guards, or services that are cosmetic in nature
- Lost or stolen appliances
- Treatment of temporo-mandibular joint (TMJ) disease
- Any dental treatment inconsistent with the Benefit Fund’s approved protocols, procedures, restrictions and time limits (including the five-year limitation on periodontal surgery, removable prosthetics (partial and complete dentures) and crowns, fixed bridgework and other methods of replacing individual teeth)
- Deep or intravenous conscious sedation and general anesthesia services that are not performed by a board-certified or eligible oral surgeon, or a dental anesthesiologist
- All general exclusions listed on Section VII. D.

Some benefits may require prior authorization. Please refer to the sections describing those specific benefits for more information.
SECTION II. L
PRESCRIPTION DRUGS

BENEFIT BRIEF

Prescription Drugs

- Coverage of FDA-approved prescription medications for FDA-approved indications, except Plan exclusions
- No co-payments if you are enrolled in the Member Choice Home Care Select Plan; no deductible when you use generic drugs and preferred drugs where available
- Co-payments for brand and generic drugs if you are not enrolled in the Member Choice Home Care Select Plan; no deductible when you use generic drugs and preferred drugs where available
- Use Participating Pharmacies
- Mandatory maintenance drug access program
- You must comply with the Fund's Prescription Programs. For a complete list of these programs, please call the Benefit Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

WHAT IS COVERED

The Fund covers drugs approved by the Food and Drug Administration (FDA) that:

- Have been approved for treating your specific condition
- Have been prescribed by a licensed prescriber
- Are filled by a pharmacist.

Benefits for prescriptions for FDA-approved drugs that are not approved for treatment of your condition must be submitted to the Fund office for consideration. Your doctor should provide a detailed explanation for prescribing this medication.

USING YOUR BENEFITS

To get your prescription:

- Ask your doctor to prescribe only covered medications as per the Fund’s Prescription Programs;
- Use Participating Pharmacies for short-term medications
- Show your Health Benefits ID card to the pharmacist when you give him or her your prescription.

Other than your co-payments, where applicable, there is no out-of-pocket cost for your prescriptions if you comply with the Fund’s Prescription Programs:

- Mandatory generic drug program
- Preferred Drug List
• Mandatory maintenance drug access program
• Prior authorization for specified medications
• Quantity and day supply limitations
• Step therapy
• Use of the Specialty Care Pharmacy for injectables and other drugs that require special handling.

PRESCRIPTION DRUG PROGRAMS

Generic Drugs
Generic Drugs are the same as brand-name drugs. The only major difference is the cost.

By law, generic drugs must contain the same active ingredients in the same quantities and be the same strength as the corresponding brand-name drug. Most importantly, they must meet the same FDA standards for safety and effectiveness.

When your doctor gives you a prescription:

• If there is a generic equivalent for a brand-name drug, you must get the generic drug. Otherwise, you will have to pay the difference in cost between the brand-name drug and the generic equivalent, plus your co-payment if applicable.

• If there is no generic equivalent, your prescription will be filled with the brand-name drug.

• In some situations, your doctor may specify the brand-name drug. In this case, your doctor must submit a written explanation to the Prescription Review Department for review, clinically stating why the brand-name drug is needed.

Preferred Drugs
The Fund and its Pharmacy Benefit Manager have developed a list of preferred drugs known as a Preferred Drug List (PDL).

Drugs were selected based on how well they work and their safety. All Participating Providers have been provided with a copy of the PDL. It should be used when prescription medication is required. If your doctor prescribes a brand-name drug that is not included in its preferred drug class listing, you will have to pay the difference in cost between the drug on the list and the prescribed drug plus your co-payment if applicable. If you would like a copy of the PDL, please call the Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.
**PRESCRIPTION DRUG PROGRAMS**

Prior Authorization for Specified Medications

You must get prior approval before benefits can be provided for prescriptions filled for certain medications. The Plan Administrator will periodically publish an updated listing of which drugs require prior authorization.

If your doctor prescribes any of those drugs, contact the Prior Authorization Department of the Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

**NOTE:** You may have to pay the entire cost of the prescription if you don’t get prior approval from the Fund.

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**QUANTITY AND DAY SUPPLY LIMITS**

These prescription programs are intended to monitor clinical appropriateness of utilization based upon FDA guidelines. Examples of these programs are:

**Proton Pump Inhibitors** – You must get prior approval if your doctor prescribes one of these drugs for more than a 90-day period.

**Migraine Medications** – Coverage is limited to a specific quantity. Prescriptions for these medications must be in compliance with the standards and criteria established by the FDA and accepted clinical guidelines for standard of care.

**Dose Optimization** – A program to help members have a more convenient “once per day” prescription dosing regimen whereby prescriptions written for twice-a-day dosing may be changed to once-a-day dosing.

**Personalized Medicine** – A voluntary program for members using drugs like Tamoxifen and Warfarin to help the physician determine which drug and dosage are clinically appropriate.

**Quantity Duration** – Based on FDA-recommended prescribing and safety information, the quantity duration rules help members receive the most clinically effective dosages of medication.
Specialty Care – Members must use the Specialty Care Pharmacy Program for injectables and other drugs that require special handling. Call the Benefit Fund or visit our website at www.1199SEIUBenefits.org for a listing of drugs included in this program.

Specialty Care drugs are available only through this mail delivery service.

Step Therapy – Step therapy is designed to provide safe, effective treatment while controlling prescription costs. With step therapy, you are required to try established, lower-cost, clinically appropriate alternatives before progressing to other, more costly medications, such as preferred brand names.

PROTECT YOUR CARD

Your Health Benefits ID card is for your use only. Do not leave your card with your pharmacist. Show it to the pharmacist when ordering your prescription and make sure it is returned to you before you leave the store.

If your card is lost or stolen, immediately report it to the Fund at (646) 473-9200. If you think someone is fraudulently using your card, call the Fund’s hotline at (646) 473-6148 or visit our website at www.1199SEIUBenefits.org.

USE A PARTICIPATING PHARMACY

For a listing of Participating Pharmacies, call the Fund’s Member Services Department at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org.

If you use a Non-Participating Pharmacy, you will have to:

- Pay for your prescription when it is filled
- Visit the Fund’s website at www.1199SEIUBenefits.org, or call the Benefit Fund’s Member Services Department for a Prescription Reimbursement Claim Form
- Call the Fund’s Member Services Department for a Prescription Claim Form
- Complete this form and send it, along with an itemized paid receipt for your prescription, to the address indicated on the form.

