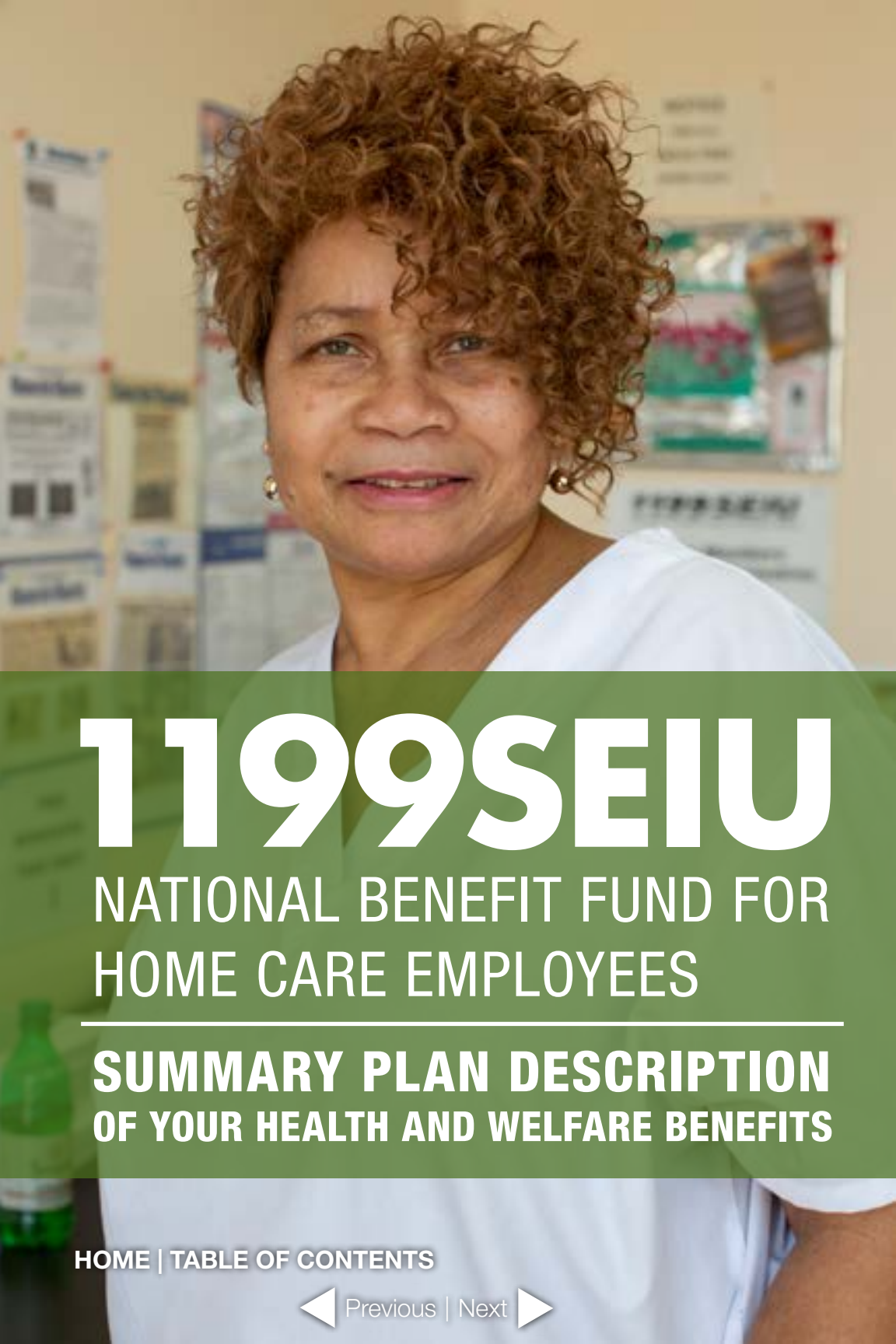

# 1199SEIU

## NATIONAL BENEFIT FUND FOR HOME CARE EMPLOYEES

# SUMMARY PLAN DESCRIPTION
## OF YOUR HEALTH AND WELFARE BENEFITS

# LANGUAGE ASSISTANCE SERVICES

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (646) 473-9200.

注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 (646) 473-9200。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (646) 473-9200.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (646) 473-9200.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다(646) 473-9200.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (646) 473-9200.

סערוויסעס פריי פון אפצאל. רופט זענען פארהאן פאר אייך שפראך הילף אויפמערקזאם: אויב איר רעדט אידיש, (646) 473-9200.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে. ফোন করুন ১ (646) 473-9200.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (646) 473-9200.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (646) 473-9200.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez (646) 473-9200.

శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషా సహాయక సేవలు ఉచితంగా లభిస్తాయి. (646) 473-9200.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (646) 473-9200.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (646) 473-9200.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në (646) 473-9200.




This booklet serves as both a Summary Plan Description ("SPD") and Plan Document for participants in the 1199SEIU National Benefit Fund for Home Care Employees employed in the metropolitan New York area and other areas covered by this Benefit 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 (the "Benefit Fund" 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 and their duly authorized designees, has any authority to interpret the provisions of this SPD or to make any promises to you about the Plan.

The 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, resolutions of the Board of Trustees, actions by the Trustees when not in session by telephone or in writing, and/or any other methods allowed for Trustee actions.

If the Plan is amended or terminated, you and other active and retired employees may not receive benefits as described in this SPD. This may happen at any time, even after you retire, if the Trustees decide to terminate the Plan or your coverage under the Plan. In no event will any active employee or retiree become entitled to any vested or otherwise non-forfeitable rights under the Plan.

The Trustees or their duly authorized designees 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 SPD and the Benefit Fund staff are your sole sources 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 Benefit Fund 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 SPD.

The 1199SEIU National Benefit Fund for Home Care Employees believes that its Eligibility Class I coverage under the Plan 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 to cover certain preventive services). 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/Agencies/EBSA. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

June 2025

**Dear 1199SEIU Member:**

Your Benefit Fund provides a wide range of benefits for eligible participants while allowing you to choose your doctor, hospital or other healthcare professionals.

This SPD is designed to make it easier for you to find the information you need and understand your rights and responsibilities under the Plan.

**It is important that you read the entire SPD so 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.

As you may know, healthcare costs have been rising every year. As costs have risen, your Benefit Fund has been looking at new opportunities and developing programs to continue providing you with coverage for primary and preventive care.

The Benefit Fund has a robust network of Participating Providers. Many providers are affiliated with institutions where you work or are located near where you live, making getting the care you need more convenient. It is important to remember: If you are Eligibility Class I, when you use a Participating Provider, including a provider in our network of participating hospitals, you and your family can receive comprehensive care at little or no cost. This SPD provides details on your coverage under the Plan.

The Benefit Fund cares about you and your family. If you have any questions or concerns about your benefits or coverage for a specific medical problem, call the Benefit Fund's Member Services Department at (646) 473-9200.

**The Board of Trustees**

## NEED HELP WITH THE SUMMARY PLAN DESCRIPTION ("SPD")?

This SPD 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, get assistance by calling the Benefit Fund at (646) 473-9200. Outside New York City, call (800) 575-7771.**

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

## ¿NECESITA AYUDA CON LA DESCRIPCIÓN ABREVIADA DEL PLAN (SUMMARY PLAN DESCRIPTION, "SPD", POR SUS SIGLAS EN INGLÉS)?

Esta SPD 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 llamando al Fondo de Beneficios al (646) 473-9200. Fuera de Nueva York, llame al (800) 575-7771.**

El horario de oficina para el Fondo es de 8:00 a.m. a 6:00 p.m., de lunes a viernes.

## У ВАС ВОЗНИКЛИ ВОПРОСЫ ПОСЛЕ ОЗНАКОМЛЕНИЯ С КРАТКИМ ОПИСАНИЕМ ВАШЕГО ИНДИВИДУАЛЬНОГО ПЕНСИОННОГО ПЛАНА (SUMMARY PLAN DESCRIPTION, SPD)?

В данном SPD содержится краткое описание ваших льгот, а также действующих политик и процедур использования этих льгот от 1199SEIU National Benefit Fund работниками по уходу на дому.

**Если у вас возникают трудности с пониманием информации, изложенной в этом документе, обратитесь за помощью, позвонив в фонд Benefit Fund по номеру (646) 473-9200. Если вы проживаете за пределами г. Нью-Йорка, звоните по номеру (800) 575-7771.**

Часы работы фонда **Benefit Fund:** с понедельника по пятницу с 8 утра до 6 вечера.

## 需要計畫摘要說明(“SPD”)的協助嗎？

本 SPD 概述了您的福利以及透過 1199SEIU 全國福利基金會家庭護理僱員使用這些福利之政策和程序。

**如果您對語言有疑問，請撥打福利基金會電話 (646) 473-9200 以尋求協助。紐約市以外地區，請撥打 (800) 575-7771。**

基金會辦公時間為星期一至星期五，上午8:00至下午6:00。

## BEZWEN ÈD AVÈK REZIME DESKRIPSYON PLAN AN (SUMMARY PLAN DESCRIPTION, SPD)?

Rezime deskripsyon plan (SPD) sa a se yon rezime avantaj ou yo ak règleman ak pwosedi yo pou itilize avantaj sa yo avèk National Fon Avantaj 1199SEIU pou Anplwaye Swen Adomisil yo.

**Si langaj la pa klè pou ou, rele Fon Avantaj pou w jwenn asistans nan (646) 473-9200. Andeyò Vil Nouyòk, rele (800) 575-7771.**

Orè biwo pou Fon lan se 8:00 am pou rive 6:00 pm, Lendi rive Vandredi.

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## NEED TO KNOW WHAT CERTAIN TERMS MEAN IN THIS SPD?

***Refer to the Definitions Section***

Section IX lists the terms used in this SPD and explains how they are defined by the Plan. Most defined terms are capitalized throughout this SPD.

Refer to Section IX if you have any questions about the meaning of specific words or phrases, such as “Disabled,” “Family,” “Contributing Employer,” etc. For example, “Family,” as used in this SPD, refers only to your children who are eligible for benefits from this Benefit Fund.

If you have any additional questions, please call the Benefit Fund’s Member Services Department at (646) 473-9200. Outside New York City, call (800) 575-7771.

# INTRODUCTION

**YOUR BENEFIT FUND**

The 1199SEIU National Benefit Fund for Home Care Employees is a self-administered, self-funded, 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.

**Self-funded** means that 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 does. It exists only to provide you and your family, and other 1199SEIU members and their families, with quality health and welfare benefits. It also means the Fund is not subject to state insurance laws. Instead, the Fund is governed by a federal law known as the Employee Retirement Income Security Act of 1974 ("ERISA") (see Section VIII.A).

**Labor-management** means the Benefit Fund is run by Trustees appointed by **1199SEIU** and by **Employers** who make payments to the Benefit Fund on behalf of their employees.

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

The Fund believes that its Eligibility Class I coverage under the Plan is a **"grandfathered health plan"** under 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 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/Agencies/EBSA. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

**Minimum essential coverage** is health coverage that the Affordable Care Act requires most people to have.

**Minimum value** is a standard of health plan benefits established under the Affordable Care Act. A health plan meets this standard if it is designed to pay at least 60% of the total cost of medical services for a standard population. Individuals who are offered Employer-sponsored minimum essential coverage that provides minimum value and is affordable won't be eligible for a premium tax credit for coverage through the Health Insurance Marketplace.

## YOUR EMPLOYER PAYS FOR YOUR BENEFITS

Your Union contract — the Collective Bargaining Agreement between your Employer and 1199SEIU — requires your Employer to make payments to the Benefit Fund on your behalf for health and welfare benefits.

The cost of your benefits is paid through contributions to the Benefit Fund by your Employer. These payments are called contributions because they go into a large pool of money used to pay for all the benefits for all 1199SEIU members and their families covered by the Plan.

Your Union dues are paid to 1199SEIU to cover the cost of running the Union — not to the Benefit Fund to cover the cost of providing health and welfare benefits.

This Benefit Fund is jointly administered together with other Benefit Funds serving people in 1199SEIU bargaining units. All these Funds are housed together and share staff, services and eligibility information. This allows your benefits to be administered efficiently.

# OVERVIEW OF YOUR BENEFITS

## IMPORTANT PHONE NUMBERS

**Member Services Department**
**(646) 473-9200**
**(Outside New York City, call (800) 575-7771.)**

For answers to questions about your benefits or to be referred to another Benefit Fund department

**Program for Behavioral Health**
**(646) 473-6900**

For mental health and Alcohol/Substance Use Disorder support

**1199SEIU CareReview Program**
**(800) 227-9360**

For Prior Authorization of hospital stays

## ONLINE RESOURCES

You can visit our website, www.1199SEIUBenefits.org, for forms, Participating Provider directories and other information. You can also visit **MyAccount**, www.My1199Benefits.org, to check your eligibility, view explanation of benefits (EOB) statements, change your address or update other information and sign up for additional benefits.

## KEY TERMS

**Member** You, the member

**Children** Your children, if eligible

**Family** You and your children, if eligible

*See Section I.A to determine if you and/or your children are eligible for benefits.*

**Important Note**

Effective January 1, 2016, your dependent children, as defined by the Plan Administrator, are eligible for the same benefits that you receive, other than life insurance and accidental death and dismemberment.

## MEDICAL BENEFITS

Members in Eligibility Class I 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 each plan are similar, the co-payments that you may pay will differ.

The Benefit Fund has no pre-existing condition exclusions. A pre-existing condition is a medical condition, illness or health problem that you had before you enrolled in the Fund.

The Fund believes that it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act").

**Your Plan Options**

As an eligible 1199SEIU Home Care member, you can choose to receive benefits through *ONE* of two plans:

**Member Choice Home Care Select Plan (Plan A):** A coordinated care plan in which you choose one Health Center—your "medical home"—for all of your primary care and medical needs. If you enroll your children, they will use the same Health Center that you use. You will have no co-payments for primary care, specialty care, hospital visits or prescription drugs. **However, if you receive primary care services from a provider other than one from your selected Health Center, you will be responsible for an office visit co-payment.**

**OR**

**Panel Provider Plan (Plan B):** A plan that provides access to more than 40,000 Participating Providers and 70 hospitals in the New York metropolitan area. Participating Providers agree to accept the Benefit Fund's schedule of payment for services and cannot bill you for additional charges. You are only responsible for making co-payments. **If you receive services from a provider who is not in the Fund's network (meaning they are *not* a Participating Provider), you will be responsible for any additional costs (beyond your co-payment) the provider may charge you.**

# OVERVIEW OF YOUR BENEFITS—ELIGIBILITY CLASS I

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

| BENEFIT | COVERAGE | COMMENTS |
|---|---|---|
| **Hospital Care** | ***Inpatient Hospital Care***<br>• 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.<br>• Up to 365 days per year<br>• Semi-private room and board<br>• Acute care for Medically Necessary services<br>• Inpatient admissions<br>• Up to 30 days per year for inpatient physical rehabilitation in an acute care facility<br>• Benefits are not provided for care in sub-acute nursing homes or Skilled Nursing Facilities | *You must call 1199SEIU CareReview at (800) 227-9360 before going to the hospital or within 48 hours of an Emergency admission.*<br><br>*Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.* |

| BENEFIT | COVERAGE | COMMENTS |
|---|---|---|
| **Hospital Care (continued)** | ***Outpatient Hospital Care***<br>• Ambulatory care<br>• Observation care and services | *Benefits are not provided for care in a nursing home or skilled nursing facility.*<br>*You must call 1199SEIU CareReview at (800) 227-9360 before going to the hospital or within 48 hours of an Emergency admission.*<br>*Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.* |
| **Hospice Care** | • Coverage for a combined total of up to 210 days per lifetime in a Medicare-certified hospice program in a hospice center, hospital, Skilled Nursing Facility or at home | *You must call 1199SEIU CareReview at (800) 227-9360 for Prior Approval of inpatient hospice care.* |
| **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, as described in Section II.H of this SPD.<br>• Use of the Emergency Department must be **for a legitimate medical Emergency Condition.** | *A co-payment may apply if you are not enrolled in the Member Choice Home Care Select Plan and if you are not admitted to the hospital.*<br>*Call the Benefit Fund at (646) 473-9200 for more information.* |

| BENEFIT | COVERAGE | COMMENTS |
|---|---|---|
| **Emergency Department Visits (continued)** | • Observation care and services (see Section II.C)<br>• Benefit Fund pays negotiated rate at Participating Hospital or reasonable charge at Non-participating Hospital | *A co-payment may apply if you are not enrolled in the Member Choice Home Care Select Plan and if you are not admitted to the hospital.*<br><br>*Call the Benefit Fund at (646) 473-9200 for more information.* |
| **Program for Behavioral Health** | ***Outpatient Care***<br>• Outpatient visits<br>***Inpatient Care***<br>• Inpatient mental health admissions<br>• Inpatient detoxification and rehabilitation<br>***Intermediate Care***<br>• Intensive outpatient programs<br>• Partial hospitalization programs<br>Note: All inpatient and intermediate care must be Pre-certified | *You must call 1199SEIU CareReview at (800) 227-9360 to pre-certify inpatient care.*<br><br>*To pre-certify PHP and IOP services, you must call the Fund at (646) 473-6868.*<br><br>*Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.* |
| **Surgery** | • Inpatient or outpatient (ambulatory) surgery<br>• Benefits based on the Fund's allowance for the surgical procedure<br>• Participating Surgeons bill the Benefit Fund directly and accept the Fund's payment as payment in full | *You must call 1199SEIU CareReview at (800) 227-9360 before having non-Emergency surgery.*<br><br>*Call the Benefit Fund at (646) 473-9200 to make sure your surgeon is a Participating Provider.* |

| BENEFIT | COVERAGE | COMMENTS |
|---|---|---|
| **Anesthesia** | • Benefits based on the Fund's Schedule of Allowances | *Call the Benefit Fund at (646) 473-9200 to make sure your anesthesiologist is a Participating Provider.* |
| **Maternity Care** | • An allowance that includes all prenatal and postnatal visits and delivery charges<br>• Hospital Benefit for the mother<br>• Hospital Benefit for the newborn, if the mother is you | *Call the Wellness Department at (646) 473-8962 to register for the Maternal Health Program.*<br><br>*Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.* |
| **Medical Services** | • Treatment in a doctor's office, clinic, hospital, Emergency Department or your home<br>• Certain screenings and immunizations<br>• X-rays and laboratory tests<br>• Hospice care<br>• Durable medical equipment and appliances<br>• Dermatology: up to 20 treatments per year<br>• Chiropractic: up to 12 treatments per year<br>• Podiatry: up to 15 treatments per year for routine care | *Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.*<br><br>*Members enrolled in the Member Choice Home Care Select Plan will have no co-payments as long as they use their chosen Health Center for all of their primary care needs.*<br><br>*Call the Benefit Fund at (646) 473-9200 for more information.* |

| BENEFIT | COVERAGE | COMMENTS |
|---|---|---|
| **Medical Services (continued)** | • Acupuncture: up to 25 visits per year, when performed by a licensed medical physician or licensed acupuncturist<br>• Allergy: up to 20 treatments per year, including diagnostic testing<br>• Physical/occupational/ speech therapy: up to 25 visits per discipline per year<br>• Ambulance services<br>• Participating Providers bill the Benefit Fund directly and accept the Fund's payment as payment in full<br>***Fertility Services***<br>• Covered for Eligibility Class I only<br>• Fertility services covered through Progyny<br>• See Section II.M for information | *Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.*<br>*Members enrolled in the Member Choice Home Care Select Plan will have no co-payments as long as they use their chosen Health Center for all of their primary care needs.*<br>*Call the Benefit Fund at (646) 473-9200 for more information.*<br>*Call Progyny at (833) 233-0431.* |
| **Telehealth Visits** | • Through telehealth, you can have an office visit by phone or video with your own Participating Provider or with the Benefit Fund's telehealth provider, who can diagnose, recommend treatment and prescribe medication for many of your medical or mental health needs | *Call the Benefit Fund at (646) 473-9200 for information on how to access the Fund's telehealth provider.* |

| BENEFIT | COVERAGE | COMMENTS |
|---|---|---|
| **Telehealth Visits *(continued)*** | • If your doctor is unavailable, use the Benefit Fund's telehealth provider for on-demand non-Emergency visits by phone or video (available 24 hours a day, 7 days a week), with doctors and pediatricians licensed in your state<br>• If you prefer to access a licensed mental health professional through the Benefit Fund's telehealth provider, you can schedule a phone or video appointment (available 7 days a week), and choose from a variety of board-certified counselors, therapists, psychologists and psychiatrists; you must be age 18 or older to use this benefit | *Call the Benefit Fund at (646) 473-9200 for information on how to access the Fund's telehealth provider.* |
| **Medical Services Requiring Prior Authorization** | • Home health care<br>• Hospital transfer ambulance services<br>• Durable medical equipment and appliances<br>• Medical supplies<br>• Specific medications, including specialty drugs<br>• MRI, MRA, PET and CAT scans and certain nuclear cardiology tests | *You must call the Prior Authorization Department at (646) 473-9200 for Prior Approval for services, except an Emergency Ambulance and the services listed below.*<br><br>*You must call eviCore healthcare at (888) 910-1199 for Prior Approval of radiological tests.* |

| BENEFIT | COVERAGE | COMMENTS |
|---|---|---|
| **Medical Services Requiring Prior Authorization *(continued)*** | • Molecular and genomic testing<br>• Radiation therapy<br>• Medical oncology services<br>• Hospice care<br>• Ambulatory surgery or inpatient admissions<br>• Certain mental health and alcohol/substance use disorder services<br>• Certain infusion drugs administered on an outpatient basis<br>• Fertility services | *You must call eviCore healthcare at (888) 910-1199 for Prior Approval of molecular and genomic testing, radiation therapy and medical oncology services.*<br><br>*Call One Call Care Management at (800) 398-8999 for a referral to a preferred radiology facility.*<br><br>*You must call 1199SEIU CareReview at (800) 227-9360 for Prior Approval of inpatient hospice care; ambulatory surgery; or inpatient admissions.*<br><br>*You must call Care Continuum at (877) 273-2122 for Prior Approval of certain infusion drugs administered on an outpatient basis.*<br><br>*For fertility services, call Progyny at (833) 233-0431.* |

