1199SEIU NATIONAL BENEFIT FUND FOR HOME CARE EMPLOYEES
SUMMARY OF MATERIAL MODIFICATIONS

This Summary of Material Modifications describes changes that affect your welfare benefit plan and updates the Summary Plan Description ("SPD") and Summary of Benefits and Coverage ("SBC") that was previously distributed to you. You should keep this summary with your current SPD and SBC until the booklet is updated to reflect the changes discussed herein.

Effective on or about January 1, 2022, the 1199SEIU National Benefit Fund for Home Care Employees (the "Fund") SPD shall be amended as follows, with bolded underlined language added and the strikethrough language shall be omitted:

OVERVIEW OF YOUR BENEFITS (p. 14)
EMERGENCY DEPARTMENT 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, depending on eligibility, as described in Section II.H of this SPD.
• Use of the Emergency Department must be for a **legitimate** medical Emergency **Condition** ~~within 72 hours of an accident, injury, or the onset of a sudden and serious illness~~.

Section II- HEALTH BENEFITS
HEALTH BENEFITS RESOURCE GUIDE (p. 53)
REMINDERS
• **In most non-emergency circumstances, if** ~~If~~ you use a Non-Participating Provider, you can be billed the difference between the Benefit Fund's allowance and whatever the provider normally charges, which could result in a significant cost to you. Also, a Non-Participating Provider that appeals a benefit denial cannot file a lawsuit on your behalf more than five years from the date of service.
• Use the Emergency Department only in the case of a legitimate medical Emergency **Condition**. ~~If it is an Emergency, your Emergency Department visit must be within 72 hours of an accident, injury, or the onset of a sudden and serious illness.~~
• **You are protected from balance billing by a medical provider if you have an Emergency Condition and receive Emergency Services from a Non-Participating provider or facility. You are also protected from balance billing for certain services rendered by a Non-Participating Provider while receiving care at a Participating hospital or ambulatory surgical center, including emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.**

SECTION II. B USING YOUR BENEFITS WISELY (p. 59-60)
EMERGENCY DEPARTMENTS ARE FOR EMERGENCIES
A hospital Emergency Department should be used only in the case of a legitimate medical Emergency **Condition**. **For Emergency Services to be covered by the Plan** ~~To be considered an Emergency~~, your Emergency Department visit must meet the definition of Emergency

Condition (see Section IX) ~~and must occur within 72 hours of an accident, injury, or the onset of a sudden and serious illness~~.

SECTION II. C HOSPITAL CARE AND HOSPICE CARE
WHEN YOU NEED TO GO TO THE HOSPITAL (p. 63)
If you require services from a surgeon or an anesthesiologist, check to make sure they are a Participating Providers. Even when you go to a Participating Hospital, the ~~doctors~~ surgeons and anesthesiologists that provide services in the facility may not be participating and may charge above the Benefit Fund's allowance. In these cases, the most those providers may bill you is your in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed. If you receive other services at Participating Hospitals or other Participating facilities, Non-Participating Providers cannot balance bill you unless you give written consent and give up your protections. You're never required to give up your protections from balance billing.

SECTION II. D EMERGENCY DEPARTMENT VISITS (p. 67)
BENEFIT BRIEF
Emergency Department Visits
• ~~Use of the Emergency Department must be within 72 hours of an accident, injury, or the onset of a sudden and serious illness~~

SECTION II. F SURGERY AND ANESTHESIA (p.71)
SURGERY
If you need to go to the hospital, **you must** call 1199SEIU CareReview at (800) 227-9360 before your hospital stay **for non-Emergency care**. See Section II.B for more information.

YOUR BENEFIT IS DETERMINED BY THE TYPE OF SURGERY YOU NEED
…

Even when you go to a Participating Hospital or other Participating facility, the surgeons and anesthesiologists that provide services in the facility may not be participating and may charge above the Benefit Fund's allowance. In these cases, the most those providers may bill you is your in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.
If you receive other services at Participating Hospitals or other Participating facilities, Non-Participating Providers cannot balance bill you unless you give written consent and give up your protections. You're never required to give up your protections from balance billing.
For the names of Participating Surgeons and Anesthesiologists in your area, call the Benefit Fund's Member Services Department at (646) 473-9200.

SECTION VII. B YOUR RIGHTS ARE PROTECTED – APPEAL**S** PROCEDURE (p. 114)

If your claim or your Request for Benefits is denied, the Plan provides for two levels of appeal, **and, in certain instances, an external review appeal,** as described in this section.

3RD STEP — INDEPENDENT EXTERNAL REVIEW

Independent External Review is available only to determine whether the plan's adverse determination was correct with respect to the following types of claims: (a) medical bills for Emergency Services received from Non-Participating Providers, (b) medical bills for a Non-Participating Provider's treatment at a Participating facility, and (c) air ambulance services by Non-Participating Providers. If this organization decides to overturn our decision, we will provide coverage or payment for your healthcare item or service.

SECTION VII.D- WHAT IS NOT COVERED (pgs 119-120)
In addition to the various exclusions and limitations set forth elsewhere in this SPD, the Benefit Fund does not cover: • Charges related to programs for smoking cessation, weight reduction, **weight management**, stress management and other similar programs that are not provided by a licensed **practitioner** ~~medical physician~~ or **participating program** ~~not Medically Necessary.~~

SECTION IX –DEFINITIONS – (p. 136)
Emergency Condition
…
"Emergency Services"
Services provided in connection with an "Emergency Condition," including screening and examination services provided to a member **or their eligible dependent** who requests medical treatment to determine if an Emergency Condition exists**, as well as such further medical examination and treatment as may be required for stabilization. Emergency care may also include post-stabilization services provided in connection with the Emergency Services visit. 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.** ----------

This summary only highlights the key changes made to the 1199SEIU National Benefit Fund for Home Care Employees. Summaries of material modifications together with the Summary Plan Description make up your official plan descriptions; please keep them together and refer to them as necessary. If you would like to review the Plan Document or have any questions, please contact the Fund's Member Services Representatives at (646) 473-9200.

The 1199SEIU National Benefit Fund for Home Care Employees believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). A grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted in 2010. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for an external review process for claims appeals. However, grandfathered health plans must comply with certain other consumer protections in the

Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan can be directed to the Plan Administrator 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.

The plan sponsor of the 1199SEIU National Benefit Fund for Home Care Employees reserves the right to amend or terminate the Fund, or any part of it, at any time.