You will only be reimbursed up to the Fund’s Schedule of Allowances.
FILLING YOUR PRESCRIPTIONS

For Short-Term Illnesses

If you need medication for a short period of time, such as an antibiotic, go to your local Participating Pharmacy to have your prescription filled.

For Chronic Conditions

- The Fund’s Mandatory Maintenance Drug Access Program – The 90-Day Rx Solution

If you have a chronic condition and are required to take the same medication on a long-term basis, you must fill your prescription through the Fund’s mandatory maintenance drug access program, The 90-Day Rx Solution.

This program requires that you order medications that you take on an ongoing basis in 90-day supplies. For your convenience, your medication will be delivered directly to you at your choice of address. If you live in New York or New Jersey, you may choose to order and pick up your 90-day supply at a designated Participating Pharmacy.

If you are currently taking a maintenance medication, ask your doctor for a 90-day prescription (with 3 refills) and fill it either by:

- Mailing the prescription to the Fund’s mail order pharmacy where it will normally be delivered within eight days;

**OR**

- Taking it to one of the designated pharmacies in New York or New Jersey.

For new maintenance medications, ask your doctor for two prescriptions: one for a 30-day supply (with one refill) and another for a 90-day supply (with 3 refills) that can be filled through the maintenance drug access program once you know that the medication works for you.

Call the Fund at (646) 473-9200 or visit our website at www.1199SEIUBenefits.org for the locations of pharmacies that participate in the maintenance drug access program, for a mail order form, or to determine if the drug that you are taking is a maintenance medication.

WHAT IS NOT COVERED

- Over-the-counter drugs (except for diabetic supplies)
- Over-the-counter vitamins
- Non-prescription items, such as bandages or heating pads, even if your physician recommends them
- Prescriptions for drugs not approved by the FDA for the treatment of your condition
- Cost differentials for drugs that are not approved through the Fund’s Prescription Drug Program.
- Experimental drugs
- Non-sedating antihistamines
• Migraine medication in excess of FDA guidelines for strength, quantity and duration
• Proton pump inhibitors in excess of a 90-day supply or FDA-approved indications by diagnosis
• Medications for cosmetic purposes
• Cold and cough prescription products
• Oral erectile dysfunction agents (except for penile functional rehabilitative therapy for up to six months immediately following prostatic surgery) and
• All general exclusions listed in Section VII.D.

Some benefits may require prior authorization. Please refer to the sections describing those specific benefits for more information.
DISABILITY BENEFITS

Disability benefits are provided through the state.

While you are receiving disability benefits, you are still eligible for the same coverage you had before your disability. This coverage may continue for up to a maximum of 26 weeks within a 52-week period. You must notify the Fund when you begin to receive disability benefits through the state and submit copies of your disability payment stubs to the Fund’s Eligibility Department as proof of your continued disability.

Follow the same procedure if you are receiving Workers’ Compensation. If you need help or advice in filing a Workers’ Compensation claim, call the Fund at (646) 473-9200.

PLEASE NOTE: You cannot receive Disability benefits for any period in which you receive any other compensation, such as pension (except for active members age 70.5 or older required to commence receiving a pension benefit), payments from the Social Security Administration as a result of a Disability Award, sick leave or wages from any other employer.

WHEN YOU RETURN TO WORK

Remember to let the Fund know when you return to work after being out on a disability or Workers’ Compensation leave. This will allow the Fund to update its records to reflect that you are once again an active member.
SECTION IV – LIFE INSURANCE BENEFIT

Effective November 2007, Home Care members were no longer eligible for a Life Insurance benefit.
SECTION V – OTHER BENEFITS

A. Social Services and Member Assistance Program

Effective November 2007, Home Care members were no longer eligible for Camp or Scholarship benefits.
WHERE TO CALL

Member Assistance Program
(646) 473-6900

Call Member Assistance:
• To make an appointment to confidentially discuss a personal or family problem; or
• To get help for an alcohol or substance abuse problem.

Citizenship Program
(646) 473-8915

Call to learn about assistance available in applying for United States citizenship.

Earned Income Tax Credit Assistance
(646) 473-6890

Call to see if you are eligible for the Earned Income Tax Credit.
SECTION V. A
SOCIAL SERVICES

BENEFIT BRIEF

Member Assistance Program
• Help and referral for personal and family problems

Citizenship Program
• Assistance in applying for United States citizenship

Earned Income Tax Credit Assistance
• Tax preparation help

MEMBER ASSISTANCE PROGRAM

The Fund’s Member Assistance Program offers assistance with personal and family problems.

If you are having a problem, speak to one of the Fund’s social workers or other staff. They can try to get you the help you need to cope with a broad range of problems, including:

• Getting help for an alcohol or substance abuse problem
• Getting decent housing
• Dealing with pressure from creditors
• Dealing with domestic violence.

Call the Member Assistance Program at (646) 473-6900 for an appointment or to reach the Program for Behavioral Health.

All information is kept strictly confidential. Your confidence and privacy are respected. You don’t have to worry about someone else finding out about your problem or concern.

CITIZENSHIP PROGRAM

A program is available to assist eligible members in applying for United States citizenship. For more information on the Citizenship program, call (646) 473-9200.

EARNED INCOME TAX CREDIT ASSISTANCE PROGRAM

The Fund can connect members with certified tax preparers to help determine if they are eligible for the Earned Income Tax Credit and to file tax returns at a discounted rate. For more information, call (646) 473-9200.
SECTION VI –
RETIREE HEALTH BENEFITS
RETIREE HEALTH BENEFITS

The Fund does not provide retiree health benefits.

However, if you are eligible for Medicare Part A and Part B, live in New York City or Nassau County and are collecting a pension from the 1199SEIU Home Care Employees Pension Fund, you may be eligible to enroll in the Fund’s Medicare Advantage Program.

This program provides basic health benefits including:

• Hospital
• Medical
• Dental
• Podiatry
• Chiropractic
• Vision
• Hearing
• Prescription drugs up to an annual maximum

For detailed information on these benefits, call the Fund’s Retiree Health Benefits Office at (646) 473-8666.
SECTION VII – GETTING YOUR BENEFITS

A. Getting Your Healthcare Benefits
   • Filing a Claim
   • Initial Claim Decision
B. Your Rights Are Protected – Appeals Procedure
C. When Benefits May Be Suspended, Withheld or Denied
D. What Is Not Covered
E. Additional Provisions
RESOURCE GUIDE

WHERE TO CALL

Member Services Department
(646) 473-9200

Call Member Services:

• If you need any claim forms;
• If you have questions about completing your claim form;
• If you have any questions about what is not covered by the Fund;
• If you have any questions about the processing of your claim; or
• If you need information on appealing your claim.