| BENEFIT | COVERAGE | COMMENTS |
|---|---|---|
| **Vision Care** | • One eye exam every two years<br>• One pair of prescription glasses or one order of contact lenses every two years<br>• No out-of-pocket costs when using a Participating Provider for lenses and frames included in the Benefit Fund's vision program | *Visit www.1199SEIUBenefits.org/find-a-provider or call the Benefit Fund at (646) 473-9200 to find a Participating Provider.* |
| **Hearing Aids** | • Once every three years<br>• Co-payments may apply when using Participating Providers | *Call the Benefit Fund at (646) 473-9200 for a referral to a Participating Provider.* |
| **Basic Dental Care** | • Basic and preventive services through Participating Provider network<br>• Initial/periodic oral exams once every six months<br>• Bitewing X-rays once every six months<br>• Prophylaxis (cleaning), scaling and fluoride once every six months<br>• Dental Emergencies<br>• Minor restorative services<br>• Denture adjustments, repairs and relines | *If you do not use a Participating DentCare Provider, you will be responsible for all charges. Call DentCare at (800) 468-0600 to find a provider convenient to you.* |

| BENEFIT | COVERAGE | COMMENTS |
|---|---|---|
| **Major Dental Care** | • Major restorative work through Participating Providers<br>• Oral surgery<br>• Crowns, bridges, dentures and periodontal care once every 60-month period | *Co-payments apply.*<br>*Call DentCare at (800) 468-0600 for additional information.* |
| **Prescription Drugs** | • Coverage of FDA-approved prescription medications<br>• No co-payments if you are enrolled in the Member Choice Home Care Select Plan; use Preferred Drugs where available<br>• Co-payments for brand-name and Preferred Drugs if you are **not** enrolled in the Member Choice Home Care Select Plan; use Preferred Drugs where available<br>• Use Participating Pharmacies<br>• Prior Authorization needed for certain medications<br>• Please refer to "What Is Not Covered" in Section II.L | *For more information, visit www.1199SEIUBenefits.org/hc-prescription or call the Benefit Fund at (646) 473-9200 or (800) 575-7771.* |
| **Life Insurance** | • A benefit of $20,000 | *Life Insurance Benefit is for the member only.*<br>*Call the Benefit Fund at (646) 473-9200 for more information.* |

| BENEFIT | COVERAGE | COMMENTS |
|---|---|---|
| **Accidental Death & Dismemberment** | • For accidental death or dismemberment<br>• Equal to, or one half of, your life insurance amount, depending on the loss suffered | *Accidental Death and Dismemberment Benefit is for the member only.*<br><br>*Call the Benefit Fund at (646) 473-9200 for more information.* |
| **Social Services** | ***Wellness Member Assistance Program***<br>• Help for personal and family problems<br><br>***Wellness Program***<br>• Exercise classes<br>• Prenatal workshops | *The Wellness Member Assistance Program and Wellness Program are available to all members regardless of whether the member meets the minimum hours worked rules or pays the required weekly premium.*<br><br>*Call the Wellness Member Assistance Program at (646) 473-6900 or the Wellness Program at (646) 473-9200 for more information.* |

| BENEFIT | COVERAGE | COMMENTS |
|---|---|---|
| **Social Services *(continued)*** | ***Citizenship Program***<br>• Assistance in applying for United States citizenship | *The Citizenship Program is available to all members regardless of whether the member meets the minimum hours worked rules or pays the required weekly premium.*<br><br>*Call the Citizenship Program at (646) 473-8915 for more information.* |
| | ***Financial Wellness and Homebuyer Education Program***<br>• Help with home ownership, managing credit and financial wellness | *Call the Financial Wellness and Homebuyer Education Program at (646) 473-9200 for more information.* |
| | ***1199SEIU Legal Clinic***<br>• Access to attorneys (by appointment only) for free legal consultations regarding various personal legal matters | *Call the 1199SEIU Legal Clinic at (646) 473-6488 for more information.* |
| | ***Weekly Workers' Compensation Legal Clinic***<br>• Assistance to members suffering from a work-related injury or illness | *Call the Weekly Workers' Compensation Legal Clinic at (646) 473-6717 for more information.* |

# SECTION I – ELIGIBILITY

A. Who Is Eligible

B. When Your Coverage Begins

C. Enrolling in the Benefit Fund

D. Maximum Benefits

E. Your ID Cards

F. Coordinating Your Benefits

G. When Others Are Responsible for Your Illness or Injury

H. When You Are on Workers' Compensation Leave

I. Losing Eligibility

J. Regaining Eligibility

K. How You Can Extend Eligibility

- Coverage While Taking Disability Leave
- Coverage While Taking Family and Medical Leave
- Coverage While Taking Uniformed Services Leave
- Your COBRA Rights

L. How to Resolve Questions Concerning Eligibility for Benefits

## ELIGIBILITY RESOURCE GUIDE

### KEY CONTACTS

**Member Services Department**
**(646) 473-9200**
**(Outside New York City, call (800) 575-7771.)**

Call the Member Services Department to:

- Check whether you are eligible to receive benefits
- Find out your benefit level
- Request forms
- Update the information on your Home Care Enrollment and Plan Election Form (address, phone number, dependents, etc.)
- Notify the Benefit Fund when you change Employers
- Report errors on your ID cards
- Notify the Benefit Fund when you're on Workers' Compensation, Disability, Paid Family or FMLA Leave
- Get the answers to your questions

**COBRA Department**
**(646) 473-6815**

Call the COBRA Department to:

- Apply for COBRA continuation coverage
- Get more information on COBRA

### REMINDERS

- You must enroll in the Benefit Fund to be eligible for benefits.
- Check the information on your ID cards and notify the Benefit Fund immediately of any incorrect information.
- Fill out all forms completely and attach all required documents. Otherwise, your claim may be delayed or your benefits denied.
- Notify the Benefit Fund of any change of address, phone number, dependents, etc.
- Notify the Benefit Fund when you change Employers in order for your coverage to continue.
- To protect your benefits, contact the Benefit Fund *immediately* if you are not working due to a Workers' Compensation, Disability, Paid Family or FMLA Leave.
- Notify the Benefit Fund of any change that will affect your right to COBRA continuation coverage.
- Call the Benefit Fund if you want to continue your life insurance after your coverage ends.

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

### NO PRE-EXISTING CONDITION EXCLUSIONS

The Benefit Fund has no pre-existing condition exclusions. A **pre-existing condition** is a medical condition, illness or health problem that existed before you enrolled in the Fund.

# SECTION I. A
# WHO IS ELIGIBLE

Effective January 1, 2016, your Dependent Children, as defined by the Plan Administrator, are eligible for the same benefits you receive, other than life insurance and accidental death and dismemberment.

### YOU

You are eligible to participate in the 1199SEIU National Benefit Fund for Home Care Employees if **all** of the following conditions are met:

- You work for a Contributing Employer who is making contributions to the Benefit Fund on your behalf based on your employment for the benefits in this SPD; and
- You have completed the waiting period specific to your Employer's Collective Bargaining Agreement (which cannot exceed the limit permitted by the Affordable Care Act).

**You may also be eligible for Benefits if** you are eligible to receive Eligibility Class I COBRA Continuation Coverage and you comply with the notice requirements and make the monthly payments required to keep this coverage (see Section I.K).

### YOUR CHILDREN

If you are enrolled in Eligibility Class I coverage, your Children may be eligible up to their 26th birthday if **all** of the following conditions are met:

- They are your biological children; or
- They are your legally adopted children (coverage for legally adopted children starts from placement); or
- You are their legal parent identified on their birth certificate; and
- You have provided updated information about their coverage under other benefit plans as requested by the Fund; and
- You are eligible for Eligibility Class I coverage, based on your covered job title and hours worked (see Section I.B); and
- You have authorized the required premium deduction.

Your stepchildren, foster children and grandchildren are **not covered** by the Benefit Fund. Your Spouse's child cannot be covered by the Benefit Fund unless you are the child's legally recognized parent or the child is legally adopted by you or placed for adoption with you. If you are in Eligibility Class II, your children are not covered.

The Plan Administrator reserves the right, in its sole and absolute discretion, to determine all questions relating to the eligibility of children.

**CHILDREN WITH DISABILITIES**

If you are in Eligibility Class I and your child is disabled, as described below, coverage for your child may continue after age 26 if **all** of the following additional conditions are met:

- There is no other coverage available from either a government agency or through a special organization;
- Your child is not married;
- Your child became disabled before age 19; and
- You file a completed Disability Certification Form with the Benefit Fund each year after your child reaches age 26.

Your child is considered disabled if the Trustees determine, in their discretion, that your child lacks the ability to engage in any substantial gainful activity due to any physical or mental impairment that is verified by a physician, and the physical or mental impairment is expected to last for a continuous period of no less than 12 months or to result in death.

NOTE: To receive benefits under this Fund, you must be a participant at the time services are provided, which means you work in a "covered job title" specified by the Collective Bargaining Agreement between 1199SEIU and the agencies that contribute to the Benefit Fund. Participation in the Benefit Fund is *not* the same as Union membership. Your Union dues do not pay for your benefits.

# SECTION I. B
# WHEN YOUR COVERAGE BEGINS

Your Eligibility Class and coverage are determined by the hours you worked and your income (explained below.) Eligibility Class I or II benefits begin the first day of the month after the administrative period if both of the following requirements have been satisfied:

1. You have submitted both a completed Home Care Enrollment and Plan Election Form and the required income documentation.
2. You have agreed to pay the required weekly premium, if any, by authorizing your Employer to deduct the cost of the premium from your paycheck. The premium amount for Eligibility Class I will differ based on whether the coverage is for you alone or for you and your dependent children. For Eligibility Class II, the premium will only apply if you elect the Health Reimbursement Benefit (see Section V.B).

### ELIGIBILITY CLASS DETERMINATION

Your Eligibility Class and coverage depends on your hours worked in two previous consecutive calendar months. This two-month period is called the **determination period**. If you earn more than 100% of the Minimum Full-time Household Income and you work at least 130 hours per month during the determination period (the "130-hour rule"), you become eligible for **Eligibility Class I**. If you earn 100% of the Minimum Full-time Household Income or less and you meet the 130-hour rule, you become eligible for **Eligibility Class II**. "Hours worked" only includes the hours you physically worked for which you were paid by your Employer. "Hours worked" does not include hours for which you received sick and/or vacation pay. The one-month period between the determination period and the date of first eligibility is the **administrative period**. (Examples of Eligibility Class determination are in this section, and additional information about Eligibility Class is in Section I.D.)

The Wellness Member Assistance Program and the Citizenship Program are available to **all** bargaining unit employees of Contributing Home Care Employers regardless of whether a member meets the minimum hours criteria or pays the required weekly premium.

**EXAMPLES OF ELIGIBILITY CLASS I MINIMUM HOURS**

**Example #1**

Ms. Hernandez began working for an 1199SEIU-covered agency as a home attendant at the end of August and, in that role, earns more than 100% of the Minimum Full-time Household Income. In September, she worked only 21 hours. In October, she worked 240 hours. In November, she worked 260 hours. By November 30, Ms. Hernandez worked the required 130 hours per month for two consecutive calendar months. After December (which will serve as the one-month administrative period), she will be eligible for Eligibility Class I benefits on January 1.

**Example #2**

Ms. Hernandez began working for an 1199SEIU-covered agency as a home attendant at the end of August and, in that role, earns more than 100% of the Minimum Full-time Household Income. In September, she worked 40 hours. In October, she worked 260 hours. Even though Ms. Hernandez worked for a combined total of 300 hours over two calendar months, she did not become eligible for Eligibility Class I benefits because she worked only 40 hours in September and participation in Eligibility Class I requires working 130 hours per month for two consecutive calendar months. If Ms. Hernandez works at least 130 hours in November, then after December (which will serve as the one-month administrative period), she will be eligible for Eligibility Class I benefits on January 1.

**REGAINING ELIGIBILITY**

You may regain eligibility for Eligibility Class I benefits by working the minimum required hours per month for two consecutive calendar months; that is, by completing the determination period again. You will have the same one-month administrative period as any other newly eligible participant.

**EXAMPLE OF REGAINING ELIGIBILITY FOR ELIGIBILITY CLASS I: THE "130-HOUR RULE"**

Ms. Ruiz was a participant in the Benefit Fund through October, but did not work 130 hours in September or October, so her coverage ended November 30. Beginning in November, she was once again working 130 hours per month. By counting November and December as the determination period, and by counting January as the administrative period, Ms. Ruiz regained her eligibility in February.

# SECTION I. C
# ENROLLING IN THE BENEFIT FUND

**TO GET YOUR BENEFITS, YOU MUST FIRST ENROLL**

You must fill out a **Home Care Benefit Enrollment and Plan Election Form** (to enroll yourself), a **Home Care Dependent Child Enrollment Form** (to enroll your dependent children) and a **Home Care Life Insurance Beneficiary Selection Form** (to designate your beneficiary) and send the completed forms to the Benefit Fund before you will be eligible for benefits.

To enroll in the Benefit Fund:

1. Get these forms from the Benefit Fund. You can access the forms:
    - In the form library on our website: www.1199SEIUBenefits.org/forms;
    - Through **MyAccount**, www.My1199Benefits.org, where you can also complete and submit the forms; or
    - By calling the Member Services Department at (646) 473-9200 or (800) 575-7771.
2. Fill out the forms completely. These forms will ask for information about you and your family, including:
    - Your name
    - Your address
    - Your Social Security number
    - Your birth date
    - The names, birth dates and Social Security numbers of each eligible child you wish to enroll
    - The name and address of your designated life insurance beneficiary
    - Information on other insurance coverage
3. Sign and date the completed forms.
4. Include copies of birth certificates for you and your eligible children to be covered.
5. Return the completed forms and any related documents, including any required income documentation, as instructed on the forms (or in **MyAccount**) as soon as possible. Your *benefits cannot begin* before you submit your completed forms.

**The Benefit Fund will not be able to process your forms if you do not include all the required information and documents.** That means you may not be eligible to receive benefits.

Members have to sign forms in order to enroll their dependent children. However, a custodial parent, legal guardian or authorized state agency may apply for Fund coverage of your children, even if you do not, if the

Plan Administrator has a Qualified Medical Child Support Order (QMCSO) directing enrollment.

Once your forms have been processed, you will become eligible to receive benefits after you have worked the required amount of hours (see Sections I.A and I.B).

If you decline to enroll yourself or your dependent children when you first become eligible, you may be able to request enrollment for yourself and your dependents in this Plan within 30 days of losing eligibility for other health plan coverage you are enrolled in (not including a loss for failure to pay premiums), or of gaining a new dependent by birth, adoption or placement for adoption. You can also request enrollment 60 days following a loss of coverage under Medicaid or CHIP (Children's Health Insurance Program). To request such enrollment, complete the Home Care Benefit Enrollment Plan Election Form and submit related documents, including any required income documentation.

**LET THE BENEFIT FUND KNOW OF ANY CHANGES**

Your claims will be processed faster—and you will receive your benefits with fewer (if any) delays—if the Benefit Fund has up-to-date information on you and your family.

You must notify the Benefit Fund when:

- You move
- You get married
- You have a new baby
- Your child reaches age 26
- A family member covered by the Benefit Fund dies
- There is a change in the status of your Dependent Child(ren)
- You want to change your life insurance beneficiary
- You change Employers
- You stop working for a Contributing Employer

Fill out a **Home Care Enrollment Change Form** and send it to the Eligibility Department so that your records can be updated. You must notify the Fund within 60 days if you stop working or you risk losing your rights to continued coverage (see Sections I.J and I.K).

Remember to send copies of all required documents, including:

- Birth certificate(s), if you are adding your child(ren)
- Adoption papers, if you are adding your child(ren)
- Any other documents required by the Benefit Fund

An English translation certified to be accurate must accompany all documents not already in English.

The Eligibility Department collects Home Care Benefit Enrollment and Plan Election Forms, Home Care Dependent Child Enrollment Forms and Home Care Enrollment Change Forms on behalf of employees and to support the enrollment, disenrollment and payroll deduction functions performed by your Employer. All information appearing on your forms will be transmitted to your Employer and to the Benefit Fund on your behalf.

**NOTE:** If you have designated your spouse as your life insurance beneficiary and you later get divorced, your divorce will automatically revoke that designation upon notification of your divorce to the Benefit Fund, unless the notification indicates that your ex-spouse should remain the named beneficiary.

**NOTE ABOUT NEWBORN CHILDREN:**
To expedite payment of claims for your newborn child, you must provide the Benefit Fund with a birth certificate, Social Security number and Coordination of Benefits (other health insurance) information, if requested.

## QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Benefit Fund will comply with the terms of any Qualified Medical Child Support Order (QMCSO) as the term is defined in the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended.

The Plan Administrator will determine the qualified status of a medical child support order in accordance with the Benefit Fund's written procedures. A copy of these procedures is available, without charge, from the Benefit Fund.

# SECTION I. D
# HOW TO DETERMINE YOUR LEVEL OF BENEFITS

### ELIGIBILITY CLASSES

The Benefit Fund has two Eligibility Classes, which determine your level of benefits. Your Eligibility Class is based on these two factors:

- The hours you work
- Your income

**How is my Eligibility Class determined?**

- If you meet the **130-hour rule** (see Section I.B) and earn **more than 100%** of the Minimum Full-time Household Income, you are eligible for **Eligibility Class I**.
- If you meet the **130-hour rule** (see Section I.B) and earn **less than 100%** of the Minimum Full-time Household Income, you are eligible for **Eligibility Class II**.

### YOUR ELIGIBILITY CLASS DETERMINES WHO IS ELIGIBLE…

If you are in Eligibility Class I, you are eligible for family coverage. This means that you and your children, if eligible, can receive benefits from the Benefit Fund. Your spouse is *not* eligible for Benefit Fund Coverage. If you are in Eligibility Category II, only you (the member) can receive benefits. Your spouse and your children are not eligible for coverage from the Benefit Fund under Eligibility Class II.

### …AND WHAT BENEFITS YOU RECEIVE

Your Eligibility Class determines which benefits you and your eligible children can receive from the Benefit Fund.

See Section II of this SPD for a description of Eligibility Class I benefits. See Section V.B for a description of Eligibility Class II benefits.

You are eligible for social service benefits if you work for a Home Care Contributing Employer in a bargaining unit position, even if you are not in Eligibility Class I or II. This means you are eligible for the Wellness Member Assistance Program, BeneStream, the Financial Wellness Program and the Citizenship Program, all described in Section V.A, regardless of whether or not you meet the minimum hours worked rules and income requirements and regardless of whether or not you pay the required weekly premium.

### IF YOU WORK FOR MORE THAN ONE CONTRIBUTING EMPLOYER

Your hours from all Contributing Employers are combined to determine your Eligibility Class. However, you can receive no more than the maximum benefit allowed by the Benefit Fund's Schedule of Allowances.

## EXAMPLES OF ELIGIBILITY CLASS I MINIMUM HOURS

**Example #1**

Ms. Hernandez began working for an 1199SEIU-covered agency as a home attendant at the end of August and, in that role, earns more than 100% of the Minimum Full-time Household Income. In September, she worked only 21 hours. In October, she worked 240 hours. In November, she worked 260 hours. By November 30, Ms. Hernandez worked the required 130 hours per month for two consecutive calendar months. After December (which will serve as the one-month administrative period), she will be eligible for Eligibility Class I benefits on January 1.

**Example #2**

Ms. Hernandez began working for an 1199SEIU-covered agency as a home attendant at the end of August and, in that role, earns more than 100% of the Minimum Full-time Household Income. In September, she worked 40 hours. In October, she worked 260 hours. Even though Ms. Hernandez worked for a combined total of 300 hours over two calendar months, she did not become eligible for Eligibility Class I benefits because she worked only 40 hours in September and participation in Eligibility Class I requires working 130 hours per month for two consecutive calendar months. If Ms. Hernandez works at least 130 hours in November, then after December (which will serve as the one-month administrative period), she will be eligible for Eligibility Class I benefits on January 1.

# SECTION I. E
# YOUR ID CARDS

If you are eligible for Eligibility Class I benefits and have enrolled in the Benefit Fund, you will receive the following ID cards:

- **An 1199SEIU Health Benefits ID card** for your Medical and Prescription Benefits; and
- **A Dental Benefits ID card** for your Dental Benefit.

Call the Fund's Member Services Department at (646) 473-9200 if you have any problems with your ID cards, including:

- You do not receive your card
- Your card is lost or stolen
- Your name is not listed correctly
- Your children's names are not listed correctly

**NOTE:** If you are no longer eligible for benefits, you may not use any ID card from the Benefit Fund. If you do, you will be personally responsible for all charges.

Your ID cards are for use by you and your eligible dependents only. To help safeguard your identity, please use the unique ID number that is included on your card rather than your Social Security number when communicating with the Fund. You should not allow anyone else to use your ID cards 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 your eligible dependents and/or may initiate civil or criminal actions against you until you repay the Fund.

If you suspect that someone is using an 1199SEIU Health Benefits ID card fraudulently, call the Fund's Fraud and Abuse Hotline at (646) 473-6148.

# SECTION I. F
# COORDINATING YOUR BENEFITS

When you and your children are covered by more than one group health plan, the two plans share the cost of your family's health coverage by coordinating benefits.

Here's how it works for Eligibility Class I:

- One plan is determined to be the **primary payer.** It makes the first payment on your claim.
- The other plan is the **secondary payer.** It may pay an additional amount, according to the terms of that plan.