You can also visit our website at www.1199SEIUBenefits.org.
SECTION VII. A
GETTING YOUR HEALTHCARE BENEFITS

PAYMENT INFORMATION FOR PARTICIPATING PROVIDERS

If you are a Participating Provider, any disputes regarding payment for services from the Fund are not “claims” subject to the U.S. Department of Labor Claims Regulations (codified at 29 C.F.R. 2560.503-1) and shall be handled under the terms set forth in your participation agreement and provider manual.

POST-SERVICE CLAIMS

Filing a Claim

A request for payment or reimbursement for benefits is called a Post-Service Care Claim or a “claim,” which may be submitted to the Fund in either electronic or paper form.

The Fund needs to receive a claim so that:

• Your doctor or healthcare provider can be paid

OR

• You can be reimbursed if you paid your doctor or healthcare provider.

If you use a Participating Provider, your doctor, hospital or healthcare provider will submit the claim to the Fund.

If you use a Non-Participating Provider you may need to submit a Claim Form to the Fund. If your provider does not have a Claim Form, you may obtain one by calling our Member Services Department at (646) 473-9200. You can also obtain a Claim Form from the “Forms” section of our website at www.1199SEIUBenefits.org. To expedite processing, your Claim Form should be submitted to the PO Box indicated on the form.

For the Fund to pay your claim to a Non-Participating Provider, you must sign an Assignment of Benefits statement. In this way, you are giving the Fund your consent to have the payment sent to your doctor, hospital or healthcare provider. However, the Fund will only pay a claim according to the Schedule of Allowances. You may be responsible for any charges over the Fund’s allowance.

NOTE: The assignment feature of the Fund is only for payment of your benefits to providers. There is no further liability for any claim by any provider or third party, and no such claims may be brought against the Fund.

If you paid your Provider and want to be reimbursed, you will need to submit a Claim Form to the Fund. If your provider does not have a Claim
Form, you may obtain one by calling our Member Services Department at (646) 473-9200. You can also obtain a Claim Form from the “Forms” section of our website at www.1199SEIUBenefits.org. Submit this form with the bill from your provider to the PO Box indicated on your Claim Form, and make sure the bill lists the amount you have paid. The Fund will only pay a claim according to the Schedule of Allowances. You may be responsible for any charges over the Fund’s allowance.

**It is very important to file your claim with the Fund promptly**

- All claims must be filed no later than 90 days after the services were provided. However, the Fund may accept claims submitted up to one year after the services were provided at the discretion of the Plan Administrator.

Claims that are late may be processed if you establish in the sole discretion of the Plan Administrator that extenuating circumstances prevented timely filing of the claim.

You may file any claim yourself, or you may designate another person as your “authorized representative” by notifying the Plan Administrator in writing of that person’s designation. In that case, all subsequent notices will be provided to you through your authorized representative.

**INITIAL CLAIM DECISION FOR POST SERVICE CLAIMS**

The Plan Administrator’s initial decision on your claim will be provided in writing no later than 30 days after the Plan Administrator receives the claim. If your claim is totally or partially denied, you will be notified of the reasons and the specific provisions of the Plan on which the decision was based. This 30-day period may be extended by the Plan Administrator for an additional 15 days due to matters beyond the Plan’s control; you will receive prior written notice of the extension. If your Claim Form is incomplete, you will be notified. You will then have 45 days to provide any additional information requested of you by the Plan Administrator. In this case, the period for resolving the claim will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information. If you fail to provide the additional information within 45 days, the initial decision on your claim will be made based on the information available to the Plan Administrator.

If your claim is totally or partially denied, you can appeal by requesting an Administrative Review. See “Administrative Review of Adverse Benefit Decision” in Section VII. B.
REQUESTS FOR BENEFITS OTHER THAN POST-SERVICE PAYMENT CLAIMS – INITIAL BENEFIT DECISION

In order to receive certain Fund benefits, you must get prior approval from the Plan Administrator. You may file a Request for Benefits yourself, or you may designate another person as your “authorized representative” by notifying the Plan Administrator in writing of that person’s designation. In that case, all subsequent notices will be provided to you through your authorized representative.

The Plan Administrator will make an initial decision on your Request for Benefits, depending on which category it falls into:

**Pre-Service Care Requests** are requests for those benefits that require Fund approval – “pre-certification” or “prior authorization” – before treatment. These include, for example, requests to pre-certify a hospital stay or an ambulatory/outpatient surgery (see Section II. B) or to authorize home nursing care or durable medical equipment (see Section II. I). In the case of requests for hospital stays or ambulatory/outpatient surgery, the Fund will have 1199SEIU CareReview, a contracted Fund Agent, review your request.

**Concurrent Care Requests** are requests to extend previously approved benefits for an ongoing course or a specific number of treatments. These include, for example, requests to receive physical/rehabilitation therapy, or visits to an allergist, podiatrist or chiropractor beyond the standard number of visits allowed by the Fund. Where possible, these requests should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought. These claims may be filed by phone or fax (see Section VII. A).

**Urgent Care Requests.** Certain Pre-Service Care or Concurrent Care Requests involve situations that have to be decided quickly because using the usual timeframes for decision-making could (i) seriously jeopardize the life or health of the patient or, (ii) in the opinion of the treating physician with knowledge of the medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment being requested. These Requests for Benefits are treated as Urgent Care Requests and include those situations commonly treated as emergencies. These claims may be filed by phone or fax. See Section II. I for requests involving hospitalization or inpatient/ambulatory surgery; see Section II. B for all other requests.
TIMEFRAMES FOR INITIAL BENEFIT DECISIONS

The Plan Administrator will provide a written decision on your initial Request for Benefits. If your request is denied, you will receive an explanation of why your benefits have been denied (or reduced) and the specific provisions of the Plan on which the decision was based. If an Urgent Care Request is denied, this information may be provided orally. A written notification will be furnished to you not later than three days after this oral notification.

Pre-Service Care Request. You or your authorized representative will be notified of the Plan Administrator’s (or 1199SEIU CareReview’s) approval or denial of your Request for Benefits no later than 15 days from the date the Fund receives the request. This 15-day period may be extended by the Plan Administrator (or 1199SEIU CareReview) for an additional 15 days due to matters beyond the Plan Administrator’s (or 1199SEIU CareReview’s) control; you will receive prior written notice of the extension. If your Request is incomplete, you will be notified within five days after it is filed. You will then have 45 days to provide any additional information requested of you by the Plan Administrator (or 1199SEIU CareReview). The period for making the benefit decision will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information. Within 45 days, the initial decision on your Request for Benefits will be made based on the information available to the Plan Administrator (or 1199SEIU CareReview).

Concurrent Care Request. You or your authorized representative generally will be notified of the Plan Administrator’s denial of your Request for Benefits sufficiently in advance of the reduction or termination of benefits to allow you to appeal and obtain a decision before the benefit is reduced or terminated (assuming that your request was filed before the end of the course of treatment for which the extension is being sought). If the request to extend the course of treatment or the number of treatments involves urgent care, the Plan Administrator will notify you of its decision, whether adverse or not, within 24 hours after receiving the request, provided that the request is made to the Fund at least 24 hours before the expiration of benefits. You will be given time to provide any additional information required to reach a decision. If you fail to provide the additional information on a timely basis, the initial decision on your Request for Benefits will be made based on the information available to the Plan Administrator.
**Urgent Care Request.** You or your authorized representative will be notified of the Plan Administrator’s approval or denial of your request as soon as possible, but in no event later than 72 hours after the Plan Administrator has received the request. If your request is incomplete, you will be notified within 24 hours. You or your authorized representative will then have 48 hours to provide the necessary information, and the Plan Administrator will notify you of its decision within 48 hours of receiving the additional information (or from the time the information was due). If you fail to provide the additional information on a timely basis, the initial decision on your Request for Benefits will be made based on the information available to the Plan Administrator.
SECTION VII. B
YOUR RIGHTS ARE PROTECTED – APPEALS PROCEDURE

If your claim or your Request for Benefits is denied, the Plan provides for two levels of appeals, as described below.

FIRST STEP – ADMINISTRATIVE REVIEW OF ADVERSE DECISION

If your claim or Request for Benefits is totally or partially denied, you may request an Administrative Review of such denial within 180 days after the receipt of the denial notice. Your request for a review must be in writing unless your request involves urgent care, in which case the request may be made orally. For hospital stays or outpatient/ambulatory procedures, the Plan Administrator will have 1199SEIU CareReview conduct the Administrative Review and appeals procedure.

NOTE: All claims by you, your spouse, your children, your beneficiaries or third parties against the Fund are subject to the Claims and Appeals Procedure. No lawsuits may be filed in any court until all steps of these procedures have been completed and the benefits requested have been denied in whole or in part.

SECOND STEP – HOSPITAL STAYS OR AMBULATORY/OUTPATIENT PROCEDURES

Non-Urgent Care Situations

If the Administrative Review by the 1199SEIU CareReview results in a denial of your Request for Benefits, you have the right to make an appeal directly to 1199SEIU CareReview. Such a request must be filed within 60 days after the receipt of the denial notice. Your request for a review must be in writing unless your claim involves urgent care, in which case the request may be made orally. If your appeal is denied by 1199SEIU CareReview, you have the right to file suit in federal court under the Employment Retirement Income Security Act (“ERISA”). You may also choose to bring a third, final appeal to the Appeals Committee of the Board of Trustees. Such requests must be filed within 60 days after the receipt of the denial notice. Your request for a review must be in writing unless your claim involves urgent care, in which case the request may be made orally. If your appeal is denied by the Appeals Committee, and you disagree with that decision, you still have the right to pursue your case under ERISA in federal court.
Urgent Care Situations

In urgent care situations regarding the prior authorization of hospital stays or ambulatory/outpatient procedures, the Administrative Review of 1199SEIU CareReview shall be final and binding on all parties. If the Administrative Review by 1199SEIU CareReview results in a denial of your Request for Benefits, you have the right to file suit in Federal Court, under ERISA.

All Other Claims or Requests for Benefits

If after the Administrative Review, your claim or Request for Benefits is totally or partially denied, you have the right to make a final appeal directly to the Appeals Committee of the Board of Trustees. Such requests must be filed within 60 days after the receipt of the denial notice. Your request for a review must be in writing unless your claim involves urgent care, in which case the request may be made orally.

WHAT YOU ARE ENTITLED TO

In connection with your right to appeal, you:

• Are entitled to submit written comments, documents, records, or any other matter relevant to your claim
• Are entitled to receive, at your request and free of charge, reasonable access to, and copies of, all relevant documents, records, and other information that was relied on in deciding your claim for benefits
• Will be given a review that takes into account all comments, documents, records and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit decision
• Will be provided with the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision
• Are entitled to have your claim reviewed by a healthcare professional retained by the Plan, if the denial was based on a medical judgment; this individual may not have participated in the initial denial
• Are entitled to a review that is conducted by a named fiduciary of the Plan who is not the person who made the benefit decision and who does not work for that person.

In the case of an Urgent Care Request, you are entitled to a fast review process in which all necessary information, including the Fund’s benefit decision on review, shall be sent to you by telephone, facsimile, or other available expeditious methods.
HOW TO REQUEST AN ADMINISTRATIVE REVIEW OR AN APPEAL TO THE APPEALS COMMITTEE OF THE BOARD OF TRUSTEES

Requests for Administrative Review of urgent care for hospitalization or ambulatory/inpatient procedures can be directed to 1199SEIU CareReview at:

- Telephone: (800) 227-9360
- Fax (Medical): (866) 623-5793
- Fax (Behavioral Health): (952) 996-2836

Requests for Administrative Review of non-urgent hospitalization or ambulatory/inpatient procedures should be sent to:

1199SEIU CareReview Program
CareAllies
1777 Sentry Park West
Dublin Hall, 4th Floor
Blue Bell, PA 19422

Requests for other Administrative Reviews and Appeals should be sent to:

1199SEIU National Benefit Fund for Home Care Employees
Claim Appeals
PO Box 646
New York, NY 10108-0646

Requests involving urgent care can be made by:

- Telephone: (646) 473-7446
- Fax: (646) 473-7447
TIMEFRAMES FOR ADMINISTRATIVE REVIEW AND APPEAL

After each step of the process (i.e., the Administrative Review, and the appeal to the Appeals Committee of the Board of Trustees), the Plan Administrator will provide you with a written decision. If your claim or your Request for Benefits is totally or partially denied, you will be given the specific reason(s) for the decision and the process, and you will be notified of the decision, according to the following timeframes:

- **Pre-Service Care Requests** – Not later than 15 days after your request for a review is received

- **Post-Service Care Claims** – Not later than 30 days after your request for a review is received

- **Urgent Care Request** – Each level of review of an Urgent Care Request shall be completed in sufficient time to ensure that the total period for completing both the Administrative Review and the appeal to the Appeals Committee of the Board of Trustees does not exceed 72 hours after your request for a review is received.