If the Benefit Fund is the:

- **Primary payer,** it will pay your claim in accordance with its Schedule of Allowances and the rules set forth in this SPD.
- **Secondary payer,** it will pay the balance of your claim in accordance with its Schedule of Allowances and the rules set forth in this SPD after you have submitted a statement from the other insurer indicating what the other insurer has paid. In no event will the Benefit Fund pay more than its Schedule of Allowances.

NOTE: In order to receive the health reimbursement benefit in Eligibility Class II (see Section V.B), you must have submitted a completed Home Care Enrollment and Plan election form, authorizing the premium deduction, and be enrolled in individual health insurance coverage or Medicare.

### 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 payer.** However, if you are enrolled in a plan under which coverage is limited to services provided by in-network providers only, **you must use that coverage first.**

The Benefit Fund may provide benefits for charges related to a co-payment or co-insurance. The Benefit Fund *will not* provide benefits for services denied by that payer solely based upon your failure to use in-network providers.

### WHEN YOU AND YOUR CHILD ARE COVERED BY DIFFERENT PLANS

When your child is covered by another plan or benefit coverage is available through your spouse's employer, the Benefit Fund will coordinate payment of your benefits with that plan.

**For your care:**

- The Benefit Fund is the **primary payer.** It makes the first payment on your claim.

- Your spouse's plan is the **secondary payer.** It may cover any remaining balance, according to the terms of that plan.

**For your child's care:**

- When your child is covered by another employer-sponsored plan (excluding parent coverage), that plan is the **primary payer.**
- When submitting a claim for your child's care, you must include a statement from your child's plan showing what action was taken.

### WHEN CHILDREN ARE COVERED BY BOTH PARENTS

If you and your spouse both have dependent coverage, benefits for your children are coordinated as follows:

- The **primary payer** is your child's employer-sponsored coverage through their employment, or through their spouse's employment, if any.
- The **secondary payer** is the plan of the parent whose birthday is earliest in the year.
- The other parent's plan is the **next payer.**

**If a dependent child does not have their own employer-sponsored coverage or coverage through their spouse, then the birthday rule would determine the primary payer.** For example, if the mother's birthday is March 11 and the father's birthday is July 10, the mother's plan would be the primary payer since the mother's birthday is earlier in the year.

In the case of a divorce or legal separation, these rules will continue to apply.

### WHEN YOUR CHILD IS COVERED BY AN IN-NETWORK-ONLY PLAN

If your child is enrolled in a primary plan under which coverage is limited to services provided by in-network providers only, **your child must use that coverage first.**

The Benefit Fund may provide benefits for charges related to a co-payment or co-insurance. The Benefit Fund *will not* provide benefits for services denied by another payer solely based upon your child's failure to use in-network providers.

### WHEN YOU ARE COVERED BY MEDICARE

*(Eligibility Class I only)*

The Benefit Fund is the **primary payer** for working members age 65 or older 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. Once enrolled, 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. If you have end-stage renal disease (ESRD), you *must* sign up for Medicare Part A and Part B and maintain such coverage. See below for details.

### WHEN YOU OR YOUR CHILD IS COVERED BY NO-FAULT INSURANCE

If you or your child sustain injuries in an accident involving a motor vehicle, including cars, buses, school buses, taxis and fire and police vehicles, 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, which provides for your health insurance protection, even if you or your child select secondary coverage under the motor vehicle insurance policy.

### MEDICARE AND END-STAGE RENAL DISEASE (ESRD)

A person with end-stage renal disease (ESRD) will be entitled to Medicare benefits. **Initially, during the Medicare Coordination Period, the Benefit Fund will be the primary payer of benefits. Thereafter, the Benefit Fund will be secondary to Medicare.** To protect your benefits, you must enroll in Medicare Part A and Part B during the Medicare Coordination Period, and you must maintain Medicare coverage prior to and after your transplant for as long as you are eligible for Medicare as the primary payer. The Fund will provide reimbursement for 50% of the standard Medicare Part B premium for months when the Fund is secondary to Medicare. You are **not eligible** for this reimbursement for any month in which the Fund is providing primary coverage. To get this benefit, you must file a claim form with the Benefit Fund once each quarter but no later than two years after the premium payment.

**Note:** Members who enroll *only* in Medicare Part A while they are in their Medicare Coordination Period may encounter Medicare penalties and delays in acquiring Medicare Part B upon completion of the Medicare Coordination Period. Members who fail to maintain Medicare Part A and Part B while they are eligible for Medicare as their primary payer will not be covered by the Benefit Fund.

# SECTION I. G
# WHEN OTHERS ARE RESPONSIBLE FOR YOUR ILLNESS OR INJURY

If someone else is responsible for your illness or injury (for example, because of an accident or medical malpractice), you may be able to recover money from that person or entity, their insurance company, an uninsured motorist fund, a no-fault insurance carrier or a Workers' Compensation insurance carrier.

**Expenses such as disability, hospital, medical, prescription or other services resulting from such an illness or injury 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 is disputed. Therefore, in certain cases, as a service to you, if you follow the required procedures, the Benefit Fund may advance benefit payments to you, or on your behalf, before the dispute is resolved. You must notify the Benefit Fund of any accident or injury for which someone else may be responsible. Additionally, the Benefit Fund must be notified of initiation of any lawsuit arising out of the accident or incident. You are required to provide the Benefit Fund with any and all information and to execute and deliver all necessary documents, including a completed Accident Questionnaire, as the Plan Administrator may require to enforce the Benefit Fund's rights.

When another party is responsible for an illness or injury, the Plan Administrator has the right to recovery and reimbursement of the full amount it has paid or will pay for expenses related to any claims that you may have against any person or entity as a result of the illness or injury. By accepting the Benefit Fund's health benefits in payment for such expenses, you are assigning your rights in any recovery to the Benefit Fund, and you are agreeing to hold such proceeds in trust for the Benefit Fund and to repay the Benefit Fund from those proceeds *immediately* upon receiving them, up to the amount of the payments that the Benefit Fund advanced to you or on your behalf. This means that the Benefit Fund has an equitable lien by agreement on the proceeds of any verdict or settlement reached in a lawsuit that you bring against someone for causing the illness or injury, up to the amount the Benefit Fund has paid for costs arising from that person's actions. This also means the Benefit Fund has an independent right to bring a lawsuit in connection with such an injury or

illness in your name and also has a right to intervene in any such action brought by you.

If you receive payments from or on behalf of the party responsible for an illness or injury, you agree that the Benefit Fund must be repaid *immediately*, up to the amount of the payments that the Benefit Fund advanced to you or on your behalf. The Benefit Fund's right to recover its advanced benefit payments comes before you can recover any payments you may have made. You must repay the Benefit 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 Benefit Fund's payments to pay for attorneys' fees, costs or expenses incurred to obtain payments from the responsible party. The Benefit Fund's rights provide the Benefit Fund with first priority to any and all recovery in connection with the injury or illness. The Benefit Fund has these rights without regard to whether you have been "made whole."

Once the Benefit Fund learns that another party may be responsible, you must sign a Lien Acknowledgment affirming the Benefit Fund's rights with respect to benefit payments and claims. If the Benefit Fund has advanced benefit payments to you and you fail or refuse to sign a Lien Acknowledgment or to comply with these terms, or dispute the Fund's entitlement to a lien, the Plan Administrator may suspend your eligibility for benefits or bring a court action against you to enforce the terms of the Plan.

In the event you comply with the Fund's terms and acknowledge the Fund's rights, but you dispute the Fund's Lien Determination, in whole or in part, you may request an Administrative Review of the Lien Determination by writing to the Liens Department at the Benefit Fund, provided that any proceeds you receive from a settlement, verdict or agreement for compensation from or on behalf of the party responsible for the illness or injury, up to the amount of the lien, are not disbursed for the duration of the appeal. The Fund will notify you, in writing, of the appeal decision and rationale within 30 days of receipt of the written appeal. If the Administrative Review results in a denial of your appeal, you have the right to request a final Administrative Review by the chief medical officer or their designee, in writing, no later than 60 days after receipt of the appeal denial. If your appeal is denied by the chief medical officer or their designee, you have the right to file a suit under the Employee Retirement Income Security Act of 1974 ("ERISA") only in a federal court in New York City.

**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, which provides for health insurance protection, even if you or your covered children select coverage under the motor vehicle insurance as secondary.

All remedies and appeals must be exhausted through your no-fault insurance carrier before the Benefit Fund will consider any payments on a primary basis. All payments advanced by the Benefit Fund for medical expenses resulting from a motor vehicle accident are subject to the Fund's first right of recovery described above. You are obligated to reimburse the Benefit Fund for any medical expenses 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 Benefit Fund will provide benefits, you must exhaust all of your benefits under your statutorily required no-fault insurance.

If the no-fault insurance carrier denies your claim for benefits, you are required to appeal this denial to your no-fault insurance carrier. You must provide proof to the Benefit Fund that you have exhausted the no-fault appeal process before the Benefit Fund will consider payment in accordance with its Schedule of Allowances.

# SECTION I. H
# WHEN YOU ARE ON WORKERS' COMPENSATION LEAVE

If you have a work-related illness, injury or quarantine, you are covered by workers' compensation, which is provided through your Employer. This includes coverage for healthcare costs, lost wages and lump-sum payments for permanent injuries.

**NOTE:** You must file a workers' compensation claim with your Employer as soon as possible after your injury, quarantine or illness diagnosis. Failure to do so will jeopardize your rights to workers' compensation and your benefits from the Benefit Fund for yourself and your eligible children. If you need help or advice concerning your workers' compensation claim, call the Benefit Fund at (646) 473-9200.

In most cases, the Benefit Fund **will not cover** any healthcare costs due to a work-related illness, accident or injury.

However, the Fund will continue to cover you and your children for benefits **not related to the work-related illness, accident or injury** while you are receiving Workers' Compensation Benefits, up to a maximum of 26 weeks leave within a 52-week period.

If you can't go back to work after 26 weeks, your coverage through the Fund will end (see Section I.I). However, you may be eligible to receive certain benefits under COBRA continuation coverage (see Section I.K).

**NOTIFY THE BENEFIT FUND**

In addition to notifying your Employer, you need to contact the Benefit Fund within 30 days of when you are not working due to a work-related illness, injury or quarantine. 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 Benefit Fund determines your eligibility for benefits based on hours 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. I
# LOSING ELIGIBILITY

You will no longer be eligible for 1199SEIU Benefit Fund Eligibility Class I or II benefits if you do not work the minimum required hours per month for two consecutive calendar months. For Eligibility Class I, that means working at least 130 hours in at least one of the months within the determination period. For Eligibility Class II, that means working at least 100 hours in at least one of the months within the determination period. Eligibility ends the first of the month following the month after the second consecutive month in which you did not work the minimum required hours. For example, if you do not work 130 hours in both January and February, your Eligibility Class I coverage will end April 1. However, you may be eligible to receive certain benefits under COBRA continuation coverage (see Section I.K).

You may also lose your eligibility if:

- You fail to submit the Benefit Fund's Enrollment and Plan Election Form; or
- **The Fund is advised by your Employer that your employment has been terminated (which includes retirement).** In this case, your coverage will end on the last date of your employment.

You may lose your eligibility for Eligibility Class I or for the health reimbursement benefit in Eligibility Class II if:

- Your Employer fails to remit the required weekly premium. In this case, your coverage may be terminated retroactive to the last day of the month that your payments were made; or
- You cancel your premium deduction authorization. In this case, your coverage will end on the day the Fund receives the withdrawal of the authorization.

**If your Employer continuously fails to make contributions and is excessively delinquent** in making contributions on your behalf, the Trustees have the right to terminate coverage.

If this occurs, you will be notified and your Employer may be obligated to provide health coverage through other sources.

**If the Collective Bargaining Agreement between your Employer and 1199SEIU expires,** and both of the following conditions are met, then your benefits may be terminated or reduced:

- The contribution rate paid on your behalf by your Contributing Employer is less than the rate required by the Trustees

- Your Employer does not agree to make contributions at the rate required by the Trustees

**NOTE:** If you are no longer eligible for benefits, you may not use benefits from the Benefit Fund. If you do, you will be personally responsible for all charges from the date your coverage ended.

### IF YOU ARE ON DISABILITY LEAVE, PAID FAMILY LEAVE, FAMILY MEDICAL LEAVE OR WORKERS' COMPENSATION LEAVE

Unless you return to work immediately, all of your Benefit Fund coverage will end 30 days after:

- The last day of your New York disability benefits and/or Paid Family Leave Benefits (up to a combined maximum of 26 weeks leave within a 52-week period);
- The last day of your Family Medical Leave (up to a maximum of 12 weeks leave); or
- The last day of your Workers' Compensation Benefits (up to a maximum of 26 weeks leave within a 52-week period).

However, if you are covered by Medicare as of the last day of your Leave, then there shall be no 30-day extension.

If you are unable to return to work when your Benefit Fund coverage ends, call the Benefit Fund's COBRA Department at (646) 473-6815.

See Section I.K for more information on COBRA continuation coverage.

**NOTE:** If your Benefit Fund coverage ends, it will not begin again until you return to work for a Contributing Employer (see Section I.B), regardless of the status of your employment leave.

### OTHER COVERAGE OPTIONS FOR YOU AND YOUR FAMILY

There may be other coverage options for you and your family when you lose group coverage under the Benefit Fund. **Under the Affordable Care Act, within 60 days of the date your coverage ended or during any open enrollment period, you and your family may buy health insurance through the Health Insurance Marketplace, which could be a lower-cost option.** In the Marketplace, you could be eligible for a tax subsidy that lowers your monthly premiums right away, and you can see what your premiums and out-of-pocket costs will be before you make a decision to enroll. Find more information about the Marketplace on www.HealthCare.gov.

You may also be eligible for COBRA continuation coverage. Being eligible for COBRA does not limit your eligibility for coverage or for a tax subsidy through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you

request enrollment within 30 days of the date your coverage ended.

**NOTE:** You must continue to pay the weekly premium to maintain your coverage if you are eligible to receive continued benefits while on Workers' Compensation, Disability, Paid Family or FMLA Leave.

### WHEN YOU RETURN TO WORK

If you stop working in Covered Employment and then begin working again in Covered Employment, or return to work for a Contributing Employer after the last day of an employment leave with Benefit Fund coverage within 45 days, you will have no break in your coverage.

Your Employer must let the Benefit Fund know that you have returned to work in order for your coverage to continue.

### UPON YOUR DEATH

Your covered children will continue to receive benefits:

- While you are Terminally Ill in the hospital; or
- For 30 days immediately following the date of your death.

The benefits they may receive are the same as would have been provided on the day before your death.

# SECTION I. J
# HOW YOU CAN EXTEND ELIGIBILITY

### NOTIFY THE BENEFIT FUND

You need to contact the Benefit Fund within 30 days of when you stop working due to a medical Leave. Call the 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 Benefit 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 an authorized Leave.

Remember to let the Benefit Fund know when you return to work after being out on a medical Leave. This will allow the Fund to update its records to reflect that you are once again an active member. You must also notify the Fund if you do not return to work following a Leave.

### COVERAGE WHILE TAKING DISABILITY LEAVE

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 Benefit 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. The issuance of an award by New York State may take some time, and notifying the Fund immediately helps you 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 continuation coverage. See Section I.K for more information.

**EXAMPLE OF EXTENDING ELIGIBILITY THROUGH DISABILITY**

Ms. Washington was covered by the Benefit 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. She had already worked enough hours to ensure that her eligibility would cover her through the end of May. Ms. Washington's 26-week disability extension will continue her coverage through a date in November (should her disability persist that long). To maintain eligibility, Ms. Washington would need to supply the Fund with evidence of her continued disability, such as paycheck stubs.

## COVERAGE WHILE TAKING FAMILY AND MEDICAL LEAVE

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

You are entitled to an FMLA extension if you are a member and experience an **FMLA qualifying event,** defined as:

- The birth of your child and to care for the baby within one year of birth
- When you adopt a child or become a foster parent within one year of placement
- When you need to care for your spouse, your child or your parent who has a serious health condition (but not your parent-in-law)
- When you have a serious health condition that keeps you from doing your job
- When your spouse, child 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"

FMLA defines a **serious health condition** as inclusive of 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 qualifying family and medical reasons listed in this section, you may receive up to 12 workweeks of **unpaid** leave during a 12-month period.

If you need to care for your spouse, child, parent or next of kin in the armed forces (current service members or certain veterans) who has a serious injury or illness incurred or aggravated in the line of active duty, you are eligible for up to 26 workweeks of **unpaid** FMLA Leave in a 12-month period. You are also eligible for up to 15 calendar days to spend with your military family member during their Rest and Recuperation Leave.

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.

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.

To be eligible for continued benefit coverage during your FMLA Leave, your Employer must notify the Benefit Fund that you have been approved for FMLA Leave.

**NOTE:** Your Employer — not the Fund — has the sole responsibility for determining whether you are granted leave under FMLA.

If you are eligible for leave under FMLA during the same period of time you take a Paid Family Leave or Disability Leave, depending on your Employer's policy, your leave may also be designated as FMLA Leave and, in that case, will run concurrently with Paid Family Leave or Disability Leave.

FMLA legislation was enacted to provide for temporary leave in situations in which an employee intends to return to work when their FMLA Leave 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 during which coverage was extended solely on the basis of your FMLA Leave.

**COVERAGE WHILE TAKING PAID FAMILY LEAVE**

You may continue to be covered by the Benefit Fund during your qualified Paid Family Leave, upon proper notification from your Employer, for up to 12 workweeks during a 12-month period.

**COVERAGE WHILE TAKING UNIFORMED SERVICES LEAVE**

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), if your coverage under the Benefit Fund ends because of your service in the U.S. uniformed services, your medical coverage will be reinstated for you 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 Section I.K for a full explanation of the COBRA Continuation 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: within 90 days from the date of discharge if the period of military service was more than 181 days; or within 14

days from the date of discharge if the period of military service was more than 30 days but less than 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 military service was less than 31 days. If you are hospitalized or convalescing from an injury caused by active duty, these time limits are extended for up to 24 months. Call the Benefit Fund at (646) 473-9200 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 the uniformed services.

**COVERAGE WHEN YOUR COVERAGE WOULD OTHERWISE END**

After your coverage under the Benefit Fund would otherwise end, in certain circumstances, you may continue to be covered by the Fund on a self-pay basis under the federal law commonly known as COBRA (see Section I.K).

# SECTION I. K
# YOUR COBRA RIGHTS

This section summarizes your rights and obligations regarding COBRA Continuation Coverage, if eligible. You should read it carefully. For more information, call the Benefit Fund's COBRA Department at (646) 473-6815.

Under the federal law commonly known as COBRA, you and your eligible children have the option of **extending your group health coverage.** You may extend this coverage for a limited time and only in the certain circumstances wherein group health coverage under the Benefit 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.

**COBRA Continuation Coverage is available on a self-pay basis.** This means that you and your eligible children pay monthly premiums directly to the Benefit Fund to continue your group health coverage.

If you elect to continue your coverage, you and your eligible children 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 drug coverage. However, note that life insurance and accidental death and dismemberment are **not covered** covered by COBRA continuation coverage.

A child born to you or placed for adoption with you while you are receiving COBRA continuation coverage will also be covered for benefits by the Benefit Fund. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the child's birth or adoption).

### WHEN AND HOW LONG YOU ARE COVERED

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

#### 18 Months of Coverage for You and Your Eligible Children

You and your eligible children 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
- Your employment terminates for reasons other than gross misconduct on your part

When the qualifying event is the end of employment or reduction of your hours of employment, and you became entitled to Medicare Benefits less than 18 months before the qualifying event, COBRA Continuation Coverage for your eligible children can last up to 36 months after the date of Medicare entitlement.

Being on FMLA Leave (see Section I.J) 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 Benefit Fund coverage because your Employer has filed a Title 11 bankruptcy proceeding. Please contact the Plan Administrator if this occurs.

**36 Months of Coverage for Your Eligible Children**

Under certain circumstances, your eligible children may have the right to elect COBRA Continuation Coverage for a maximum of 36 months. These include loss of coverage because:

- You die;
- Your child is no longer an eligible dependent; or
- You become entitled to Medicare.

Under federal law, you or your children are responsible for notifying the Benefit Fund within 60 days of the date your children lose (or would lose) coverage.

**EXTENDED COVERAGE**

**Second Qualifying Event Extension**

Additional qualifying events can occur while COBRA Continuation Coverage is in effect. If your family experiences another qualifying event while receiving 18 months (or in the case of a Disability Leave extension, 29 months) of COBRA Continuation Coverage, your children receiving COBRA Continuation Coverage can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Benefit Fund.

This extension may be available to your children receiving COBRA Continuation Coverage if:

- You die;
- You become entitled to Medicare; or
- Your child is no longer an eligible dependent;

but only if the additional qualifying event would have caused a loss of coverage had the initial qualifying event not occurred.

This extension due to a second qualifying event is available only if you notify the Benefit Fund of the second qualifying event within 60 days of the later of:

- The date of the second qualifying event;
- The date on which the qualified beneficiary would have lost coverage as a result of the second

qualifying event if it had occurred while the qualified beneficiary was still covered; or

- The date on which the qualified beneficiary is informed, through this SPD or the COBRA notice, of the responsibility to notify the Plan and the procedures for doing so.

**Uniformed Services Leave Extension**
If you take a leave of absence under USERRA (see Section I.J) and are on active duty for 31 days or more, you and your eligible children may have the right to elect COBRA Continuation Coverage for a maximum of 24 months while you are on active duty.

**Disability Extension**
If you or your child covered under the Benefit Fund is determined by the Social Security Administration (SSA) to be Disabled and you notify the Benefit Fund in a timely fashion, you or your child 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 or Job Security Fund continuation period, whichever is sooner, and must last at least until the end of the 18-month period of Continuation Coverage.

The continuation period will not extend past the last day of the next calendar month after the SSA determines that you or your child are no longer Disabled.