- **Concurrent Care Requests** – An appeal of a Concurrent Care Request will be treated as either an Urgent Care Request, a Pre-Service Request or a Post-Service Claim, depending on the facts.

The decision of the Appeals Committee shall be final and binding on all parties, subject to your right to file suit in federal court, under ERISA.
SECTION VII. C
WHEN BENEFITS MAY BE SUSPENDED, WITHHELD OR DENIED

It is important that you provide the Fund with all the information, documents or other material it needs to process your claim for benefits. The Fund may be unable to process your claim if you:

• Do not repay the Fund for benefits that you were not entitled to receive
• Do not sign an agreement (or comply with such an agreement) to repay the Fund in the case of legal claim against a third party
• Do not sign the Assignment of Benefits authorization when you want your benefits paid directly to your provider
• Do not allow the disclosure of medical information, medical records or other documents and information when requested by the Fund.

Benefits may be suspended, withheld or denied for the purpose of the recovery of any and all benefits paid:

• That you were not entitled to receive
• For claims that you would otherwise be entitled to until full restitution (which may include interest and expenses incurred by the Fund) has been made for any fraudulent claims that were paid by the Fund
• That were the subject of a legal claim against a third party for which a lien form was not signed and received by the Fund as required in Section I.G.
SECTION VII. D
WHAT IS NOT COVERED

In addition to the various exclusions and limitations set forth elsewhere in this booklet, the Fund does not cover:

- Charges in excess of the Fund’s Schedule of Allowances
- Charges for services provided and supplies or appliances used before you became eligible for Fund coverage
- Charges for services covered under any mandatory automobile or no-fault policy
- Charges related to any work-related accidental injuries or diseases that are covered under Workers’ Compensation or comparable law
- Charges for care resulting from an act of war
- To the extent permitted by law, charges related to an illness or injury that was deliberately self-inflicted, except where such illness or injury is attributable to a mental condition or that resulted from the person participating in an illegal act
- Charges for services or materials that do not meet the Fund’s standards of professionally recognized quality
- Charges that would not have been made if no coverage existed or charges that you were not required to pay. For example, the Fund will not pay for services provided by the member’s immediate family.
- Charges made by your provider for broken appointments
- Charges for in-hospital services that can be performed on an ambulatory or outpatient basis
- Charges for procedures, treatments, services, supplies or drugs for cosmetic purposes, except to remedy a condition that results from an accidental injury that occurred while covered by the Fund
- Charges for experimental or unproven procedures, services, treatments, supplies, devices, drugs, etc. (see Definitions, Section IX).
- Charges for services, treatments and supplies covered under any other insurance coverage or plan, or under a plan or law of any government agency or program, unless there is a legal obligation to pay
- Charges for services that are not FDA-approved for a particular condition
• Charges that are unreasonable, excessive or beyond the provider's normal billing rate or beyond their scope or specialty
• Charges for services that are not covered by the Fund, even if the service is Medically Necessary
• Charges for services that are not Medically Necessary in the judgment of the Plan Administrator (see Section VIII. C)
• Charges related to interest, late charges, finance charges, court or other legal costs
• Charges related to programs for smoke cessation, weight reduction, stress management and other similar programs that are not provided by a licensed medical physician or not Medically Necessary
• Charges for infertility treatment, including, but not limited to, in vitro fertilization, artificial insemination and reversal of sterilization
• Charges for claims submitted more than 12 months after the date of service
• Charges related to an illness or injury resulting from the conduct of another person, where payment for those charges is the legal responsibility of another person, firm, corporation, insurance company, payer, uninsured motorist fund, no-fault insurance carrier or other entity
• Charges for services that are custodial in nature
• Charges for services in excess of or not in compliance with the Fund's guidelines, policies or procedures.
• Charges that are not itemized
• Charges for over-the-counter, personal, comfort or convenience items, such as bandages or heating pads (even if your physician recommends them)
• Charges for services that are not pre-approved in accordance with the terms of the Plan
• Charges for claims containing misrepresentations or false, incomplete or misleading information
• Charges for invalid and/or obsolete CPT or HCPCS codes.
SECTION VII. E ADDITIONAL PROVISIONS

Nothing in this booklet shall be construed as creating any right in any third party to receive payment from this Fund.

Payments shall not be made to a person who is:

- A minor (under age 18)
- Unable to care for his or her affairs due to illness, injury or incapacity.

Instead, the payment shall be made to a duly appointed legal representative or to such person who, in the judgment of the Plan Administrator, is maintaining or has custody of the person entitled to payments.

No legal action may be brought against the Fund or the Trustees until all remedies under the Fund have been exhausted, including requests for Administrative Reviews or Appeals.

Payments made by the Fund that are not consistent with the Plan – as stated in this booklet or as it may be amended – must be returned to the Fund.

No benefit payable under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge (except for benefit assignments to providers).

Any action by way of anticipating, alienating, selling, pledging, encumbering or charging the same shall be void and of no effect. Nor shall any benefit be in any manner subject to the debts, contracts, liabilities, engagements or torts of the person entitled to such benefit.

Notwithstanding the foregoing, the Fund shall have the power and authority to authorize the distribution of benefits in accordance with the terms of a court order that it determines is a qualified medical child support order, as required by applicable federal law.

The Fund does not cover claims containing misrepresentations or false, incomplete or misleading information. If a false or fraudulent claim is filed, the Fund may seek full restitution plus interest and reimbursement of any expenses incurred by the Fund. In addition, the Fund may suspend the benefits to which the participant would otherwise be entitled until full restitution has been made. The Trustees reserve the right to turn any such matter over to the proper authorities for prosecution.
SECTION VIII – GENERAL INFORMATION

A.  Your ERISA Rights
B.  Plan Amendment, Modification and Termination
C.  Authority of the Plan Administrator
D.  Information on Your Plan
SECTION VIII. A  
YOUR ERISA RIGHTS

You have certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA).