**NOTE:** If the Disabled qualified beneficiary is a child born to you or adopted by you during the initial 18-month continuation period, the child must be determined to be Disabled during the first 60 days after the child was born or adopted.

The disability extension is available only if you notify the Fund of the Social Security disability determination within 60 days of the later 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 of the responsibility to provide the Plan notice of the Social Security disability determination, but before the end of the first 18 months of COBRA Continuation Coverage.

**YOU MUST NOTIFY THE BENEFIT FUND TO OBTAIN COBRA CONTINUATION COVERAGE**

Under the law, you or your children are responsible for notifying the Benefit Fund within 60 days if your children are no longer eligible dependents.

**You** must notify the Benefit Fund at (646) 473-6815 or PO Box 1036, New York, NY 10108-1036, within 60 days of the later of:

- 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 this SPD or the COBRA notice, of the responsibility to notify the Plan and the procedures for doing so.

**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 (which includes retirement);
- You become entitled to Medicare; or
- You die.

**INFORMING YOU OF YOUR RIGHTS**

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

Each qualified beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered employees may elect COBRA Continuation Coverage on their own behalf. Parents may elect COBRA Continuation Coverage on behalf of their eligible children.

If you decide to elect COBRA Continuation Coverage, you or your children must notify the Benefit Fund of your decision, in writing, within 60 days of the date (whichever is later) that:

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

In order for your election to be timely and valid, your COBRA Election Form must be:

- Actually received by the Benefit Fund on or before the 60-day period noted in this section; **or**
- Mailed to the Benefit Fund at PO Box 1036, New York, NY 10108-1036, and postmarked on or before the 60-day period noted in this section.

If you or your dependent children do not elect COBRA Continuation Coverage in a timely manner, your group health Coverage under the Fund will end as described in Section I.I and you will lose your right to elect Continuation Coverage.

Even if you decide not to elect COBRA Continuation Coverage when you qualify, each of your children, if eligible, has a right to elect this Coverage.

There may be other Coverage options for you and your family when you lose group Coverage under the Benefit Fund. **Under the Affordable Care Act, within 60 days of the date your Coverage ended or during any open enrollment period, you and your family can buy health Coverage through the Health Insurance Marketplace, which could be a lower-cost option.** In the Marketplace, you could be eligible for a tax subsidy that lowers your monthly premiums right away. You can also see what your premiums and out-of-pocket costs will be before you make a decision to enroll. You may also be eligible for COBRA Continuation Coverage. Being eligible for COBRA does not limit your eligibility for Coverage or for a tax subsidy through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days of the date your Coverage ended.

**COST OF COBRA COVERAGE**

Each qualified beneficiary is 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-, 29- or 36-month 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 Benefit Fund is terminated;
- Your premium for your coverage is not paid on time (within any applicable grace period);
- You or your children get coverage under another group health plan that does not include a pre-existing condition clause that applies to you or your children (as applicable);
- Your end-stage renal disease (ESRD) Medicare Coordination Period ends;
- A qualified beneficiary becomes entitled to Medicare; or
- Coverage has been extended for up to 29 months due to a disability but there has been a final determination that the qualified beneficiary is no longer disabled.

Continuation Coverage may also be terminated for any reason the Benefit Fund would terminate coverage of a participant or beneficiary not receiving Continuation Coverage (such as fraud or changes in the Plan's eligibility requirements). The Plan Administrator reserves the right to end your COBRA Continuation Coverage retroactively if you are found to be ineligible for coverage.

You must notify the Benefit Fund within 30 days of any change in your Medicare, SSA or group health plan status. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. 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) 473-6815.

Remember to notify the Benefit Fund immediately if any of the following occur:

- You get married
- You get divorced or legally separated
- You move
- Your child is no longer an eligible dependent

**CONTINUING YOUR LIFE INSURANCE**

Life insurance is **not covered** by COBRA Continuation Coverage.

To continue your life insurance coverage, you may make payments directly to the insurance administrator if:

- You have been eligible for this coverage for at least one year; and
- You apply within 30 days of your Benefit Fund coverage ending.

# SECTION I. L
# 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 a misinterpretation or an underreporting of hours by Employers. Hours are reported to the Benefit Fund according to the date of a paycheck rather than the dates the work was actually performed. Often, the Fund can make adjustments upon presentation of evidence from either an Employer's (agency's) payroll office or upon examination of paycheck stubs presented by the Home Care worker.

The Benefit 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 must be sent by your Employer to:

Employer Services Unit
Eligibility Department
1199SEIU National Benefit Fund for Home Care Employees
498 Seventh Avenue
New York, NY 10018

This information may also be sent by your Employer via email to EmployerServices@1199Funds.org.

The Benefit Fund has sole authority and discretion to resolve all eligibility questions.

# SECTION II – HEALTH BENEFITS FOR ELIGIBILITY CLASS I

A. Participating Providers
   - Getting the Care You Need
   - How It Works
   - Member Choice Home Care Select

B. Using Your Benefits Wisely
   - 1199SEIU CareReview Program
   - Program for Behavioral Health
   - Emergency Departments Are for Emergencies
   - Care Management Program
   - Maternal Health Program
   - Wellness Programs

C. Hospital Care and Hospice Care

D. Emergency Department Visits

E. Program for Behavioral Health: Mental Health and Alcohol/ Substance Use Disorder

F. Surgery and Anesthesia

G. Maternity Care
   - Maternity Benefits
   - Maternal Health Program

H. Medical Services
   - Doctor Visits
   - Therapy Visits
   - Preventive Care
   - X-Ray and Laboratory Services
   - What Is Not Covered

I. Services Requiring Prior Authorization

J. Vision Care and Hearing Aids

K. Dental Benefits

L. Prescription Drugs

## HOW TO REACH THE BENEFIT FUND

Did you know you can find useful information and enroll in benefits online? You can visit our website, **www.1199SEIUBenefits.org,** for forms, directories, benefit information and more. To access information about your eligibility and claims history, enroll in and coordinate benefits for eligible dependents or update your information, go to **www.My1199Benefits.org** to log into **MyAccount.** If you have program- or department-specific questions or need prior authorization, please use the following contact information and guidelines.

### For Member Services

Call the Member Services Department at **(646) 473-9200 (outside New York City, call (800) 575-7771)** if you have any questions about your benefits, the programs or services offered by the Benefit Fund or any procedures that need to be followed.

You can also call for:

- A list of Participating Providers or Home Care Select Networks in your area
- A list of Participating Hospitals in your area
- A Schedule of Allowances for Non-participating Providers
- A list of Participating Dentists in your area
- A list of Participating Pharmacies in your area
- A list of Preferred Drugs, also known as the Preferred Drug List (PDL) or formulary

### For Prior Authorization

You must call (646) 473-9200 for Prior Authorization if:

- You require home care services
- You require certain diagnostic tests
- You need Prior Authorization for certain medications, including specialty drugs

If you have questions about the treatment your doctor is recommending, call the same number and ask to speak to a Care Management Program staff member.

**For Ambulatory/Outpatient Surgery Pre-Certification**

You must 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 the Maternal Health Program**

Register within the first three months of pregnancy by logging into **MyAccount** (www.My1199Benefits.org), calling (646) 473-8962 or emailing MaternalHealth@1199Funds.org.

**For Inpatient Hospital Stays**

You must call the 1199SEIU CareReview Program at **(800) 227-9360** to:

- Pre-certify your hospital stay **before** going to the hospital for non-Emergency care
- Notify the Fund within **two business days** of an Emergency admission
- Pre-certify inpatient and intermediate behavioral health treatment (including mental health or alcohol/substance use disorder treatment)

**For the Program for Behavioral Health**

Call **(646) 473-6900** to get help with a mental health concern or alcohol/substance use disorder.

**For the Dental Program**

Call **(800) 468-0600** to select a Participating DentCare Dentist.

**REMINDERS**

- In most non-Emergency circumstances, 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 cannot file a lawsuit on your behalf more than three years from the date of service.
- You must call 1199SEIU CareReview to Pre-certify your hospital stay before going to the hospital for non-Emergency care, or within two business days of an Emergency Admission.
- Use the emergency department only in the case of a legitimate medical Emergency Condition.
- 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.
- Show your 1199SEIU Health Benefits ID card when you go to the emergency department or when you are admitted to the hospital. The Benefit Fund will pay the hospital directly.
- Show your 1199SEIU Health Benefits ID card to the pharmacist when you have a prescription filled.
- If you are pregnant, register with the Benefit Fund's Maternal Health Program.
- You must call the Prior Authorization Department to get certain services and supplies approved **in advance.** The Benefit Fund will pay only for Medically Necessary services.

## QUALITY CARE ASSESSMENT

Your Benefit Fund is concerned about the quality of the care you and your family receive. If the Fund's medical or dental 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.

The Benefit Fund will pay only for Medically Necessary services. If the Benefit Fund determines that services provided to you were not Medically Necessary, the Fund will not pay the charges and you may be responsible for such charges.

# SECTION II. A
# PARTICIPATING PROVIDERS

### GETTING THE CARE YOU NEED

The Benefit Fund contracts with thousands of doctors, hospitals, diagnostic facilities, pharmacies, medical equipment suppliers and other healthcare professionals that provide comprehensive healthcare services (in addition to the providers in the Member Choice Home Care Select Network). In addition, the Fund has designated certain laboratory facilities (including your Member Choice hospital-based lab, if applicable), certain radiology (X-ray) facilities and certain durable medical equipment (DME) vendors as **preferred.** You must use these Participating Providers to avoid out-of-pocket expenses and to help control costs.

**Participating (or Panel) Providers:**

- Accept the Benefit Fund's payment as payment in full for most services beyond your co-payments;
- Are conveniently located near where you work or live;
- Are licensed physicians and practitioners (in almost all cases, board-certified or board-eligible in their specialty); and
- Are affiliated with highly regarded institutions throughout the area.

For the names of Participating Doctors and other healthcare providers, including lab and radiology facilities and DME vendors, in your area, visit **www.1199SEIUBenefits.org/find-a-provider** or call the Benefit Fund at (646) 473-9200.

### HOW IT WORKS

You can choose any Participating Doctor, Hospital or other healthcare provider you want for your family's care. For children, you may designate a pediatrician as the Primary Care Doctor. You and your family can receive comprehensive care at no cost to you, except for your co-payments. And, there are no claim forms for you to file.

If you need care for a non-Emergency situation and your doctor is unavailable, you can use the Benefit Fund's Telehealth Benefit to visit Participating Providers by phone or video.

You should see your Primary Care Doctor (including pediatricians for children) for regular checkups, vaccinations and other preventive care, as well as whenever you are sick.

If you have a special medical problem, talk to your Primary Care Doctor first. Your doctor can determine whether or not you need to be referred to a specialist. If you see a specialist while enrolled in the Member Choice Home Care Select Plan (Plan A), make sure

the specialist is also participating in your Member Choice Home Care Select Network in order to avoid out-of-pocket costs. If you are enrolled in the Panel Provider Plan (Plan B), make sure the specialist is a Participating Provider. This is important because if the specialist is a Non-participating Provider, you cannot be sure that the specialist will accept the Benefit Fund's allowances as payment in full. You may face a high out-of-pocket cost when using a Non-participating Provider.

You do not need a referral to see an obstetrician or gynecologist.

## MEMBER CHOICE HOME CARE SELECT (MCHCS)

### Access to Comprehensive Care

Through MCHCS, you choose one Health Center — your "medical home" — for your primary care and access the Benefit Fund's panel of Participating Providers and Participating Hospitals for all other services.

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 your primary care needs. And, there are no claim forms for you 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. Visit **www.1199SEIUBenefits.org/find-a-provider** for the list of Health Centers or call the Benefit Fund's Member Services Department at (646) 473-9200.
2. Complete the **Home Care Enrollment and Plan Election Form** and select the Health Center that you and your eligible dependents would like to use.
3. Choose a Primary Care Doctor.
4. Send your completed form to the Fund.

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

### Notes:

If you enroll your eligible dependents in health coverage through the Benefit Fund, they must be enrolled in the same plan as you. And if you are all enrolled in the MCHCS Plan, you must all use the same Health Center.

If you do not submit a Home Care Enrollment and Plan Election Form, you will be eligible to use Participating Providers only, not MCHCS providers.

**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 Benefit Fund's Participating Providers are independent practitioners who 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.

# SECTION II. B
# USING YOUR BENEFITS WISELY

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

### 1199SEIU CAREREVIEW PROGRAM

If you or a member of your family needs to go to the Hospital or requires ambulatory or outpatient surgery, **you must call the 1199SEIU CareReview Program at (800) 227-9360 to Pre-certify the following:**

- Your Hospital stay **within two business days** of an Emergency Services admission
- Your Hospital stay **before** going to the hospital for non-Emergency care
- Inpatient and intermediate mental health or alcohol/substance use disorder treatment
- Inpatient hospice care
- Inpatient physical rehabilitation in an acute care facility
- Outpatient or ambulatory surgical procedures

**Pre-certification** is a review of medical necessity of covered services only. Pre-certification of the above services does not mean you are eligible on the date of service or that a Non-participating Provider will accept the Benefit Fund's payment as payment in full.

### WHEN YOU USE NON-PARTICIPATING PROVIDERS

You can go to any doctor or hospital you choose, but 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. **You may have to pay any cost over the Benefit Fund's allowance, which could result in a significant cost to you.**

Also, a Non-participating Provider cannot file a lawsuit on your behalf more than three years from the date of service.

Before you receive services from a Non-participating Provider, you should ask the provider to find out the total Benefit Fund allowance for the planned service and notify you of what your out-of-pocket expenses will be. Non-participating Providers should call (646) 473-7160 for the schedule of allowances.

**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. They can also let you know the Benefit Fund's allowance for a planned service (meaning they can help you understand what the Benefit Fund will pay and what your out-of-pocket cost might be).

## EMERGENCY DEPARTMENTS ARE FOR EMERGENCIES

A hospital Emergency Department should be used only in case of a **legitimate medical Emergency Condition**. For Emergency Services to be covered by the Plan, your Emergency Department visit must meet the definition of Emergency Condition (see Section IX).

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

## NON-EMERGENCY TREATMENT IN AN EMERGENCY DEPARTMENT CAN BE COSTLY TO YOU

The cost of non-Emergency treatment in an Emergency Department is much higher than non-Emergency treatment in your doctor's office or a clinic, or even an urgent care center, which may be conveniently located near where you live. These urgent care centers are generally open seven days a week and have extended hours.

For non-Emergency treatment rendered in an Emergency Department, you will be responsible for the difference between some of the Benefit Fund's payment and the actual cost of the care you receive in the Emergency Department, resulting in a high out-of-pocket cost to you.

## PROGRAM FOR BEHAVIORAL HEALTH

### Mental Health and Alcohol/Substance Use Disorder

The Benefit Fund has a special program to help you and your family receive behavioral healthcare. **All calls and treatment information are kept strictly confidential.** To Pre-certify partial hospitalization program and intensive outpatient program services, you must call the Benefit Fund at (646) 473-6868.

To Pre-certify inpatient mental health or alcohol/substance use disorder treatment, you must call 1199SEIU CareReview at (800) 227-9360 before going to the hospital for inpatient care.

### Habilitative and Rehabilitative Therapies

Physical/occupational/speech therapies beyond 25 visits per discipline per year must be authorized in advance by the Plan Administrator.

## CARE MANAGEMENT PROGRAM

This program utilizes a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services required to meet a member's health needs. If you or your covered family require ongoing medical treatment from a catastrophic or severe illness or injury, including after-hospital care, the Care Management ("CM") staff may consult with your doctor and/or hospital during the planning of Medically Necessary and appropriate care. CM works with you and your doctors to optimize your treatment plan to delay the onset of complications from chronic conditions. CM aims to coordinate your care under the terms of the Plan to help 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 healthcare services provided to a member or eligible dependent. This process helps 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:

- Prospective (including Prior Authorization), review **before** services are provided;
- Concurrent, review **as services are being** provided; or
- Retrospective, review **after** services have been rendered.

## MATERNAL HEALTH 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 visits to your doctor and medical care you receive while you are pregnant.

To participate in the Benefit Fund's Maternal Health Program, register within the first three months of pregnancy. You can register by:

- Logging into **MyAccount** (www.My1199Benefits.org), navigating to the "Health" menu and selecting "Prenatal Program Registration";
- Calling (646) 473-8962; or
- Emailing MaternalHealth@1199Funds.org.

## WELLNESS PROGRAM

The Benefit Fund's Wellness Program offers worksite programs, health fairs, workshops and other wellness events (provided by Worksite Medical Services, P.C.) to help keep you and your family healthy and help you manage existing medical conditions. Visit **www.1199SEIUBenefits.org/wellness** to learn more and find

events. You may also call the Benefit Fund at (646) 473-9200 to get started.

### PREFERRED LABORATORY FACILITIES

The Benefit Fund has contracted with certain freestanding labs (in addition to Member Choice hospital-based labs, where applicable). You must use these providers to avoid additional out-of-pocket costs.

If you require lab work:

- Make sure your doctor sends your lab samples to a preferred lab; or
- Take the referral slip from your doctor to a patient care (drawing) center at one of the preferred labs if you need to have your lab work done outside of your doctor's office.

### PREFERRED RADIOLOGY (X-RAY) FACILITIES

Prior Authorization is required for certain high-end imaging tests (such as an MRI, MRA, PET scan or CAT scan) and certain nuclear cardiology tests. If your doctor prescribes one of these tests, you or your doctor must call (888) 910-1199 for Prior Authorization.

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 One Call Care Management at (800) 398-8999 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.

### RADIATION THERAPY

Prior Authorization is required for radiation therapy services. Your doctor must call (888) 910-1199.

### PREFERRED DURABLE MEDICAL EQUIPMENT (DME) VENDORS

The Plan covers rental of standard durable medical equipment such as hospital beds, wheelchairs and breast pumps. By using these vendors, you will avoid out-of-pocket costs. You must call (646) 473-9200 for Prior Authorization.

### CERTAIN OUTPATIENT LABORATORY PROCEDURES

Prior Authorization is required for certain outpatient laboratory services, such as molecular, genomic and other diagnostic tests. A list of certain outpatient laboratory procedures and tests that require Prior Authorization can be found on the Benefit Fund's website at **www.1199SEIUBenefits.org/providers/prior-authorization.** If your doctor prescribes one of these tests, they or the laboratory must request and obtain Prior Authorization. Your provider can request Prior Authorization online by visiting www.evicore.com and logging into the provider portal or over the phone by calling (888) 910-1199.

See Section II.I for more information about Prior Authorization. Other benefits may also require Prior Authorization, so please refer to the sections describing those specific benefits for more information.

# SECTION II. C
# HOSPITAL CARE AND HOSPICE CARE

**BENEFIT BRIEF**

**Inpatient Hospital Care**

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.

- Up to 365 days per year
- Acute care that is Medically Necessary
- Semi-private room and board
- Up to 30 days per year for inpatient physical rehabilitation in an acute care facility

**Outpatient Hospital Care**

- Ambulatory care
- Observation care and services

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

You must call the 1199SEIU CareReview Program at (800) 227-9360 **before** going to the hospital or **within two business days** of an Emergency admission to avoid out-of-pocket costs.

**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 per Calendar Year in a semi-private room in a Hospital if Medically Necessary to treat your medical condition. If you need Hospital care, you must:

- Call the 1199SEIU CareReview Program at (800) 227-9360; and
- Show your 1199SEIU Health Benefits ID card when you get to the Hospital.

Note: 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 Benefit Fund reviews hospital admissions. Based on this review, the Plan Administrator determines the number of days the Benefit Fund will pay for a given admission based upon the diagnosis when you are admitted and discharged. Your doctor may consult with 1199SEIU CareReview, the Benefit Fund's designated agent, 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.

**If you require services from a surgeon or an anesthesiologist, check to make sure they are a Participating Provider.** Even when you go to a Participating Hospital, 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 covered emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, 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 are never required to give up your protections from balance billing.

### 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 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
- 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.

### ACUTE INPATIENT REHABILITATION

You are covered for up to 30 days per calendar year in a hospital for Medically Necessary acute inpatient treatment. Benefits are not provided for care in a sub-acute setting, such as a nursing home or skilled nursing facility (SNF).

Your doctor must provide the Benefit Fund with a detailed written treatment plan. This plan must be reviewed and approved by 1199SEIU CareReview

before the Fund will agree to provide benefits for any rehabilitation care.

**ELECTIVE/SCHEDULED ADMISSIONS**

Before you go to the hospital, you must call 1199SEIU CareReview at (800) 227-9360.

**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 treatment as a hospital inpatient 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 Benefit Fund will reimburse the member directly for reasonable costs of 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, as well as a certified translation, if requested by the Fund.

For coverage of behavioral health partial hospitalization and intensive outpatient services, see Section II.E.

**PAYMENT TO A HOSPITAL**

The Benefit Fund has negotiated rates with many hospitals in the metropolitan New York area. These are called **Participating Hospitals.** When you go to a Participating Hospital for Medically Necessary care, the Benefit Fund will pay the hospital directly for all services. If you go to a hospital that is not a Participating Hospital for an elective admission, the Benefit 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 a large out-of-pocket cost for the balance of the hospital bill.

**WHAT IS NOT COVERED**

The Benefit Fund **does not cover:**

- Admissions for cosmetic services
- Custodial care or sub-acute care in a hospital, residential facility, nursing home, skilled nursing facility or any other institution
- Hospitalization covered under federal, state or other laws, except where otherwise required by law
- Personal or comfort items
- Private rooms
- Rest cures
- Services related to a claim filed under Workers' Compensation

- Services that are not Medically Necessary
- Services that are not pre-authorized 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.