GETTING INFORMATION

You have the right to:

• Examine, without charge, at the Fund office, all required Fund documents, including collective bargaining agreements, insurance contracts, detailed annual reports (Form 5500 series) and descriptions.

• Obtain copies of all required Fund documents, such as insurance contracts, collective bargaining agreements, copies of the latest annual report and Summary Plan Description, and any other Fund information by writing to the Fund Administrator. The Fund Administrator can make a reasonable charge for copies.

• Receive a summary of the Fund's Annual Financial Report. The Fund Administrator is required by law to provide each member with a copy of this Summary Annual Report. Union and Fund periodicals may be used for this purpose.

CONTINUE GROUP HEALTH COVERAGE

• Continue healthcare coverage if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

• Reduce or eliminate the exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
FIDUCIARY RESPONSIBILITY

In addition to creating rights for Fund participants, ERISA imposes duties on the people responsible for operating the Fund, called “fiduciaries.”

The fiduciaries have a responsibility to operate the Fund prudently and in the interest of all Benefit Fund members.

No one, including your employer or any other person, may fire you or discriminate against you in any way to prevent you from obtaining a benefit from this Fund or from otherwise exercising your rights under ERISA.

If your claim for benefits is entirely or partially denied:

• You must receive a written explanation of the reason for the denial, obtain copies of documents relating to the decision without charge and

• You have the right to have the Fund review and reconsider your claim, using the appeal procedure on page 102.

ENFORCING YOUR RIGHTS

Under ERISA, there are steps you can take to enforce your rights:

• If you request a copy of Plan documents or the latest annual report from the Plan and you do not receive them within 30 days, you may file suit in federal court. In this case, the court may require the Plan Administrator to provide the documents and possibly pay you up to $110 a day until you receive the materials, unless the documents were not sent because of reasons beyond the control of the Plan Administrator.

• If you have a claim for benefits that is entirely or partially denied or ignored, you may file suit in a state or federal court, after you have completed the appeals procedure (see Section VII. B), if you believe that the decision against you is arbitrary and capricious.

• If you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

• If it should happen that the Fund’s fiduciaries misuse the Fund's money or if you are discriminated against for asserting your rights, you may get help from the U.S. Department of Labor or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order that you be paid these costs and fees. If you lose, the court may require you to pay these costs and fees (for example, if it finds your claim is frivolous).

QUESTIONS?

If you have any questions about:

• Your Fund, contact the Fund office at (646) 473-9200.

• Your rights under ERISA, or if you need assistance in obtaining
documents from the Plan Administrator, contact the nearest area office of the U.S. Department of Labor Employee Benefits Security Administration, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Publications Hotline of the Employee Benefits Security Administration.
SECTION VIII. B
PLAN AMENDMENT, MODIFICATION AND TERMINATION

The Plan Administrator reserves the right, within its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of this Plan (including any related documents and underlying policies), at any time and for any reason, by action of the Board of Trustees, or any duly authorized delegate of the Board of Trustees, in such manner as may be duly authorized by the Board of Trustees.

Neither you, your beneficiaries, nor any other person have or will have a vested or non-forfeitable right to receive benefits under the Fund.
SECTION VIII. C
AUTHORITY OF THE PLAN ADMINISTRATOR

Notwithstanding any other provision in the Plan, and to the full extent permitted by ERISA and the Internal Revenue Code, the Plan Administrator shall have the exclusive right, power and authority, in its sole and absolute discretion:

- To administer, apply, construe and interpret the Plan and any related Plan documents
- To decide all matters arising in connection with entitlement to benefits, the nature, type, form, amount and duration of benefits, and the operation or administration of the Plan
- To make all factual determinations required to administer, apply, construe and interpret the Plan (and all related Plan documents).

Without limiting the generality of the statements above, the Plan Administrator shall have the ultimate discretionary authority to:

(i) Determine whether any individual is eligible for any benefits under this Plan
(ii) Determine the amount of benefits, if any, an individual is entitled to under this Plan
(iii) Interpret all of the provisions of this Plan (and all related Plan documents)
(iv) Interpret all of the terms used in this Plan
(v) Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms
(vi) Decide questions, including legal or factual questions, relating to the eligibility for, or calculation and payment of, benefits under the Plan
(vii) Resolve and/or clarify any ambiguities, inconsistencies and omissions arising, under the Plan or other related Plan documents
(viii) Process and approve or deny benefit claims and rule on any benefit exclusions.

All determinations made by the Plan Administrator (or any duly authorized designee thereof) and/or the Appeals Committee with respect to any matter arising under the Plan and any other Plan documents shall be final and binding on all parties.
SECTION VIII. D
INFORMATION ON YOUR PLAN

NAME OF THE PLAN
The 1199SEIU National Benefit Fund for Home Care Employees

TYPE OF PLAN
Taft-Hartley (Union Employer) Jointly Trusteed Employee Welfare Benefit Fund

ADDRESS
Headquarters:
330 West 42nd Street
New York, NY 10036

SOURCE OF INCOME
Payments are made to the Fund by your employer and other Contributing Employers and the state of New York, according to the collective bargaining agreements with 1199SEIU National Benefit Fund for Home Care Employees. Contribution rates are set forth in the applicable collective bargaining agreements.

You may receive a copy of any collective bargaining agreement by writing to the Fund Administrator or by examining a copy at the Fund office. You can get a complete list or find out if a particular employer or employee organization is a sponsor of the Fund by writing to the Fund office. The address of the sponsor will also be given.

ACCUMULATION OF ASSETS
The Fund’s resources are held in checking and savings accounts to pay benefits and expenses. Assets are also invested by investment managers appointed by the Home Care Trustees to whom the Home Care Trustees have delegated this fiduciary duty.

PLAN YEAR
The Fund’s fiscal year is January 1 to December 31.

PLAN ADMINISTRATOR
The Fund is self-administered and primarily self-insured. The Plan Administrator consists of the Home Care Plan Board and its duly authorized delegates and subordinates, including, but not limited to, the Executive Director, the Appeals Committee and other senior employees.

The Trustees and the Home Care Trustees may be contacted at:
c/o Executive Director
1199SEIU National Benefit Fund for Home Care Employees
330 West 42nd Street
New York, NY 10036

FOR SERVICE OF LEGAL PROCESS
Legal papers may be served on the Fund Trustees or the Fund’s counsel.