**BENEFIT BRIEF**

**Inpatient and Outpatient Hospice Care**

- Coverage for a combined total of up to 210 days per lifetime in a Medicare-certified hospice program in a hospice center, hospital, skilled nursing facility or at home
- Life expectancy for hospice care patients is estimated to be six months or less

## HOSPICE CARE

Hospice care is a type of care and a philosophy of care that focuses on bringing comfort and relief of symptoms to patients nearing the end of life. The Benefit Fund pays for inpatient and outpatient charges made by a Hospice Care Agency and may include, but are not limited to:

- Room and board and other services and supplies received during a stay for pain control and other acute and chronic symptom management
- Services and supplies given to you on an outpatient basis
- Part-time or intermittent nursing care by an RN (registered nurse) or LPN (licensed practical nurse) for up to eight hours a day
- Part-time or intermittent home health aide services for up to eight hours a day
- Physical and occupational therapy
- Consultation or case management services by a physician

- Psychological counseling
- Respite care (care received during a period of time when your family or usual caretaker cannot attend to your needs)

**WHAT IS NOT COVERED**

Unless specified above, the following charges are **not covered** under this Benefit:

- Bereavement counseling
- Daily room and board charges over the semi-private room rate
- Financial or legal counseling, including estate planning and the drafting of a will
- Funeral arrangements
- Homemaker or caretaker services (services that are not solely related to your care; these may include, but are not limited to, transportation, maintenance of your residence or sitter or companion services)
- Pastoral counseling
- Services that were not pre-authorized (see Section II.I)

Some benefits may require Prior Authorization. Please refer to the sections describing those specific benefits for more information.

# SECTION II. D
# EMERGENCY DEPARTMENT VISITS

**BENEFIT BRIEF**

**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, as described in Section II.H.

- Benefit Fund pays negotiated rate at Participating Hospital or reasonable charge at Non-participating Hospital
- Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan and if you are not admitted to the hospital

The Benefit Fund has negotiated Emergency Department rates with many hospitals in the metropolitan New York area. **If you go to the Emergency Department of a Participating Hospital, you will have no out-of-pocket cost for the hospital's charge for the use of its facility.** (You may have a co-payment if your are not enrolled in the Member Choice Home Care Select Plan (Plan A).)

**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, your Emergency Department visit must meet the definition of Emergency Condition (see Section IX).

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

When you go to the Emergency Department, you must:

1. Show your 1199SEIU Health Benefits ID card. The Benefit Fund will pay the hospital directly.
2. Call 1199SEIU CareReview at (800) 227-9360 **within two business days** if you are admitted.

If you go to the Emergency Department in a hospital with which the Fund does not have an Emergency Department contract, you may incur out-of-pocket costs. If you have any questions about a bill for Emergency Department treatment, call the Benefit Fund's Member Services Department at (646) 473-9200.

## NON-EMERGENCY TREATMENT IN AN EMERGENCY DEPARTMENT CAN BE COSTLY TO YOU

The cost of non-Emergency treatment in an Emergency Department is much higher than non-Emergency treatment in your doctor's office or a clinic, or even an urgent care center, which may be conveniently located near where you live. Urgent care centers are generally open seven days a week and have extended hours.

For non-Emergency treatment, you will be responsible for the difference between some of the Benefit Fund's payment and the actual cost of the care you receive in the Emergency Department, resulting in a high out-of-pocket cost to you.

## CALL YOUR DOCTOR FIRST

If you are not sure whether or not you need to go to the Emergency Department:

1. Call your doctor first. Your doctor may be able to recommend treatment over the phone or have you go to the doctor's office or to the hospital.
2. If your doctor's office is closed, call your doctor's Emergency afterhours number.

If you do not have a Primary Care Doctor or cannot reach your doctor, find a Participating Provider by visiting www.1199SEIUBenefits.org/find-a-provider (available 24/7) or calling the Benefit Fund at (646) 473-9200 (available during regular business hours).

For accidents, injuries and illnesses that aren't life threatening, go to a participating urgent care center. As an alternative, you can access care from the comfort of your own home, 24 hours a day, 7 days a week, through your Telehealth Benefit. You can schedule a phone or video visit with Participating board-certified doctors and pediatricians. Visit www.1199SEIUBenefits.org/find-a-provider to get started. (This Telehealth Benefit is in addition to your Teladoc Benefit.)

# SECTION II. E
# PROGRAM FOR BEHAVIORAL HEALTH: MENTAL HEALTH AND ALCOHOL/SUBSTANCE USE DISORDER

**BENEFIT BRIEF**

**Inpatient Mental Health**

- Medically Necessary services, which may include inpatient stays and partial hospitalization programs

**Inpatient Alcohol/Substance Use Disorder**

- Medically Necessary services for inpatient detoxification and rehabilitation

**Outpatient Mental Health and Alcohol/Substance Use Disorder**

- Outpatient visits
- Intensive outpatient programs

## GET THE HELP YOU NEED

If you or a family member are struggling with stress, anxiety, relationship or family problems, emotional difficulties, work pressures or alcohol/substance use disorder, you can get help. All information is kept strictly confidential in accordance with privacy laws.

You can call the Benefit Fund's Wellness Member Assistance Program to help you and your family receive treatment for alcohol/substance use disorder or mental health problems. The Benefit Fund's social workers will discuss your problems and concerns with you and refer you to appropriate resources and licensed professionals as needed. Call the Wellness Member Assistance Program at (646) 473-6900.

You can also connect with a counselor, therapist, psychologist or psychiatrist by phone or video to get the help you need. To access this benefit, check with your Participating Provider for more information. If you are age 18 or older, you may use the Benefit Fund's telehealth provider, Teladoc, available 7 days a week.

**NOTE:** Telehealth services should not be used for Emergency medical situations.

## BEHAVIORAL HEALTH BENEFITS

Medically Necessary treatment of mental health issues and alcohol/substance use disorder are included in the Behavioral Health Program.

**Outpatient Care**

- Outpatient visits

Note: Physical/occupational/speech therapy for medical conditions associated with autism or developmental delay is also covered. See Section II.H

**Inpatient Care**

- Inpatient mental health admissions
- Inpatient detoxification and rehabilitation

**Intermediate Care**

- Intensive outpatient programs
- Partial hospitalization programs

Note: All inpatient and intermediate care must be Pre-certified

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

**PARTIAL HOSPITALIZATION PROGRAMS (PHP) AND INTENSIVE OUTPATIENT PROGRAMS (IOP) FOR MENTAL HEALTH AND ALCOHOL/ SUBSTANCE USE DISORDER**

PHPs and IOPs provide intermediate levels of coordinated care and can help prevent hospitalizations and restore maximum function in a clinically appropriate setting. To Pre-certify these services, call the Fund at (646) 473-6868.

**IF YOU NEED TO GO TO THE HOSPITAL**

If you or a member of your family need to go to the hospital, you must call 1199SEIU CareReview at (800) 227-9360:

- **Before** going to the hospital for non-Emergency care (to Pre-certify your hospital stay); or
- **Within two business days** of an Emergency admission.

If you need hospital care, 1199SEIU CareReview staff will authorize your hospital stay (if appropriate) and may refer you to the Benefit Fund for additional follow-up. In the case of an Emergency admission, you or a family member must call 1199SEIU CareReview **within two business days.**

Note: Custodial care charges for intermediate care rendered at a facility are not covered by the Fund. If you receive behavioral health services at a residential treatment center, only services that qualify as the covered services listed above will be covered.

**YOUR RIGHTS UNDER THE MENTAL HEALTH PARITY ACT**

The Benefit Fund complies with federal law, which generally requires group health plans to ensure that financial requirements and treatment limitations applicable to Mental Health or Substance Use Disorder Benefits are no more restrictive than the predominant requirements or limitations applied to Medical/ Surgical Benefits.

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; and
- In an accredited hospital, ambulatory surgical center or office-based surgery suite.

**Note:** Effective January 1, 2026, assistant surgery services are not covered, except for Emergency Care. Prior to January 1, 2026, assistant surgery services were only covered if the surgery was performed in a facility with no surgical residents.

**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

The Benefit 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.

If you use a Non-participating Provider, you could face high out-of-pocket costs. Before you receive services from a Non-participating Provider, you should ask the provider to find out the total Benefit Fund allowance for the planned service by calling (646) 473-7160 and notify you of what your out-of-pocket expenses will be.

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 covered emergency medicine, anesthesia, pathology,

radiology, laboratory, neonatology, 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 Fund's Member Services Department at (646) 473-9200.

**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, ambulatory care center or office-based surgery suite. If your procedure can be safely performed in one of these settings, you must have it performed on an ambulatory or outpatient basis, and the Benefit Fund will cover the procedure under the terms of this Plan.

If the procedure is performed in a hospital or ambulatory surgery center certified under Article 28 of the New York Public Health Law, the Benefit Fund also pays for:

- Operating room charges; and
- Ancillary hospital or ambulatory surgical center charges.

**NOTE:** The Fund does not cover operating room charges, or facility fees, to office-based surgery suites regulated under Section 230-d of the New York Public Health Law.

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

**ANESTHESIA**

The amount of reimbursement for anesthesia under the Benefit Fund's Schedule of Allowances varies depending upon:

- The type of anesthesia provided; and
- The length of time anesthesia is given.

Coverage includes:

- Anesthesiologist services;
- Supplies; and
- Use of anesthesia equipment.

Payment for local anesthesia is normally included in the Fund's surgical allowance.

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

The Benefit Fund complies with federal law related to mastectomies. If a member or dependent 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; and
- Treatment for physical complications associated with the mastectomy (including lymphedema).

### WHAT IS NOT COVERED

The Benefit Fund **will not pay** Surgical or Anesthesia Benefits if your surgery was or included:

- Covered by Workers' Compensation (see Section I.H);
- Not Medically Necessary;
- Performed primarily for cosmetic purposes, except when needed to correct gross disfigurement resulting from surgery, an illness, accident or injury;
- Related to infertility treatment for reversal of voluntary sterilization;
- Services of a type usually performed by a dentist, except certain oral surgical procedures; or
- Any general exclusions listed in Section VII.D.

In addition, services by an assistant to the surgeon performing the operation are not covered except in Emergency Care situations.

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 that includes all prenatal and postnatal visits and delivery charges
- Hospital Benefit for the mother, if the mother is you
- Hospital Benefit for the newborn, if the mother is you
- Lactation consulting by a certified provider
- Breast pump
- Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan

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

**MATERNITY BENEFITS**

**For You**

If you are the expectant mother, your Maternity Benefit includes:

- An allowance for all prenatal and postnatal clinical visits and delivery charges;
- An allowance for a total of eight prenatal and postnatal doula visits and doula support during labor and delivery;
- Anesthesia allowance;
- Hospital Benefit (See Section II.C);
- Lactation consulting by a certified provider (up to three consultations per calendar year); and
- Rental of one hospital-grade breast pump (Prior Authorization required; for details, call the Benefit Fund at (646) 473-9200); or
- Reimbursement for one electric or manual retail breast pump (prescription required; for details, call the Benefit Fund at (646) 473-9200).

**For Your Dependent Child**

If your dependent child is the expectant mother, their Maternity Benefit includes:

- An allowance for all prenatal and postnatal clinical visits and delivery charges;
- An allowance for a total of eight prenatal and postnatal doula visits and doula support during labor and delivery;
- Anesthesia allowance;
- Lactation consulting by a certified provider (up to three consultations per calendar year); and
- Rental of one hospital-grade breast pump (Prior Authorization required; for details, call the Benefit Fund at (646) 473-9200); or
- Reimbursement for one electric or manual retail breast pump (prescription required; for details, call the Benefit Fund at (646) 473-9200).

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

The Benefit Fund complies with the federal law in that:

- A mother and their newborn child are allowed to stay in the Hospital for at least 48 hours after delivery (or 96 hours after cesarean section); and
- A provider is not required to obtain authorization for prescribing these minimum lengths of stay.

However, the mother and their provider still may decide that the mother and newborn should be discharged before 48 (or 96) hours.

NOTE: Newborn children will not be covered, including for charges in connection with childbirth, unless eligible and enrolled.

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

Through the Benefit Fund's Maternal Health Program, you can get important information, take part in practical workshops and receive supportive advice. You'll also learn about making healthier choices and get tips on what to expect during your pregnancy and on caring for your baby. Learn more about the Maternal Health Program by visiting www.1199SEIUBenefits.org/maternal-health, and register for the program through **MyAccount** (www.My1199Benefits.org) or by calling (646) 473-8962.

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, Emergency Department or your home
- Certain screenings and immunizations
- Acupuncture: up to 25 visits per year when performed by a licensed medical physician or licensed acupuncturist
- Allergy: up to 20 visits per year, including up to two testing visits
- Chiropractic: up to 12 visits per year
- Dermatology: up to 20 visits per year
- Podiatry: up to 15 visits per year for routine foot care
- Physical/occupational/speech therapy: up to 25 visits per discipline per year
- X-rays and laboratory tests
- Durable medical equipment and appliances
- Hospice care
- Ambulance services
- Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan
- 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

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**

Participating Providers are doctors, labs and other health providers that are part of the Benefit Fund's Member Choice Home Care Select Plan and Panel Provider Plan. Participating Providers accept your co-payment and the Benefit Fund's allowance as payment in full. See Section II.A for more information.

**If you use a Non-participating Provider, you could face high out-of-pocket costs.** You may have to pay the difference between the Benefit Fund's allowance and whatever the provider normally charges. Before you receive services from a Non-participating Provider, you should ask the provider to find out the total Benefit Fund allowance for the planned service by calling (646) 473-7160 and notify you of what your out-of-pocket expenses will be.

## GET THE CARE YOU NEED

### Doctor Visits

You and your eligible dependents are covered for medical services provided at home or in a doctor's office, clinic, hospital or Emergency Department. You are also covered for Telehealth and videoconferencing visits with Participating Providers.

A licensed medical provider must provide your care. Specialists must be board-certified or board-eligible in their area of specialty.

For accidents, injuries and illnesses that don't need to be treated immediately, make an appointment with a Participating Doctor's office.If your doctor is unavailable, you can use the Benefit Fund's Telehealth provider to visit board-certified doctors, including pediatricians, by phone or video, 24 hours a day, 7 days a week. For accidents, injuries and illnesses that need to be treated right away but are not life threatening, go to your doctor. If your doctor is not available, go to a participating urgent care center. To find a participating urgent care center, visit **www.1199SEIUBenefits.org/find-a-provider.**

**NOTE:** Telehealth should not be used for Emergency medical situations.

### Specialist and Therapy Visits

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

- **Acupuncture:** up to 25 visits per year when performed by a licensed medical physician or licensed acupuncturist
- **Allergy:** up to 20 visits per year, including up to two testing visits
- **Chiropractic:** up to 12 visits per year
- **Dermatology:** up to 20 visits per year
- **Podiatry:** up to 15 visits per year for routine foot care
- **Physical/occupational/speech therapy:** up to 25 visits per discipline per year; includes Habilitative and Rehabilitative Services.

If it is determined by the Benefit Fund 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 **authorized in advance** by the Plan Administrator. Habilitative Services provided in an educational setting are **not covered.**

## PREVENTIVE CARE

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

- **Periodic checkups**
  Through regular exams, your doctor is better able to detect problems early, when they are easier to treat.
- **Immunizations**
  Immunizations help protect against disease. In addition to the general health benefits, certain immunizations are required for entrance into the public school system.
- **Well-child care**
  Your dependent children are covered for regular exams.

### CHOOSE A PRIMARY CARE DOCTOR FOR COMPREHENSIVE CARE

A **Primary Care Doctor** is an internist, family physician or pediatrician who coordinates your care or your children's care. Your Primary Care Doctor gets to know you and your medical history, sees you when you are sick and provides regular checkups and immunizations.

Your Primary Care Doctor 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.

## LABORATORY SERVICES

The Benefit Fund has contracted with certain freestanding "preferred labs" in addition to Member Choice hospital-based labs. The Fund also covers a limited number of routine lab tests performed in your doctor's office. If you need to have lab work done outside of your doctor's office or hospital, you must use a preferred lab to avoid out-of-pocket costs. To use a preferred lab:

- Make sure that your doctor sends your lab samples to a preferred lab; or
- Take your referral slip from your doctor to a patient care (drawing) center at one of the preferred labs.

Visit **www.1199SEIUBenefits.org/find-a-provider** or call the Benefit Fund at (646) 473-9200 to find a preferred laboratory facility in your area.

## RADIOLOGY (X-RAY) SERVICES

The Fund covers a limited number of routine X-rays performed in your doctor's office. Prior Authorization is required for certain high-end imaging tests (such as MRI, MRA, PET and CAT scans) and certain nuclear cardiology tests. If your doctor prescribes one of these tests, you or your doctor must call EviCore at (888) 910-1199 for Prior Authorization.

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 One Call Care Management at (800) 398-8999 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 equipment, such as hospital beds, wheelchairs and breast pumps. By using these vendors, you will avoid out-of-pocket costs. Call the Benefit Fund at (646) 473-9200 for Prior Authorization.

### HOSPICE CARE

Coverage provides for a combined total of up to 210 days per lifetime in a Medicare-certified hospice program at home or in a hospice center, hospital or skilled nursing facility. See Section II.C for details. For Prior Authorization of inpatient hospice care, call 1199SEIU CareReview at (800) 227-9360. See Section II.I for details.

### AMBULANCE SERVICES

The Plan covers Emergency transportation and services to the closest hospital where you can be treated in the case of an accident, injury or the onset of a sudden and serious illness.

Ambulance transportation between hospitals, including air transportation when necessary, is covered if you need specialized care that the first hospital cannot provide *and* you are taken to the closest acute care hospital where you can be treated. Prior Authorization is required for transportation between hospitals.

For international air ambulance transportation, the closest acute care hospital will be in the same country or a neighboring country. The Benefit Fund does not cover ambulance transportation to a different hospital or back to the U.S. for the sake of patient or family preferences rather than medical necessity.

**NOTE:** If you use an international air ambulance transportation provider, you could face high out-of-pocket costs. Plan reimbursements are limited. Consider purchasing travel health insurance for overseas travel.

### WHAT IS NOT COVERED

The Benefit Fund **does not cover:**

- Acupuncture when administered by anyone other than a licensed medical physician or licensed acupuncturist
- Air ambulance transportation to a facility that is not the nearest appropriate acute care hospital
- Charges for telehealth services not provided in compliance with applicable state laws or the Benefit Fund's telehealth policy
- Charges for your co-payments
- Charges in excess of the Benefit Fund's Schedule of Allowances

- Charges related to refractions when performed by an ophthalmologist
- Employment or return-to-work physicals
- Experimental, unproven or non-FDA-approved treatments, procedures, facilities, equipment, drugs, devices or supplies (see definitions of “Experimental/ Investigational” and “Unproven” in Section IX)
- Laboratory tests that are not FDA-approved
- Private physicians when care is given in a government or municipal hospital
- Services provided in an educational setting
- Treatment for illness or injury covered by Workers’ Compensation
- Treatment that is cosmetic in nature
- Treatment that is custodial in nature
- Treatment that is determined to be not Medically Necessary
- Venipuncture
- 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
- Long-term acute care hospital services
- Hospital transfer ambulance services
- Durable medical equipment and appliances
- Medical supplies
- Cellular and gene therapy
- Specific medications, including specialty drugs
- Certain radiological tests
- Certain behavioral health services
- Certain outpatient laboratory procedures
- Radiation therapy and medical oncology services
- Hospice care
- Ambulatory surgery or inpatient admissions
- Certain infusion drugs administered on an outpatient basis

**Prior Authorization reviews Medical Necessity of Covered Services only.** It does not guarantee services or payment.

Doctors and health professionals who are part of the Benefit Fund's Participating Provider programs accept the Fund's allowance as payment in full.

If you use a Non-participating Provider, you could face high out-of-pocket costs. You may have to pay the difference between the Benefit Fund's allowance and whatever the provider normally charges.

**Authorization of services does not mean a Non-participating Provider will accept the Benefit Fund's payment as payment in full.** Before you receive services from a Non-participating Provider, you should ask the provider to find out the total Benefit Fund allowance for the planned service by calling (646) 473-7160 and notify you of what your out-of-pocket expenses will be.

### WHAT IS COVERED

To be covered, services in this section must be:

- Ordered by your physician;
- Medically Necessary to treat your condition;
- Not considered Experimental (see definition of "Experimental" in Section IX);
- In compliance with the Benefit Fund's clinical guidelines, policies, protocols and procedures; and
- Authorized in advance by the Benefit Fund's Prior Authorization Department.

In addition, new technology/treatment that requires Prior Authorization must offer a significant benefit or a cost-effective alternative over conventional treatment.

**PRIOR AUTHORIZATION NEEDED**

Call the Benefit Fund's Prior Authorization Department at (646) 473-9200. The Benefit 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; and
- Contact you if there are any Participating Providers who can provide the course of treatment or equipment you need.

Prior Authorization determinations are not contracts or promises to pay benefits. For more information about getting Prior Authorization, see Section VII.A.

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

**Home Health Care**

Home health care services will be covered up to the maximum amount of benefits available. This includes a combined total of up to 60 visits per calendar year for:

- Intermittent skilled nursing care;
- Intermittent non-skilled care; and
- 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.

**Long-term Acute Care Hospital Services**

Long-term acute care hospital services will be covered up to the maximum amount of benefits available, which is 60 days per calendar year. Call the Benefit Fund at (646) 473-9200 for Prior Authorization.

**Hospital Transfer Ambulance Services**

Ambulance transportation between hospitals, including air transportation, when necessary, is covered if you need specialized care that the first hospital cannot provide and you are taken to the closest acute care hospital where you can be treated.

**NOTE:** Even when authorized, international hospital-to-hospital transportation is only reimbursable at a limited rate and to limited destinations.

**Durable Medical Equipment and Appliances**

The Plan covers rental of standard durable medical equipment, such as hospital beds, wheelchairs and breast pumps.

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 that are both medically needed to treat your illness and approved by the Food and Drug Administration (FDA), such as:

- Blood and blood processing
- Catheters
- Dressings
- Oxygen
- Prostheses

**Cellular and Gene Therapy**

The Plan covers cellular therapies and gene therapies that are: approved by the Food and Drug Administration (FDA); medically needed to treat your disease; and received at a certified hospital or certified outpatient facility.

**Specific Medications**

You must get Prior Authorization before benefits can be provided for certain prescriptions, including specialty drugs. Call EviCore at (888) 910-1199 if you require certain infusion drugs administered on an outpatient basis or if you require certain oncology infusion drugs administered on an outpatient basis.

The Benefit Fund will periodically publish an updated list of drugs that require Prior Authorization.

For a list of these drugs, call the Benefit Fund at (646) 473-9200 or visit our website at **www.1199SEIUBenefits.org.** See Section II.L for details.

**NOTE:** You may have to pay the entire cost of the prescription if you don't get Prior Authorization from the Benefit Fund.

**Ambulatory Surgery or Inpatient Admissions**

You must get Prior Authorization for hospital stays and ambulatory or outpatient surgeries. See Section II.B for details.

**Certain Radiological Tests**

Prior Authorization is required for certain high-end imaging tests (such as MRI, MRA, PET and CAT scans) and certain nuclear cardiology tests. If your doctor prescribes one of these tests, you or your doctor must call EviCore at (888) 910-1199 for Prior Authorization.

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 One Call Care Management at (800) 398-8999 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.

**Behavioral Health Care**

Prior authorization is required for intermediate levels of coordinated care. It can help prevent hospitalizations and restore maximum function in a clinically appropriate setting. Prior Authorization is required for partial hospitalization programs (PHP), intensive outpatient programs (IOP), applied behavioral analysis and transcranial magnetic stimulation (TMS) for mental health.

To Pre-certify or pre-authorize these services, call the Fund at (646) 473-6868.

**Certain Outpatient Laboratory Procedures**

Prior Authorization is required for certain outpatient laboratory services, such as molecular, genomic and other diagnostic tests. A list of certain outpatient laboratory procedures and tests that require Prior Authorization can be found on the Benefit Fund's website at **www.1199SEIUBenefits.org/providers/prior-authorization.** If your doctor prescribes one of these tests, your doctor or the laboratory must request Prior Authorization by either calling EviCore at (888) 910-1199 or logging into the "Portal Login" at www.EviCore.com.

**Radiation Therapy and Medical Oncology Services**

Prior Authorization is required for radiation therapy and medical oncology services. If your doctor prescribes these services, your doctor must request Prior Authorization by either calling EviCore at (888) 910-1199 or logging into the "Portal Login" at www.EviCore.com.

**Hospice Care**

Hospice care coverage is provided for a combined total of up to 210 days per lifetime in a Medicare-certified hospice program at home or in a hospice center, hospital or skilled nursing facility. See Section II.C for details.

For Prior Authorization of inpatient hospice care, call 1199SEIU CareReview at (800) 227-9360.

Other benefits may require Prior Authorization. For more information, please refer to the Benefit Fund's website, **www.1199SEIUBenefits.org/providers/prior-authorization.**

# SECTION II. J
# VISION CARE AND HEARING AIDS

**BENEFIT BRIEF**

**Vision Care**

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

**Hearing Aids**

- Once every three years
- Co-payments may apply when using Participating Providers

Benefits are paid according to the Benefit Fund's Schedule of Allowances. Co-payments may apply when you use Participating Providers.

**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. You may have to pay any cost over the Benefit Fund's allowance.**

Call the Benefit Fund's Member Services Department at (646) 473-9200 to check your eligibility for Benefits. To find a Participating Provider, call Member Services or visit www.1199SEIUBenefits.org/find-a-provider.

## VISION CARE

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; and
- One pair of prescription glasses or one order of contact lenses every two years.

If you need a list of Participating Optometrists, visit **www.1199SEIUBenefits.org/vision-providers** or call the Fund at (646) 473-9200. Certain Participating Vision Care Providers also provide hearing aids.

## FILING FOR BENEFITS

**If You Use a Participating Provider**
Participating Optometrists and Opticians bill the Benefit Fund directly. If you select frames, lenses or other services that are not included in the Benefit Fund's vision program with your provider, you may incur out-of-pocket costs.

Call the Benefit Fund at (646) 473-9200 if you have questions about what is included in the Fund's vision program.

**If You Use a Non-participating Provider**

1. Obtain an itemized bill from your provider on their letterhead.
2. File a reimbursement claim with the Benefit Fund. You can choose to file online or by mail:
    - **Online:** Log into **MyAccount** (www.My1199Benefits.org) and select "Submit a Medical Claim Reimbursement" from the "Health" dropdown menu. You will be able to complete the form and submit a copy of the paid itemized bill through the portal.
    - **Mail:** Visit www.1199SEIUBenefits.org/forms to download the Member Reimbursement Medical Claim Form or call Member Services at (646) 473-9200 to request a copy. Return the completed form and a copy of your paid itemized bill as instructed on the form.
3. You will be reimbursed up to the Benefit Fund's allowance.

**WHAT IS NOT COVERED**

The Benefit Fund **does not cover:**

- Lens coatings (scratch resistant and/or ultraviolet treatment)
- Non-prescription sunglasses
- Visual training
- All general exclusions listed in Section VII.D

**HEARING AIDS**

- Hearing aids are covered once every three years. Call the Benefit Fund's Member Services Department at (646) 473-9200 or visit www.1199SEIUBenefits.org/hearing-providers to find a Participating Provider.
- Benefits are paid according to the Benefit Fund's Schedule of Allowances. **Co-payments may apply when you use Participating Providers.**
- **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. You may have to pay any cost over the Benefit Fund's allowance.**

# SECTION II. K
# DENTAL BENEFITS

**BENEFIT BRIEF**

Dental Benefits are provided by DentCare Delivery Systems, Inc., and are administered by Healthplex, Inc., a UnitedHealthcare company. For questions regarding Dental Benefits, call DentCare at (877) 591-1789.

- 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 (877) 591-1789 to select a primary care dentist. Then call your dentist to make an appointment.

All dental treatment is subject to the applicable protocols, procedures, restrictions and time limits.

### BASIC AND PREVENTIVE SERVICES

You and your children are covered in full for the following:

- 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
- Extractions
- Fillings
- Oral surgery

### MAJOR RESTORATIVE CARE

There is a co-payment for major services including:

- Periodontics (treatment of gum disease), subject to a five-year limitation;
- Endodontics (treatment of the tooth's nerve system);
- Removable prosthetics (partial and complete dentures), subject to a five-year limitation; and
- Crowns, fixed bridgework and other methods of replacing individual teeth, subject to a five-year limitation.

## ORTHODONTICS

- Orthodontics (treatment and appliances to correct tooth misalignment) for eligible dependent children
- Benefits covered for limited, interceptive and comprehensive treatment
- Orthodontia Treatment in the PPO is subject to lifetime maximums and treatment limitations, and it must be pre-authorized by the Plan Network Administrator
- Orthodontia Treatment in the DMO is limited to one course of treatment per lifetime

## THE PRIOR AUTHORIZATION PROCESS

If your dentist is planning major restorative care or orthodontics, ask DentCare to review and approve your treatment **before** the work is done. Your dentist must submit:

- The proposed treatment plan; and
- Any supporting X-rays.

You and your dentist will receive a predetermination form indicating:

- What treatment will be covered, if any; and
- What DentCare will pay.

If DentCare authorizes the procedure, it will be covered based upon your continued eligibility throughout the period of treatment. You will be responsible for charges in excess of your applicable annual maximum or, for members in the DMO, charges incurred by Non-participating Dentists.

## 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.

If you need Emergency treatment in your dentist's office, Prior Authorization is not required. However, you must file the following information with DentCare together with the claim for benefits:

- A completed claim form
- The appropriate X-rays

Co-payments will apply, if applicable.

## GETTING YOUR BENEFITS

### When Using a Participating Dentist

Participating Dentists send your claim form to and receive payment directly from DentCare.

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:

- Any dental treatment inconsistent with DentCare's approved protocols, procedures, restrictions and time limits;
- Deep or intravenous conscious sedation and general anesthesia services that are not performed by a board-certified or board-eligible oral surgeon or a dental anesthesiologist;
- Dental treatment of temporomandibular joint (TMJ) disorder;
- Emergency Department differential charges for non-Emergency treatment;
- Implants, as well as services, supplies, appliances or restorations made necessary by or in connection to the implants, are usually not covered unless they meet DentCare's clinical guidelines and approved protocols;
- Lost or stolen appliances;
- Periodontal splinting of otherwise healthy teeth with crowns or inlays/onlays;
- Services provided by a dentist not affiliated with DentCare (unless services were provided during an Emergency);
- Services, supplies or appliances that are not Medically Necessary based upon DentCare's clinical policies and guidelines;
- Services that are cosmetic in nature;
- Temporary services, including, but not limited to, crowns, restorations, dentures or fixed bridgework or night guards;
- Treatment provided by someone other than a dentist (except for cleanings performed by a licensed dental hygienist under the supervision of a dentist); and
- All general exclusions listed in Section VII.D.

# 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 and you use Preferred Drugs where available
- Co-payments for brand-name and Preferred Drugs if you are not enrolled in the Member Choice Home Care Select Plan
- Use Participating Pharmacies
- You must comply with the Benefit Fund's prescription drug programs, including Prior Authorization where required; for a complete list of these programs, please call the Benefit Fund at (646) 473-9200 or visit our website at **www.1199SEIUBenefits.org /hc-prescription.**

## WHAT IS COVERED

**There are no co-payments if you are enrolled in the Member Choice Home Care Select Plan and you use Preferred Drugs where available.**

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

- Have been approved for treating your specific condition and are proven to be safe and effective in the clinical trial process;
- Have been prescribed by a licensed prescriber;
- Are filled by a licensed pharmacist; and
- Are not excluded by the Plan.

## USING YOUR BENEFITS

To get your prescription:

- Ask your doctor to prescribe only Preferred Drugs (typically Tier 1 or Tier 2 drugs) whenever possible, as per the Benefit Fund's prescription drug programs
- Use Participating Pharmacies for short-term medications
- Show your 1199SEIU Health Benefits ID card to the pharmacist when you pick up your medication

**Other than your co-payments, where applicable, there are no out-of-pocket costs for your prescriptions if you adhere to the Benefit Fund's prescription drug programs and policies:**

- Preferred Drug List (or formulary)
- Prior Authorization for certain medications
- Quantity and day supply limitations
- Specialty Care Pharmacy: use this for injectables and other drugs that require special handling
- Step therapy

## PRESCRIPTION DRUG PROGRAMS

For a complete list of these programs, please call the Benefit Fund at (646) 473-9200 or visit **www.1199SEIUBenefits.org/hc-prescription.**

### PREFERRED DRUGS

We use a **formulary** developed by our pharmacy benefit manager (PBM), **CVS Caremark.** A formulary is a list of drugs that are available through the Plan. (The formulary is similar to what you might know as our Preferred Drug List.)

The formulary places covered US Food and Drug Administration–approved drugs into tiers based on their clinical effectiveness, safety and cost. It is designed to control costs for you and the Plan. Covered prescription drugs are divided into three tiers:

- Tier 1 (primarily Preferred Generic Drugs)
- Tier 2 (primarily Preferred Brand Drugs)
- Tier 3 (primarily Non-Preferred Drugs)

All Participating Providers have access to a copy of the formulary. It should be used when prescription medication is required.

**Your doctor must prescribe a Tier 1 or Tier 2 drug to treat your condition.** If there is no Tier 1 or Tier 2 therapeutic option, you or your Provider may seek a waiver, which, if approved by the Benefit Fund, would allow you to use a Tier 3 or non-formulary drug with no out-of-pocket costs to you beyond your co-pay, if applicable. If the Benefit Fund **does not approve your waiver request,** you may be billed the difference between the Benefit Fund's allowance and whatever the pharmacy charges, which could result in a significant cost to you. The Benefit Fund's allowance for non-covered non-formulary brand drugs is $0. **Please note:** Prescription drugs that are not Medically Necessary are not covered.

Visit **www.1199SEIUBenefits.org/pdl** for an interactive list of Preferred Drugs on the CVS Caremark 1199SEIU Formulary or to download a copy of the full formulary. You may also call the Benefit Fund at (646) 473-9200 for this and other information.

## PRESCRIPTION DRUG PROGRAMS

### PRIOR AUTHORIZATION FOR CERTAIN MEDICATIONS

You must get Prior Authorization before benefits can be provided for prescriptions filled with certain medications. The formulary will be updated periodically to reflect which drugs require Prior Authorization.

If your doctor prescribes any of those drugs, call the Benefit Fund's pharmacy benefit manager at (833) 250-3237 (or (855) 299-3262 for Special Drugs) for Prior Authorization.

**NOTE:** You may have to pay the entire cost of the prescription if you don't get Prior Authorization. These claims **will not be** reimbursed.

## PRESCRIPTION DRUG PROGRAMS

### 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 must be in compliance with the standards and criteria established by the FDA and with accepted clinical guidelines for standard of care.

### SPECIALTY CARE

You must use the Specialty Care Pharmacy Program for injectables and other drugs that require special handling. Call the Benefit Fund's Specialty Care Pharmacy at (800) 803-2523 or visit **www.1199SEIUBenefits.org/hc-prescription** for a list of drugs included in this program.

Specialty care drugs are available only through 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 Tier 2 drugs.

## PROTECT YOUR CARD

Your 1199SEIU Health Benefits ID card is for your use only. Do not leave your card with a pharmacist. Show it to the pharmacist when picking up your prescription and make sure it is returned to you before you leave the pharmacy.

If your card is lost or stolen, *immediately* report it to the Benefit Fund at (646) 473-9200. If you think someone is fraudulently using your card, call the Fund's Fraud and Abuse Hotline at (646) 473-6148 or email BenefitFraud@1199Funds.org.

## USE A PARTICIPATING PHARMACY

For a list of Participating Pharmacies, call the Benefit Fund's Member Services Department at (646) 473-9200 or visit **www.1199SEIUBenefits.org/pharmacies.**

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

1. Pay for your prescription when it is filled.
2. Submit your reimbursement claim, including itemized paid receipts, to the Benefit Fund's pharmacy benefit manager (PBM). You can do this one of two ways:
    a. Log into the PBM online portal (www.Caremark.com). You can submit receipts and complete the form in the portal.
    b. Download the Prescription Drug Reimbursement Form (Direct Claim Form) from our website, **www.1199SEIUBenefits.org/hc-prescription,** or call the Benefit Fund's Member Services department at (646) 473-9200 and ask for the form. After completing the form, follow the return instructions on the form.

You will only be reimbursed up to the Benefit Fund's Schedule of Allowances.

## FILLING YOUR PRESCRIPTIONS

### For Short-term Illnesses

If you need medication for a short period of time, have your doctor transmit the prescription to your local Participating Pharmacy, where you can pick it up once it's been filled.

### For Chronic Conditions

If you have a chronic condition and are required to take the same medication on a long-term basis, your prescription can be filled through the Benefit Fund's Maintenance Drug Access Program, *The 1199SEIU 90-Day Rx Solution.*

This program offers options for ordering medications you take on an ongoing basis in 90-day supplies. For your convenience, your medication can be filled either through a Participating Pharmacy in your neighborhood or through the PBM's Mail-order Pharmacy, which will deliver medication to your home address.

**If you are already taking a maintenance medication,** ask your doctor for a 90-day prescription (with three refills). Your doctor can fill it either by:

- Submitting the prescription to your Participating Mail-order Pharmacy, in which case it will normally be delivered to you; or
- Transmitting the prescription to your local Participating Pharmacy, where you can pick it up once it's been filled.

**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 three refills) that can be filled once you know the medication works for you.

Call the Benefit Fund at (646) 473-9200 or visit **www.1199SEIUBenefits.org/90-day-rx** for more information about maintenance medications.

## COORDINATING PRESCRIPTION DRUG BENEFITS

If your dependent is covered by another plan, the Benefit Fund may be their **secondary plan** (see Section I.F). In such cases, the Benefit Fund may provide coverage for any co-payments that your dependent may incur, up to the Benefit Fund's Schedule of Allowances.

Although your dependent's name will appear on your 1199SEIU Health Benefits ID card, they must use their primary prescription insurer first.

## WHAT IS NOT COVERED

The Benefit Fund **does not cover:**

- Cold and cough prescription products
- Compound drugs (except reformulations for injection or administration)
- Cost differentials for drugs that are not approved through the Benefit Fund's prescription drug programs
- Drugs obtained without a prescription, except for diabetic supplies
- Experimental and unproven drugs
- Medications for cosmetic purposes
- Migraine medications in excess of FDA guidelines for strength, quantity and duration
- Non-prescription items, such as bandages or heating pads, even if your physician recommends them
- Non-sedating antihistamines
- Oral erectile dysfunction agents (except for penile functional rehabilitative therapy for up to six months immediately following prostatic surgery)
- Over-the-counter drugs (except diabetic supplies)

- Over-the-counter home test kits, except for limited FDA-approved COVID-19 tests using your pharmacy benefit
- Over-the-counter vitamins
- Prescriptions for drugs not approved by the FDA for the treatment of your condition
- Proton pump inhibitors in excess of a 90-day supply for FDA-approved indications by diagnosis
- 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. M
# FERTILITY SERVICES

**WHAT IS COVERED**

Coverage for you and your adult dependent begins after you have been enrolled as Eligibility Class I for at least 18 months. In order to be eligible for these benefits, the covered person must have an Infertility diagnosis (as defined in Section IX: Definitions). Eligibility Class II members are not eligible for this benefit.

The Plan's fertility program is administered by Progyny. Fertility benefits must be provided by a Progyny in-network provider. **No benefits will be provided outside of this network.** Progyny Rx is the fertility medication provider.

Benefits are payable for the diagnosis and treatment of Infertility, subject to a **lifetime maximum of two "Smart Cycles"** per member or adult dependent. Smart Cycles are Progyny's benefit "currency" and are used to customize your new lifetime benefit. (See full definition in Section IX: Definitions.) Each Smart Cycle is designed to cover treatment bundles, which include individual services, tests and medications. The following are parts of the Smart Cycle; please contact Progyny for current equivalencies.

- IVF fresh cycle
- IVF freeze, all cycle
- Frozen embryo transfer (FET)
- Frozen oocyte transfer (FOT)
- Pre-transfer embryology services
- Intrauterine insemination (IUI)
- Timed intercourse
- Donor sperm
- Donor oocyte cohort
- Donor embryo

If you are undergoing or seeking to begin fertility treatment, you must contact Progyny (toll free) at (833) 233-0431. Representatives are available Monday through Friday from 9:00 am to 9:00 pm.

**WHAT IS NOT COVERED**

- Home ovulation prediction kits
- Services and supplies furnished by an out-of-network provider
- Services and supplies not listed as covered in the Progyny Member Guide
- Charges associated with a non- or gestational carrier program for the person acting as the carrier, including but not limited to fees for laboratory tests
- Treatments considered experimental by the American Society of Reproductive Medicine
- Women with natural menopause

# SECTION III – DISABILITY BENEFITS

The Benefit Fund does not offer Disability Benefits. Please see Section I.J: How You Can Extend Eligibility for information about maintaining health coverage while you are on a Disability Leave.

# SECTION IV – LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

Home Care members were not eligible for a Life Insurance Benefit during the period of November 5, 2007, through August 31, 2014.

Home Care members are now eligible for the Life Insurance and Accidental Death & Dismemberment Benefit described in this section, effective September 1, 2014. This benefit is for the member only.

## LIFE INSURANCE BENEFIT RESOURCE GUIDE

### CONTACT INFORMATION

**Member Services Department**
**(646) 473-9200**
**(Outside New York City, call**
**(800) 575-7771.)**

Call the Member Services Department to:

- Request a **Life Insurance Beneficiary Selection Form** or an **Enrollment Change Form**
- Request a claim form for life insurance

### REMINDERS

- Complete your **Life Insurance Beneficiary Selection Form** and select a beneficiary.
- You may change your beneficiary at any time.
- You or your beneficiary need to file a claim for Accidental Death and Dismemberment Benefits within 31 days of your death or dismemberment.

**Please visit www.1199SEIUBenefits.org for forms, directories and other information.**

**BENEFIT BRIEF**

**Life Insurance**

- A benefit of $20,000
- Life Insurance Benefit is for the member only

**Accidental Death and Dismemberment (AD&D)**

- For accidental death or dismemberment
- Equal to or half of your life insurance amount, depending on the loss suffered
- Accidental Death and Dismemberment Benefit is for the member only (for both Eligibility Classes I and II)

## WHO IS COVERED

While you are enrolled in the Benefit Fund and are eligible for Eligibility Class I or II benefits, **only you—not your children**—are covered for Life Insurance Benefits and Accidental Death and Dismemberment (AD&D) Benefits. Your benefits end in accordance with Section I.I.

## ABOUT THE POLICY

The **Life Insurance Benefit** is $20,000. If you are covered by the Benefit Fund at the time of your death, the amount ($20,000) is payable to your designated beneficiary or beneficiaries.

Your policy is a **term group insurance policy,** which means that it builds no cash value that you can carry with you if you lose coverage.

The Life Insurance Benefit provides double indemnity in the event of AD&D.

This means that an additional $20,000 is payable if your death is directly attributable to an accident that:

- Is caused directly and exclusively by external and accidental means, independent of all other causes;
- Occurs within 90 days of the date of your accident or injury; and
- Occurs while you are employed and while you are covered by the Benefit Fund.

Your **Accidental Death Benefit** is equal to your life insurance amount. It is paid in *addition* to your Life Insurance Benefit. Proof of the cause of death is required.

Your **Accidental Dismemberment Benefit** is:

- **Half of your life insurance amount** for the loss of one hand, one foot or sight in one eye;
- **Equal to your life insurance amount** for the loss of both hands, both feet or sight in both eyes; or
- **Equal to your life insurance amount** for any combined loss of hands, feet and eyesight.