IDENTIFICATION NUMBER
Employer Identification Number:
13-4129368
Fund’s Plan Number: 501
HOME CARE TRUSTEES

The Home Care Plan Board is composed of an equal number of Union and Employer Home Care Plan Trustees. Employer Home Care Plan Trustees are elected by the Employers.

Union Home Care Trustees are chosen by the Union. The Home Care Trustees of the Fund are:

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<td>Carolyn Brooks</td>
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<td>Minerva Pena</td>
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<td>Aida Garcia</td>
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<td>Kwai (David) Ho</td>
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<td>Doris Spencer</td>
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<td>FEGS Home Attendant Services</td>
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<tr>
<td>240 East 123rd Street, 3rd Floor</td>
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<td>New York, NY 10035</td>
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<tr>
<td>Bruce McIver</td>
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<tr>
<td>President</td>
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<tr>
<td>League of Voluntary Hospitals &amp; Homes of New York</td>
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<tr>
<td>555 West 57th Street, Suite 1530</td>
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<tr>
<td>Louise Weathers</td>
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<td>Rockaway Home Attendant Services</td>
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<td>16-03 Central Avenue, Suite 100</td>
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<td>Far Rockaway, NY 11691</td>
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DEFINITIONS

Accident
An unusual, unexpected, fortuitous, unintended event causing injury for which no third party is legally responsible.

Administrative Review
The procedure to appeal a claim that the Fund has rejected or denied in part. An administrative review can be requested by you, your dependents (your spouse or children), or a provider of services that has received an Assignment of Benefits.

Ambulatory Care
Health services that do not require an overnight hospital stay. These services may be performed in the outpatient center of a hospital, surgical center, Ambulatory Care center or in the operating room at a doctor’s office.

Assignment of Benefits
1. The Fund will pay its allowance to your doctor, laboratory, etc. directly when you request it to do so by signing the Assignment of Benefits statement on your Claim Form. The Fund will pay only those benefits allowed under the Plan.
   The Fund pays the hospital directly for the inpatient and emergency room care charges allowed by the Plan.
2. See Lien/Subrogation Reimbursement Agreement.

Benefit(s)
Any of the scheduled payment(s) or services provided by the Plan.

Chiropractor
A person licensed by the appropriate department of the state to practice within the chiropractic profession for which he or she has been licensed.

Claim Form
One of the Fund forms that must be completed to request any of the benefits provided by the Plan.

COBRA Continuation Coverage
Coverage provided to a member for a temporary period under certain circumstances. The member must pay for this coverage. (See Section I. J for more detailed information.)

Contributing Employer
1. An employer who has a collective bargaining agreement with 1199SEIU United Healthcare Workers East or one of their affiliates who provides for regular monthly payments in an amount specified by the Trustees to this Fund on behalf of the employees covered by the agreement.
2. 1199SEIU United Healthcare Workers East or its affiliates, the Fund or any other employer
accepted as a contributor by the Trustees and its affiliated and related Funds that is obligated to make regular monthly payments in an amount specified by the Trustees to the Benefit Fund on behalf of its employees.

Coordination of Benefits
A method of sharing costs among payers that sets the order of payment by each. (See Section I. E for more detailed information.)

Cosmetic Surgery
Cosmetic surgery includes any procedure whose primary purpose is to improve, alter or enhance appearance. Procedures to correct a cosmetic disfigurement due to disease are not covered unless the disfigurement causes a functional impairment, or unless the surgical correction of the cosmetic disfigurement due to disease is performed in conjunction with a staged reconstructive surgical procedure to improve or restore bodily function.

Cosmetic surgery for psychological or emotional reasons is not covered when no functional impairment is present.

Custodial Care
Care is considered custodial when it is primarily for the purpose of attending to the participant’s daily living activities and could be provided by persons without professional skills or training. Examples of this include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets and supervision of medication that can be self-administered by the member.

Dentist
A person licensed by the appropriate department of the state to practice within the dental profession for which they have been licensed.

Disabled
You are temporarily unable to work due to an accident or illness. You are receiving either New York State Disability benefits or payment for lost wages and healthcare costs from Workers’ Compensation. The Fund will not provide coverage for work-related illness or injury.

Doctor
A person licensed by the appropriate department of the state to practice within the medical profession for which he or she has been licensed.

Eligible
You have met the criteria adopted by the Trustees of the Fund to determine your enrollment for benefits.
Eligible Charges
The maximum amount that the Fund recognizes as a reasonable charge for the service rendered, as set forth in the Fund’s Schedule of Allowances.

Emergency
Services provided in connection with an “emergency condition,” including screening and examination services provided to a member who requests medical treatment to determine if an emergency condition exists. The term “emergency condition” refers to a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person. Emergency care includes healthcare procedures, treatments or services, including psychiatric stabilization and medical detoxification from drugs or alcohol, that are provided for an emergency condition.

Enrollment Form
The form used to provide the Fund with the personal, employment, and beneficiary information needed to determine your benefits and process your claims.

Executive Director
The Executive Director is the person who has been authorized by the Board of Trustees to administer, apply and interpret the Plan on a day-to-day basis.

Experimental
Experimental means any treatment, procedure, facility, equipment, drug, device, or supply that does not meet any one or more of the following criteria:

i. If a drug, biological product, device or other item requires governmental approval, that item has completed the required clinical trials and has received final approval from the appropriate governmental regulatory bodies for commercial distribution for use in treating the condition being reviewed.

ii. The treatment is endorsed by an appropriate medical society.

iii. There must be scientific evidence, including peer-review literature, demonstrating that the technology improves net health outcomes in terms of efficacy, safety and reliability.

iv. The technology must be at least as beneficial as any established alternatives.
v. The improvement in net health outcome must be attainable under the usual conditions of medical practice.

**FDA**

The Food and Drug Administration, the U.S. Department of Health and Human Services agency responsible for ensuring the safety and effectiveness of all drugs, biologics, vaccines, and medical devices.

**Fiduciary**

Each of the Trustees and others responsible for directing the administration of the Fund, and their responsibilities under the law.

**Full Time**

The number of hours worked in a normal regular work week as set forth in the applicable Union contract. Overtime is not included.

**Fund or Trust Fund**

The 1199SEIU National Benefit Fund for Home Care Employees, whose principal office is located at 330 West 42nd Street in New York City.

**Habilitation Therapies**

Physical, occupational or speech therapy services that help a developmentally delayed or disabled person learn, keep or improve skills and functional abilities that they may not be developing normally.

**Health Benefits ID Card**

The card issued by the Fund to serve as identification to assist you in getting various benefits.

**Home Care Trustees**

A special Board of Trustees acting in accordance with the Trust Agreement who are responsible for the Plan of Benefits for Home Care Employees.

**Hospital**

An institution that:

- Primarily provides services to diagnose, treat and care for injured, disabled or sick patients by or under the supervision of a doctor
- Provides 24-hour nursing service with the care given or supervised by a registered professional nurse
- Maintains clinical records on all patients
- Has bylaws in effect with respect to its staff of physicians
- Has a hospital utilization review plan in effect
- Is licensed by the federal government and by the state in which the hospital is located
- Has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

The term “hospital” does not include an institution or part of an institution that is used mainly as:

- A rest or nursing facility
• A facility for the aged, chronically ill, convalescents or alcohol or drug addicts
• A facility providing custodial, psychiatric, education or rehabilitative care.

**Illness**
Sickness, disease or disorder of body or mind of such character as to affect the general soundness and the healthfulness of the system.

**Lien/Subrogation**
Reimbursement Agreement
An agreement that gives the Fund the right to recover payment for any amount it has paid or will pay arising out of, or relating to, any and all of the rights, claims, causes of action and interest that you (or your spouse or covered children) may have against any person, firm, corporation, insurance company, payor, uninsured motorist fund, no-fault insurance carrier, or other entity in regard to such injuries, expenses or losses.

**Medically Necessary**
Those services or supplies that are determined by the Plan Administrator as Medically Necessary and rendered at the appropriate level of care to evaluate, diagnose or treat the non-occupational illness, non-occupational injury or pregnancy, which a Doctor has diagnosed or reasonably suspects. To be Medically Necessary, the Plan Administrator must determine in its sole exercise of discretion that the services or supplies:

A. Are consistent with the diagnosis and treatment of the patient’s condition
B. Are clinically appropriate in terms of type, frequency and duration and are considered effective for the patient’s illness, injury or disease
C. Are in accordance with the standards of accepted medical practice
D. Are not solely for the convenience of the patient, physician and/or supplier
E. Are performed at a level of care not greater than required for the patient’s condition
F. Will result in a measurable and significant improvement related to the patient’s specific medical condition (for example, if the maximum therapeutic benefit has been met, then medical necessity cannot be established)
G. Will result in a change in diagnosis or proposed treatment plan (for example, if other procedures have already established a diagnosis, ongoing procedures are not considered Medically Necessary if their only purpose is confirmatory)
H. Are advanced therapies that have only been rendered after more conservative medical treatments have been attempted without therapeutic improvements
I. Are not maintenance or supportive care.
Medicare
The program of health insurance legislated by the federal government and administered by the Social Security Administration of the U.S. Department of Health and Human Services.

Member
An employee who is working for a Contributing Employer on whose behalf payments to the Fund are required in the contract specified by the Trustees.

Mental Health Benefits
Services for illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, or subsequent editions, regardless of etiology, and typically treated by psychiatrists, psychologists or other licensed therapists using psychotherapy and/or psychotropic drugs.

NBF-Home Care
1199SEIU National Benefit Fund for Home Care Employees.

Network
See Participating Provider.

Non-Panel or Non-Participating
A duly licensed healthcare professional or other provider who does not have any fee agreement with the Fund.

Outpatient Observation Care and Services
Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Generally, observation services are for a period of less than 48 hours and usually less than 24 hours.

Over-the-Counter
Any medication that is customarily and legally purchased without a prescription.

Panel Doctor
See Participating Provider.

Participant
An employee who is working for a Contributing Employer on whose behalf payments to the Fund are required in the contract specified by the Trustees.
Participating Pharmacy
A licensed, registered pharmacy that has signed an agreement with the Fund’s Pharmacy Benefit Manager (PBM).

Participating Provider
A duly licensed health practitioner, such as a dentist, dental specialist, physician, board-certified or board-eligible specialist, podiatrist, chiropractor, psychologist, psychiatric social worker, optician, optometrist or medical supplier who has signed an agreement with the Fund to charge no more than the Fund’s Schedule of Allowances.

Part Time
An employee who is regularly scheduled to work a number of hours per week that is less than the number of hours stipulated in the applicable Union contract for full-time employees performing the same work.

Physician
A person licensed by the appropriate department of the state to practice within the medical profession for which he or she has been licensed.

Plan
The benefits and the rules and regulations pertaining thereto for the various levels of benefits as adopted and interpreted by the Trustees and the official documents, such as the Trust Agreement and this booklet, including its preface, in which they are described.

Plan Administrator
As used in this booklet, the Board of Trustees and any individuals, such as the Executive Director, duly designated by the Trustees to carry out administrative functions.

Podiatrist
A person licensed by the appropriate department of the state to practice within the podiatric profession for which he or she has been licensed.

Prior Authorization
See Prior Approval.

Prior Approval
A requirement to submit a treatment plan or call the Fund or its agents prior to receiving treatment. This includes, but is not limited to, admissions for mental health or substance abuse, admissions for physical rehabilitation, certain prescription drugs, all non-emergency hospital admissions and surgical procedures. There may be certain penalties, as described in this booklet, if you fail to obtain prior approval.

Psychiatric Social Worker
A person licensed by the appropriate department of the state to practice within the psychiatric social work profession for which he or she has been licensed.
Psychologist
A person licensed by the appropriate department of the state to practice within the psychology profession for which he or she has been licensed.

Unemployed Member
Any employee covered by the Plan whose employment has been terminated and who immediately qualified for and continues to receive statutory unemployment insurance.

Schedule
A list of items covered and/or amounts paid.

You
As used in this booklet, the term “You” refers to the member.

Schedule of Allowances
Any one of the various fee schedules, such as medical/surgical or vision, established by the Trustees that is used to determine the amount allowed or paid by the Plan for the appropriate service, which is subject to change.

Surgeon
A person licensed by the appropriate department of the state to practice within the surgical profession for which he or she has been licensed.

Trust Agreement
The Agreement and Declaration of Trust entered into between the Union and Contributing Employers establishing the Fund.

Trustees
The Fund Trustees acting pursuant to the Agreement and Declaration Trust establishing the Fund, and any successor Trustees, duly designated in the manner set forth in the Agreement and Declaration of Trust.