Loss means:

- Dismemberment at or above the wrist for hands;

- Dismemberment at or above the ankle for feet; or
- Total and irrecoverable loss of sight for eyes.

Your AD&D Benefit will be no more than an amount equal to your life insurance amount. If you have more than one loss as a result of the same accident, payment will be made only for one of the combinations listed above.

### FILING YOUR CLAIM

You or your beneficiary must complete a claim form and return it to the Benefit Fund within 31 days of your death or dismemberment.

Your eligibility for this benefit is the same as your eligibility for life insurance.

### CONTINUING YOUR LIFE INSURANCE

To continue your life insurance coverage after it would otherwise end, you may make payments directly to the insurance administrator if:

- You have been eligible for this coverage for at least one year; and
- You apply within 30 days of your active Benefit Fund coverage ending.

### CHOOSING YOUR BENEFICIARY

Your beneficiary is the person you choose to receive your Life Insurance Benefit when you die.

When you fill out your **Life Insurance Beneficiary Selection Form,** designate at least one person as your beneficiary.

You may change your beneficiary at any time. To change your beneficiary:

1. Obtain an Enrollment Change Form from the Benefit Fund by either calling (646) 473-9200 or visiting **www.1199SEIUBenefits.org/forms.**
2. Complete the form.
3. Return the form to the Fund according the instructions on the form. The change of beneficiary will not be effective until the completed form is received by the Fund.

**NOTE:** If you have designated your spouse as your beneficiary and you later get divorced, your divorce will automatically revoke that designation upon notification of your divorce to the Fund. If you do not designate or change your beneficiary after your divorce, your Life Insurance Benefit will be paid as if there is no beneficiary (see "If There Is No Beneficiary" on the next page).

### HOW YOUR BENEFICIARY APPLIES FOR BENEFITS

After your death, your beneficiary must, as soon as reasonably possible:

1. Notify the Benefit Fund's Member Services Department.
2. Submit a certified original copy of your death certificate and a completed claim form to the Benefit Fund.

**IF THERE IS NO BENEFICIARY**

If you do not list a beneficiary; if your beneficiary dies before your death; or if the Benefit Fund cannot locate your beneficiary after reasonable efforts, your Life Insurance Benefit and AD&D Benefit are paid to your survivors in the following order:

- Your spouse;
- Your children, shared equally;
- Your parents, shared equally;
- Your siblings, shared equally; or
- If none of the above survive, to your estate after it has been established.

**IF THERE IS A DISPUTE**

If there is a dispute as to who is entitled to receive your Life Insurance Benefit, no payment will be made until the dispute is resolved.

If the dispute is not timely resolved by and between the parties claiming a right to this benefit, the Plan Administrator may, in its discretionary authority, make a determination regarding entitlement to benefits and/or deposit the benefits into a court-monitored account.

**IF YOU BECOME PERMANENTLY DISABLED**

**If you become permanently disabled before age 60,** you will continue to be covered for life insurance if *all* of the following conditions are met:

- You have been covered by the Benefit Fund for at least 12 months;
- You become permanently disabled at the time you stopped working and receive a disability award from the Social Security Administration;
- Your medical condition is certified no later than nine months after you stop working; and
- Your medical condition is recertified by your doctor three months before each anniversary of the start of the disability.

**If you become permanently disabled after age 60,** you will be eligible for life insurance for a maximum of 12 months from the date your disability began if *all* of the following conditions are met:

- You have been covered by the Benefit Fund for at least 12 months;
- You become permanently disabled at the time you stopped working and receive a disability award from the Social Security Administration; and
- Your medical condition is certified no later than nine months after you stop working.

**ASSIGNMENTS**

Proceeds of a Life Insurance Benefit may be assigned, by you or your beneficiary, to pay the costs of your funeral. If your beneficiary chooses to assign their benefit after your death, that assignment shall be considered irrevocable.

**CONVERSION**

If your life insurance coverage with the Benefit Fund ends because you are no longer a Fund participant, the Fund will send you information about your right to purchase continued coverage directly from the insurance carrier. When you convert your insurance policy from a group to an individual policy, you will be paying the premiums for this coverage.

**WHAT IS NOT COVERED**

AD&D Benefits are not available for losses resulting from:

- Acts of war
- Bacterial infection (except pyogenic infections resulting solely from injury)
- Bodily or mental infirmity
- Committing or participating in a crime or act that can be prosecuted as a crime
- Disease or illness of any kind
- Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft, except while as a fare-paying passenger in any aircraft that is licensed to carry passengers
- Intentionally self-inflicted injury
- Medical or surgical treatment (except where necessary solely by injury)
- Suicide or any attempt thereof
- The use of alcohol or substance use disorder

# SECTION V – OTHER BENEFITS

A. Social Services
   - Wellness Member Assistance Program
   - Citizenship Program
   - Financial Wellness and Homebuyer Education Program
   - 1199SEIU Legal Clinic
   - Weekly Workers' Compensation Legal Clinic

B. Eligibility Class II

## KEY PROGRAMS AND CONTACT INFORMATION

**Wellness Member Assistance Program**
**(646) 473-6900**
**Wellness@1199Funds.org**

Contact the Wellness Member Assistance Program to:

- Make an appointment to confidentially discuss a personal or family problem
- Reach the Program for Behavioral Health, which includes resources for dealing with alcohol and/or substance use disorder

**Citizenship Program**
**(646) 473-8915**
**1199SEIUCitizenship.Program@1199Funds.org**

Contact the Citizenship Program to learn about assistance with USCIS applications, including for United States citizenship.

**Financial Wellness and Homebuyer Education Program**
**(646) 473-6484**

Offers tools and workshops related to home ownership, managing credit and financial wellness.

**1199SEIU Legal Clinic**
**(646) 473-6488**

Provides free legal assessments and referral services (by appointment only) by an attorney for various personal legal matters.

**Weekly Workers' Compensation Legal Clinic**
**(646) 473-6717**

Provides free legal consultation services by an attorney for Workers' Compensation claims.

**Please visit www.1199SEIUBenefits.org for forms, directories and additional information.**

# SECTION V. A
# SOCIAL SERVICES

**BENEFIT BRIEF**

**Wellness Member Assistance Program**

- Help and referrals for personal and family problems for you and your children

**Citizenship Program**

- Assistance in applying for United States citizenship

**Financial Wellness and Homebuyer Education Program**

- Tools and workshops related to home ownership, managing credit and financial wellness

**1199SEIU Legal Clinic**

- Access to attorneys (by appointment only) for free legal consultations regarding various personal legal matters

**Weekly Workers' Compensation Legal Clinic**

- Assistance for members suffering from a work-related injury or illness

The Wellness Member Assistance Program and Citizenship Program are available to ***all*** bargaining unit employees of Contributing Home Care Employers regardless of whether a member meets the minimum hours worked rules and income requirements or pays the required weekly premium.

## WELLNESS MEMBER ASSISTANCE PROGRAM

The Benefit Fund's Wellness Member Assistance Program offers support for personal and family problems. The Fund's multilingual and multicultural trained social workers, counselors and other professionals can guide you to available resources and also provide direct support to help you cope with a broad range of challenges. Some of the areas in which assistance can be provided are:

- Adjusting to life changes
- Alcohol, tobacco, opiates and substance addiction
- Domestic violence
- Family/relationship issues
- Job jeopardy (early intervention before job loss)
- Mental health concerns, such as anxiety and depression

- Referrals to entitlement programs (food stamps, Medicaid, public assistance, etc.)
- Stress or emotional difficulties
- Weight reduction and weight management (when provided by a participating program; co-payments may apply)

The Wellness Member Assistance Program staff will help coordinate care for members and dependents who have been hospitalized for psychiatric care or substance use disorder detoxification or rehabilitation.

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

Visit **www.1199SEIUBenefits.org/map** to learn more.

**CITIZENSHIP PROGRAM**

The 1199SEIU Citizenship Program, jointly administered by the 1199SEIU Benefit and Pension Funds and the 1199SEIU Training and Employment Funds, provides support to you and your eligible family members as you navigate the U.S. Citizenship and Immigration Services (USCIS) application processes, including:

- Assistance with U.S. citizenship application preparation
- One-on-one counseling and legal advice
- Classes to prepare you for the naturalization interview and test
- Classes for English as a Second Language (ESL)
- Help with other needs, such as adjustment of status and consular processing, Green Card renewals and more

For more about program assistance, and to obtain up-to-date immigration-related information, visit **www.1199SEIUBenefits.org/citizenship,** call (646) 473-8915 or email 1199SEIUCitizenship.Program@1199Funds.org. Appointments are available throughout the week and on select Saturdays. Services are available in English, Spanish, Russian, Mandarin, Cantonese, Haitian Creole and French. Services are free of charge but do not include USCIS filing fees.

**FINANCIAL WELLNESS AND HOMEBUYER EDUCATION PROGRAM**

The Financial Wellness and Homebuyer Education Program offers tools, referrals and workshops related to home ownership, managing credit and overall financial wellness. For more information, call (646) 473-6484, visit **www.1199SEIUBenefits.org/financial-wellness** or refer to the

1199SEIU Home Care Employees Pension Fund SPD.

**1199SEIU LEGAL CLINIC**

This benefit provides eligible Benefit Fund members with access to attorneys for free legal consultations regarding various personal legal matters. The clinic is by appointment only. For more information or to make an appointment, call (646) 473-6488.

**WEEKLY WORKERS' COMPENSATION LEGAL CLINIC**

The Benefit Fund Workers' Compensation Walk-in Legal Clinic provides assistance to eligible members suffering from a work-related injury or illness. The clinic operates on Wednesdays from 4:00 pm to 6:00 pm. For more information about this clinic, call the Workers' Compensation/Liens Department at (646) 473-6717.

# SECTION V.B
# ELIGIBILITY CLASS II

**BENEFIT BRIEF**

**Eligibility Class II**

Eligibility Class II working members are eligible for a member-only package of benefits that includes:

- Co-pay reimbursement
- Life insurance benefits
- Social services

## ELIGIBILITY CLASS II BENEFITS

When you are in Eligibility Class II, you are eligible for life insurance benefits (see Section IV) and social services (see Section V.A). (Note: Some benefits have eligibility requirements. Please see each section for details.) In addition, Members in Eligibility Class II can enroll in a premium deduction to elect the Fund's health reimbursement benefit. The benefit provides payment or reimbursement of your premiums and co-payments for medical and dental expenses, up to $2,000 a year (or $4,000 a year for those over age 65), for services and items you receive while enrolled in one of the following:

- Self-only individual health coverage
- Medicare Parts A and B
- Medicare Part C (Medicare Advantage)

Your health reimbursement benefit will be pro-rated depending on when your applicable coverage begins and is subject to your continued eligibility. This benefit is only for your expenses. You cannot use your reimbursement benefit to pay for your spouse's or dependents' expenses.

**NOTE:** Individual health coverage does not include group health plans, short-term, limited-duration insurance or excepted benefits coverage (such as insurance that only provides benefits for dental and vision care).

# SECTION VI – RETIREE HEALTH BENEFITS

The Benefit Fund does not provide Retiree Health Benefits.

# SECTION VII – GETTING YOUR BENEFITS

A. Getting Your Healthcare Benefits
   - Filing a Claim
   - Initial Claim Decision

B. Your Rights Are Protected — Appeal Procedure

C. When Benefits May Be Suspended, Withheld or Denied

D. What Is Not Covered

E. Additional Provisions

## KEY CONTACTS

**Member Services Department**
**(646) 473-9200**
**(Outside New York City, call (800) 575-7771.)**

Call the Member Services Department if you:

- Need a claim form
- Have questions about completing your claim form
- Have questions about what is not covered by the Benefit Fund
- Have questions about the processing of your claim

**Appeals Department Hotline**
**(646) 473-8951**

Call the Benefit Fund's Appeals Hotline if you need information on appealing your claim.

**Please visit www.1199SEIUBenefits.org for forms, directories and other information.**

# SECTION VII. A
# GETTING YOUR HEALTHCARE BENEFITS

**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 Benefit Fund in either electronic or paper form.

The Fund needs to receive a claim so that:

- Your doctor, hospital or healthcare provider can be paid; or
- You can be reimbursed if you paid your doctor, hospital or healthcare provider.

**If You Use a Participating Provider**

Your doctor, hospital or healthcare provider will submit the claim to the Benefit Fund.

**If You Use a Non-participating Provider**

Your provider may give you a claim form. If they do not or if you wish to submit the form online, you may obtain the form from the Fund. Visit **www.My1199Benefits.org** to log into **MyAccount,** where you can complete and submit a claim reimbursement request. You may also access the Member Reimbursement Medical Claim Form by visiting **www.1199SEIUBenefits.org/forms** or calling the Member Services Department at (646)-473-9200 and requesting a copy. To expedite processing, your claim form should be submitted as directed on the form.

For the Fund to pay your claim to a Non-participating Provider, you must sign the "Assignment of Benefits" authorization on your claim form. By doing this, 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 its Schedule of Allowances. You may be responsible for any charges over the Benefit Fund's allowance.

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

The Plan Administrator reserves the right to deny certain assignments. For non-Emergency Services, Assignments of Benefits to Non-participating surgeons and surgery practices are not permitted without express authorization from the Benefit Fund.

**If You Paid Your Provider and Want to Be Reimbursed**

You will need to submit a claim form to the Benefit Fund. Your provider

may give you a claim form. If they do not or if you wish to submit the form online, you may obtain the form from the Fund. Visit **www.My1199Benefits.org** to log into **MyAccount,** where you can complete and submit a claim reimbursement request. You may also access the Member Reimbursement Medical Claim Form by visiting **www.1199SEIUBenefits.org/forms** or calling the Member Services Department at (646)-473-9200 and requesting a copy.

Submit your claim form with the bill from your provider as directed on the form, and make sure the bill lists the amount you have paid. The Benefit Fund will only pay a claim according to its Schedule of Allowances. You may be responsible for any charges over the Fund's allowance.

**If You Receive an Overpayment from the Benefit Fund**

If you (or your provider by assignment) receive an overpayment from the Benefit Fund as a result of an improperly billed claim for benefits, the overpaid funds belong to the Benefit Fund, and you agree to hold that money in trust for the Benefit Fund and to reimburse the Benefit Fund within 30 days of receiving the overpayment.

**It Is Important to File Your Claim with the Benefit Fund Promptly**

- Disability claims must be filed within 30 days of the start of your disability.
- Claims for end-stage renal disease patient reimbursement for 50% of the standard Medicare Part B premium must be filed within two years of the premium payment.
- All other claims will be denied if they are filed more than one year after the services were provided.
- Life insurance and accidental death and dismemberment claims must be filed no longer than one year after the date of death or loss.

A claim that is 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 why 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 on hold 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 Decision" in Section VII.B.

### INITIAL CLAIM DECISION FOR PRE-SERVICE AND CONCURRENT CARE BENEFITS

In order to receive certain Fund benefits, you must get Fund approval — **Pre-certification** or **Prior Authorization** — before treatment. You may file any request for Pre-certification or Prior Authorization yourself, or you may designate another person as your authorized representative, in which case all subsequent notices will be provided to you through your authorized representative.

The Plan Administrator will make an initial claim decision on your request for Pre-certification or Prior Authorization, which is a determination about whether the services are Medically Necessary to treat your condition and are in compliance with the Benefit Fund's clinical coverage guidelines, policies, protocols and procedures. A Prior Authorization determination is not an independent contract or promise to pay benefits.

The Plan Administrator will provide a written decision on your initial request for benefits. If your request is denied, you will be notified of the reasons why your benefits have been denied (or reduced), as well as the specific provisions of the Plan on which the decision was based. The timeline for requesting Pre-certification or Prior Authorization depends on the category of the request:

#### Pre-service Care Requests

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

radiological or genetic tests or durable medical equipment (see Section II.I). In the case of requests for hospital stays or ambulatory/outpatient surgery, the Benefit Fund will have 1199SEIU CareReview, the Fund's designated agent, review your request.

You or your authorized representative generally 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 Benefit 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 of its being filed. You will then have 45 days to provide any additional information requested of you by the Plan Administrator (or 1199SEIU CareReview). In this case, the period for making the benefit decision will be on hold 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 request for benefits will be made based on the information available to the Plan Administrator (or 1199SEIU CareReview).

**Concurrent Care Requests**

Concurrent care requests are requests to extend either previously approved benefits for an ongoing course of treatment or a specific number of treatments. These include, for example, requests to receive physical/rehabilitative therapy or requests for visits to an allergist, podiatrist or chiropractor beyond the standard number of visits allowed by the Benefit 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.B).

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 of receiving the request, provided that the request is made to the Benefit 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 in a timely fashion, the initial decision on your request for benefits will be made based on the information available to the Plan Administrator.

**Urgent Care Requests**

Certain pre-service care or concurrent care requests involve situations that have to be decided quickly because using the usual time frames 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, 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 Emergency Conditions.

These claims may be filed by phone or fax (see Section VII.B).

You or your authorized representative generally will be orally notified of the Plan Administrator's approval or denial of your request for benefits as soon as possible but no 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 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 in a timely fashion, the initial decision on your request for benefits will be made based on the information available to the Plan Administrator. A written notification will be given to you no later than three days after the oral notification.

**PAYMENT INFORMATION FOR PROVIDERS**

If you are a Non-participating Provider, any disputes regarding payment for services from the Benefit Fund are "claims" subject to the U.S. Department of Labor Claims Regulations, and no communications should be construed as a contract or promise to pay outside this Plan. If you are a Participating Provider, payment disputes shall be handled exclusively under the terms set forth in your participation agreement and provider manual.

# SECTION VII. B
# YOUR RIGHTS ARE PROTECTED — APPEAL PROCEDURE

If your claim or request for benefits is denied, the Plan provides for two levels of appeal, as well as a third-level, external review appeal, as described in this section.

### FIRST-LEVEL APPEALS

#### 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 of 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 ambulatory/outpatient procedures, the Plan Administrator will have 1199SEIU CareReview conduct the Administrative Review and appeal procedure. For Dental Benefits, Healthplex will conduct the Administrative Review.

**NOTE:** All claims by you, your children or your beneficiaries against the Benefit Fund are subject to the Claims and Appeal Procedure. No lawsuits may be filed until all steps of these procedures have been completed by you or a representative authorized by you (i.e., until all applicable appeal levels have been exhausted), and the benefits requested have been denied in whole or in part. No lawsuits may be filed by providers as an assignee of you or your children after three years from the date of service. All lawsuits must be filed in a federal court in New York City.

#### Urgent Care Situations

In urgent care situations regarding the Prior Authorization of hospital stays or ambulatory/outpatient procedures, the Administrative Review by 1199SEIU CareReview shall be final and binding on all parties. If this review results in a denial of your request for benefits, you have the right to file a suit under ERISA only in a federal court in New York City.

### SECOND-LEVEL APPEALS

#### Hospital Stays or Ambulatory Outpatient Procedures (Non-urgent Care Situations)

If the Administrative Review by 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 in writing within 60 days of receipt of the denial notice, unless:

- Your claim involves urgent care, in which case the request may be made orally; or
- Your claim involves a retroactive denial as a result of a Lien Determination, in which case the request must be made in accordance with Section I.G.

**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 Board of Trustees Appeals Committee. Such requests must be filed within 60 days of 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.

**THIRD-LEVEL APPEALS**

**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.

If your appeal is denied by 1199SEIU CareReview, you have the right to file a suit under the Employee Retirement Income Security Act of 1974 (ERISA) only in a federal court in New York City.

You may also choose to bring a final appeal to the Board of Trustees Appeals Committee. Such requests must be filed within 60 days of 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 file a suit under ERISA only in a federal court in New York City.

**Lien Determinations**

If the Benefit Fund has determined that your claim for benefits is an expense resulting from an illness, accident or injury caused by the conduct of a third party, it is not covered. Please see Section I.G for a description of your appeal procedures.

**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;

- 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;
- 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;
- Know the identity 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;
- Have your claim reviewed by a healthcare professional retained by the Plan if the denial was based on a medical judgment;
- A review that is conducted by a named fiduciary of the Plan who is not the person that made the benefit decision and who does not work for that person;
- Authorize a representative to appeal on your behalf. Except in the case of an urgent care request, in order to authorize anyone, including a provider, to represent you in an appeal of a benefit denial, you must complete and sign a **Benefit Fund Appeal Representation Authorization Form** following the benefit denial. No other form will be accepted by the Fund to show that you are allowing someone else to exercise your right to appeal. A representative authorized by you to appeal on your behalf cannot authorize anyone else to appeal; only you can authorize a representative; and
- A fast review process, in the case of an urgent care request, in which all necessary information, including the Fund's benefit decision on review, shall be sent to you by telephone, fax or other available expeditious methods.

| HOW TO REQUEST AN ADMINISTRATIVE REVIEW OR AN APPEAL TO THE BOARD OF TRUSTEES APPEALS COMMITTEE | |
|---|---|
| **Requests for Administrative Review of urgent care for hospitalization or ambulatory/outpatient procedures can be directed to 1199SEIU CareReview by:**<br>• Phone: (800) 227-9360<br>• Fax (medical): (866) 535-8972<br>• Fax (behavioral health): (855) 816-3497 | **Requests for Administrative Review of non-urgent care for hospitalization or ambulatory/ outpatient procedures should be sent to:**<br>1199SEIU CareReview Program<br>CareAllies<br>150 S. Warner Road, 3rd Floor<br>King of Prussia, PA 19406 |
| **Reviews and appeals of all other claims can be submitted by:**<br>• Phone (post-service): (646) 473-8951<br>• Fax (post-service): (646) 473-8958<br>• Phone (urgent or concurrent care): (646) 473-7446<br>• Fax (urgent or concurrent care): (646) 473-7447<br>• Mail:<br>1199SEIU National Benefit Fund for Home Care Employees<br>Claim Appeals<br>PO Box 646<br>New York, NY 10108-0646 | **Requests for Administrative Review of dental claims can be submitted by:**<br>• Mail:<br>Healthplex, Inc.<br>PO Box 30567<br>Salt Lake City, UT 84130-0567<br>• Phone: (877) 363-5621 |

## WHAT YOUR PROVIDER IS ENTITLED TO

A Participating Provider has a contract with the Benefit Fund agreeing that any payment disputes may only be addressed with the Fund, through its contract, and, therefore, it generally cannot appeal an adverse determination on your behalf and cannot sue on an assignment of your benefits.

Non-participating Providers have no independent right to appeal an Adverse Benefit Decision, and you cannot assign your right to appeal. However, you can authorize a Non-participating Provider to appeal on your behalf the Fund's determination of your Plan benefits by signing a **Benefit Fund Appeal Representation Authorization Form.** If an authorized provider completes the administrative appeal process on your behalf, you will no longer have the right to appeal the same claim.

A provider's challenge to the design of the Plan or to the Benefit Fund's Schedule of Allowances is not an appeal because those "settlor functions" are not the proper subjects of appeal or a lawsuit.

For assignments of rights and benefits, see Section VIII.A.

## TIME FRAMES FOR ADMINISTRATIVE REVIEW AND APPEAL

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

- **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 Requests**
  Each level of review of an urgent care request shall be completed in sufficient time to help ensure that the total period for completing both the Administrative Review and the appeal to the Board of Trustees Appeals Committee (if applicable) does not exceed 72 hours after your request for a review is received.
- **Concurrent Care Requests**
  Administrative Review of a concurrent care request will be treated as either an urgent care request, a pre-service care request or a post-service care claim, depending on the facts.

For appeals of Administrative Review decisions, the Appeals Committee's appeal decision shall be final and binding on all parties, subject to your right to file a suit under ERISA only in a federal court in New York City. The decision shall be made at the committee meeting following the Plan's receipt of a request (not later than the next scheduled meeting after the month the request is received for post-service care appeals, unless special circumstances require an extension to the following meeting), and the claimant will be notified in writing.

# SECTION VII. C
# WHEN BENEFITS MAY BE SUSPENDED, WITHHELD OR DENIED

**It is important that you provide the Benefit Fund with all the information, documents or other materials it needs to process your claim for benefits.**

The Fund may be unable to process your claim if you or your children do not:

- Repay the Benefit Fund for benefits that you were not entitled to receive;
- Sign an agreement (or comply with such an agreement) to repay the Benefit Fund in the case of legal claim against a third party;
- Sign the "Assignment of Benefits" authorization when you want your benefits paid directly to your provider; or
- 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 or your children were not entitled to receive;
- For claims that you or your children 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; or
- That were the subject of a legal claim against a third party for which a lien form was not signed and received by the Benefit Fund or was not repaid to the Fund, as required in Section I.G.

### BENEFIT FUND'S RIGHT TO CONFIRM CLAIMS

Before paying any benefits, the Benefit Fund may require that:

- You or your children be examined by a doctor or dentist selected by the Benefit Fund as often as required during the period of the claim; or
- An autopsy be performed to determine the cause of death, except where prohibited by law.

# SECTION VII. D
# WHAT IS NOT COVERED

In addition to the various exclusions and limitations set forth elsewhere in this SPD, to the extent permitted by law, the Benefit Fund **does not cover** the following:

- Charges associated with any work-related accidental injuries or diseases that are covered under the Workers' Compensation Law or a comparable law
- Charges for care resulting from an act of war
- Charges for claims containing misrepresentations or false, incomplete or misleading information
- Charges for claims submitted more than 12 months after the date of service
- Charges for commercially available over-the-counter home ovulation predication test kits or pregnancy test kits
- Charges for educational therapy or for services provided in an educational setting
- Charges for Experimental or unproven procedures, services, treatments, supplies, devices, drugs, etc. (see definition of "Experimental" and exceptions for clinical trials in Section IX)
- Charges for infertility treatment furnished by an out-of-network provider
- Charges for in-hospital services that can be performed on an ambulatory or outpatient basis
- Charges for items provided without cost to the provider, supplier or practitioner, including credit received for replacement devices (e.g., covered under warranty, replaced due to defect, free samples)
- Charges for invalid and/or obsolete CPT or HCPCS codes
- Charges for over-the-counter, healthcare, personal, comfort or convenience items such as bandages or heating pads (even if your physician recommends them), except the following *when Medically Necessary*:
  - » Blood pressure cuffs/monitors
  - » Diabetic supplies
  - » Limited FDA-approved COVID-19 tests using your pharmacy benefit
- Charges for procedures, treatments, services, supplies or drugs for cosmetic purposes, except to remedy a condition that results from an illness or accidental injury

- Charges for service codes that are inconsistent with the diagnosis or service rendered
- Charges for services covered under any mandatory automobile or no-fault insurance policy
- Charges for services in excess of or not in compliance with the Benefit Fund's guidelines, policies or procedures
- Charges for services or materials that do not meet the Benefit Fund's standards of professionally recognized quality
- Charges for services provided and supplies or appliances used before you or your children became eligible for Benefit Fund coverage
- Charges for services that are custodial in nature or inpatient charges for intermediate care, including Skilled Nursing Facilities and residential treatment facilities
- Charges for services that are not covered by the Benefit Fund, even if the service is Medically Necessary
- Charges for services that are not FDA-approved for a particular condition
- Charges for services that are not Medically Necessary
- Charges for services that are not preauthorized in accordance with the terms of the Plan
- Charges for services, treatments and supplies covered under any other insurance coverage or plan, or covered under a plan or law of any government agency or program, unless there is a legal obligation to pay
- Charges for telehealth services not provided in compliance with applicable state laws or the Benefit Fund's Telehealth policy
- Charges in excess of the Benefit Fund's Schedule of Allowances
- Charges made by your provider for broken appointments
- Charges related to an illness, accident 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 related to an illness, accident or injury that was the result of your committing a criminal act (except as a victim of domestic abuse) or was deliberately self-inflicted (except where attributable to a mental condition)
- Charges related to interest, late charges, finance charges, court or other legal costs
- 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 or participating program

- Charges that are not itemized
- Charges that are unreasonable, excessive or beyond the provider's normal billing rate, scope or specialty
- Charges that would not have been made if no coverage existed or charges that neither you nor any of your dependents are required to pay; for example, the Benefit Fund will not pay for services provided by members of your or your dependent's immediate family

# SECTION VII. E
# ADDITIONAL PROVISIONS

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

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.

No legal action may be brought against the Benefit Fund or the Trustees by a provider as an assignee of you or your children after three years from the date of service. For claims not involving the receipt of services, no legal action may be brought against the Benefit Fund or the Trustees after three years from the date of the Benefit Fund's initial denial or, where there is no service, after three years from the date of the initial denial.

No legal action for benefits under this Plan or for a breach of ERISA may be brought in a forum other than a federal court in New York City.

Payments made by the Fund that are not consistent with the Plan — as described in this SPD 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 as expressly provided in Section VIII. Any such action shall be void and of no effect. No benefit shall be in any manner subject to the debts, contracts, liabilities, engagements or torts of the person entitled to such benefit.

Notwithstanding the foregoing, the Benefit 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 Benefit 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 and their dependents 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 the Plan

# SECTION VIII. A
# YOUR ERISA RIGHTS

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

### GETTING INFORMATION

You have the right to:

- Request the latest updated Summary Plan Description, Summary of Benefits and Coverage, annual report and trust agreement. You can obtain copies of these documents by writing to the Plan Administrator at PO Box 2661, New York, NY 10108-2661. The Plan Administrator can charge a reasonable fee for copies requested by mail. You can also examine these documents, as well as the Schedule of Allowances and any terminal report, without charge at the Benefit Fund's headquarters.
- Receive a copy of the Summary Plan Description within 90 days of becoming a Plan participant.
- Receive an updated copy of the Summary Plan Description at least every five years.
- Receive a summary of the Benefit Fund's annual financial report. Union and Benefit Fund periodicals may be used for this purpose.

**NOTE:** The aforementioned rights may NOT be transferred or assigned to a third party. Only you, as the participant or beneficiary, are entitled to request the documents described in this section.

### CONTINUING GROUP HEALTH COVERAGE

If you lose health coverage for yourself or your dependents under the Plan as a result of a qualifying event, you or your dependents may have to pay for continued coverage. Review this SPD and the documents governing the Plan to understand the rules governing your COBRA Continuation Coverage rights.

You may request a Certificate of Creditable Coverage, free of charge, from the Benefit Fund when you lose coverage under the Plan.

### PRIVACY OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act (HIPAA), a federal law, imposes certain confidentiality and security obligations on the Benefit Fund with respect to medical records and other individually identifiable health information used or disclosed by the Benefit Fund. HIPAA also gives you rights with respect to your health information, including certain rights to receive copies of the health

information the Benefit Fund maintains about you and knowing how your health information may be used. The 1199SEIU Family of Funds' Eligibility Department may share eligibility and enrollment information with the Benefit Fund, your Employer or the Union for enrollment and outreach purposes. Similarly, the Benefit Fund may share enrollment information with the 1199SEIU Family of Funds' Eligibility Department for enrollment purposes. A complete description of how the Benefit Fund uses your health information, and your other rights under HIPAA's privacy rules, is available in the Benefit Fund's Notice of Privacy Practices, which is distributed to all named participants and posted on the Fund's website at **www.1199SEIUBenefits.org/HIPAA.** Anyone may request an additional copy by calling the Benefit Fund at (646) 473-9200.

**FIDUCIARY RESPONSIBILITY**

In addition to creating rights for Benefit 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 and eligible dependents.

No one, including your Employer, 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 and 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 in Section VII.B.

**ENFORCING YOUR RIGHTS**

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

- If you request a copy of the required Benefit Fund documents described in this section from the Plan (by writing to the Plan Administrator at PO Box 2661, New York, NY 10108- 2661) and you do not receive them within 30 days, you have the right to file a suit under ERISA only in a federal court in New York City. In such cases, 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 Plan Administrator's control.
- If you have a claim for benefits which is entirely or partially denied or ignored, you have the right to file a suit under ERISA only in a federal court in New York City after

you have completed the appeal procedure (see Section VII.B) if you believe the decision against you is arbitrary and capricious or violates ERISA.

- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you have the right to file a suit under ERISA only in a federal court in New York City.
- If the Benefit 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. You also have the right to file a suit under ERISA only in a federal court in New York City.

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 (for example, if the court finds your claim is frivolous), the court may require you to pay these costs and fees.

For information regarding your federal civil rights, see Section VIII.D.

**ASSIGNING YOUR RIGHTS**

You may not transfer or assign your Plan rights or benefits to anyone, with one exception: You may assign to Non-participating Providers your right to a Plan benefit and to sue to get a Plan benefit. If you assign to a Non-participating Provider your right to a Plan benefit, the provider will have no greater rights than you have and may not, in turn, assign the right to anyone else. If the provider exercises your right to the benefit, you will no longer have the right to receive that benefit. A Non-participating Provider can only file a lawsuit disputing an Adverse Benefit Determination:

- As an assignee of your right to Plan benefits and to bring an ERISA claim;
- In a federal court in New York City;
- Within three years of the date of service or pre-service authorization denial, whichever is earlier; and
- After the administrative appeal has been completed, in accordance with Section VII.B.

**NOTE:** No other rights conferred under the terms of the Plan or ERISA may be transferred or assigned. You cannot assign your right to appeal an Adverse Benefit Determination, but you can authorize a representative to appeal on your behalf (see Section VII.B).

**QUESTIONS?**

If you have any questions about:

- Your Benefit Fund, call the Fund at (646) 473-9200.
- Your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest U.S. Department of Labor's Employee

Benefits Security Administration office, which you can find online, www.DOL.gov/Agencies/EBSA/About-EBSA/About-Us/Regional-Offices, or write to: Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration's publications hotline at (866) 444-3272.

# 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 the Plan (including any related documents and underlying policies), at any time and for any reason, by action of the Board of Trustees, including any duly authorized designee 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 has or will have a vested or non-forfeitable right to receive benefits under the Benefit 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;
- 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; and
- 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 in this section, 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; and

(ix) Deny, restrict or prohibit Assignments of Benefits to Non-participating Providers.

All determinations made by the Plan Administrator (including any duly authorized designee thereof) and/or the Board of Trustees Appeals Committee with respect to any matter arising under the Plan and any other Plan documents shall be final and binding on all parties. In addition, the Plan Administrator may bring a court action to enforce the terms of the Plan or to recover benefit overpayments.

# SECTION VIII. D
# INFORMATION ON THE 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 and offices:

498 Seventh Avenue
New York, NY 10018

**SOURCE OF INCOME**
Payments are made to the Benefit Fund by your Employer, other Contributing Employers and the state of New York, according to the Collective Bargaining Agreements with 1199SEIU United Healthcare Workers East.

Employers' contribution rates are set forth in the applicable Collective Bargaining Agreements. They are estimated to adequately meet the anticipated cost of claims and administration. Because the Benefit Fund is a multiemployer fund, costs are calculated on a pooled basis.

You may obtain a copy of any Collective Bargaining Agreement by writing to the Plan Administrator at PO Box 2661, New York, NY 10108-2661, or by examining a copy at the Benefit Fund.

You can find out if a particular Employer contributes to the Benefit Fund by writing to the Plan Administrator. The Employer's address will also be given.

**ACCUMULATION OF ASSETS**
The Benefit Fund's assets are held in trust to pay benefits and expenses. Assets are also invested by investment managers appointed by the Trustees to whom the 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 Board of Trustees and its duly authorized designees and subordinates, including, but not limited to, the Executive Director, the Board of Trustees Appeals Committee and other senior employees. If you have any questions, please call our Benefit Fund's Member Services Department at (646) 473-9200.

The Trustees may be contacted at:

1199SEIU National Benefit Fund for Home Care Employees
c/o Executive Director
498 Seventh Avenue, 10th Floor
New York, NY 10018
Phone: (646) 473-9200

**FOR SERVICE OF LEGAL PROCESS**

Legal process may be served on the Board of Trustees, the Plan Administrator or the Benefit Fund's Counsel.

The Trustees may be contacted at:

1199SEIU National Benefit Fund for Home Care Employees
c/o Executive Director
498 Seventh Avenue, 10th Floor
New York, NY 10018
Phone: (646) 473-9200

The Benefit Fund's Counsel may be contacted at:

1199SEIU National Benefit Fund for Home Care Employees
General Counsel's Office
498 Seventh Avenue, 10th Floor
New York, NY 10018
Phone: (646) 473-9200

**IDENTIFICATION NUMBER**

Employer Identification Number: 13-4129368

ERISA Plan Number: 501

**DISCRIMINATION IS AGAINST THE LAW**

The 1199SEIU Benefit Funds comply with applicable federal civil rights laws and do not discriminate against or exclude people on the basis of race, color, national origin, age, disability or sex. The Funds provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats).

The Funds provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the compliance coordinator.

If you believe the Funds have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Compliance Coordinator
498 Seventh Avenue
New York, NY 10018
(646) 473-8959 (fax)
PrivacyOfficer@1199Funds.org (email)

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, contact the compliance coordinator at PrivacyOfficer@1199Funds.org or (646) 473-6600 for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services' Office for Civil Rights.

- Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
- Write to U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201
- Call (800) 368-1019 or (800) 537-7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/complaints/index.html.

**TRUSTEES**

The Board of Trustees is composed of Union and Employer Trustees. Employer Trustees are elected by the Employers. Union Trustees are chosen by the Union. The Trustees of the Benefit Fund are:

| UNION TRUSTEES | |
|---|---|
| Harold Fong-Sam<br>Vice President<br>1199SEIU<br>United Healthcare Workers East<br>498 Seventh Avenue<br>New York, NY 10018 | Keith Joseph<br>Vice President<br>1199SEIU<br>United Healthcare Workers East<br>498 Seventh Avenue<br>New York, NY 10018 |
| Vladimir Fortunny<br>Vice President<br>1199SEIU<br>United Healthcare Workers East<br>498 Seventh Avenue<br>New York, NY 10018 | Daniel Ratner<br>Trustee<br>1199SEIU<br>United Healthcare Workers East<br>498 Seventh Avenue<br>New York, NY 10018 |
| Katia Guillaume<br>Vice President<br>1199SEIU<br>United Healthcare Workers East<br>498 Seventh Avenue<br>New York, NY 10018 | Rona Shapiro<br>Executive Vice President<br>1199SEIU<br>United Healthcare Workers East<br>498 Seventh Avenue<br>New York, NY 10018 |
| Kwai (David) Ho<br>Vice President<br>1199SEIU<br>United Healthcare Workers East<br>498 Seventh Avenue<br>New York, NY 10018 | |

NOTE: This list is current as of the date of this SPD and does not include Alternate Trustees.

| EMPLOYER TRUSTEES | |
|---|---|
| Gladys Confident<br>Executive Director<br>Home Care Services for<br>Independent Living, Inc.<br>2044 Ocean Avenue, Suite B-4<br>Brooklyn, NY 11230 | Adria Powell<br>President<br>Cooperative Home Care Associates<br>400 East Fordham Road, 12th Floor<br>Bronx, NY 10458 |
| Julian Kang<br>Fiscal Director<br>Chinese-American Planning Council<br>Home Attendant Program<br>1 York Street, 2nd Floor<br>New York, NY 10013 | James Rolla<br>Senior Vice President<br>VNS Health, Personal Care Services<br>220 East 42nd Street, 2nd Floor<br>New York, NY 10017 |
| Marc Z. Kramer<br>President<br>League of Voluntary Hospitals<br>and Homes of New York<br>555 West 57th Street, Suite 1530<br>New York, NY 10019 | Andrea Thomas-Randall<br>Associate Executive Director<br>Sunnyside Community Services<br>43-31 39th Street<br>Sunnyside, NY 11104 |

NOTE: This list is current as of the date of this SPD and does not include Alternate Trustees.

# SECTION IX – DEFINITIONS

# DEFINITIONS

**Accident**

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

**Accidental Death and Dismemberment**

A Plan-sponsored Amalgamated Life Insurance Company policy providing for payments to a beneficiary designated by the employee under the circumstances described in Section IV, as well as in the Certificate of Coverage (a discrete policy).

**Administrative Review**

The procedure to appeal a claim that the Benefit Fund has rejected or denied in part. An Administrative Review can be requested by you, your dependents or another individual who has received your written authorization to appeal on your behalf. Your authorized representative cannot, in turn, authorize another party to appeal on their behalf.

**Adverse Benefit Decision or Adverse Benefit Determination**

A denial or partial denial of a claim for benefits.

**Affordable Care Act**

The Patient Protection and Affordable Care Act (ACA), as amended from time to time.

**Ambulance**

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

**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(s) of Benefits**

Authorization for the Benefit Fund to pay its allowance to your doctor, dentist, laboratory or other provider directly. To request and authorize this, you must sign the "Assignment of Benefits" authorization 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 Department care charges allowed by the Plan.

No other rights conferred under the terms of this Plan or ERISA may be assigned.

**Beneficiary(ies)**

The person(s) you have named to receive any Life Insurance Benefit.

**Benefit(s)**

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

**Brand-name Prescription Drug**

An FDA-approved prescription drug marketed with a specific brand name by the company that manufactures it, usually the company that develops and patents it.

**Calendar Year**

The 12-month period beginning January 1 and ending December 31.

**Children**

Your children who are eligible to receive benefits from the Benefit Fund, as described in Section I.A.

**Chiropractor**

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

**Claim Form**

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

**COBRA Continuation Coverage or COBRA Coverage**

Health coverage provided to a member or eligible dependent for a temporary period under certain circumstances. The member or eligible dependent must pay for this coverage. See Section I.K for detailed information.

**Concurrent Review**

Administrative Review that occurs as services are being provided to you. In such reviews, a request to extend a course of treatment is considered, and a determination regarding whether such services continue to be Medically Necessary Covered Services is made.

**Contributing Employer**

1. An Employer who has a Collective Bargaining Agreement with 1199SEIU United Healthcare Workers East, or one of its affiliates, that provides for regular monthly payments in an amount specified by the Trustees to this Benefit Fund on behalf of the employees covered by the agreement for all benefits in this Summary Plan Description.
2. 1199SEIU United Healthcare Workers East, its affiliates, the Benefit Fund or any other Employer accepted as a contributor by the Trustees and its affiliated and related Funds that are 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, which sets the order of payment by each. See Section I.F for details.

**Co-payment**

A dollar amount paid by you directly to the healthcare provider at the time services are received. Some of the benefits to which you are entitled are subject to co-payments. These co-payments are described on a separate list, which will be supplied to you. Co-payments may be changed by the 1199SEIU National Benefit Fund for Home Care Employees from time to time.

**Cosmetic Surgery**

Includes any procedure for which the 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.

**Covered Expenses or Covered Services**

Medical, dental, prescription, vision or hearing services and supplies shown as covered under this SPD.

**Custodial Care**

Care is considered custodial when it is primarily for the purpose of attending to the participant's daily living activities. Custodial care can be prescribed by a physician; it can also be given by trained medical personnel or by persons without professional skills or training. Examples of this include, but are not limited to, assistance with walking, getting in and out of bed, bathing, dressing, feeding, using the toilet and post-operative or chronic conditions; changing dressings of non-infected wounds; preparing food for 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.

**Dependent**

Your child or children who are eligible to receive benefits from the Benefit Fund, as described in Section I.A.

**Detoxification**

The process by which an alcohol-intoxicated or -dependent person or a drug-intoxicated or -dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol- or drug-dependent factors; or
- Alcohol in combination with drugs.

**Disabled**

The condition of being temporarily unable to work due to an accident, injury or illness.

**Doctor**

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

**Doula**

A trained professional who provides continuous physical, emotional and informational support to their client before, during and shortly after childbirth to help them achieve the healthiest, most satisfying experience possible.

**Durable Medical Equipment**

Devices, tools and other aids ("equipment") that can withstand repeated use, are primarily and usually used to serve a medical purpose and are generally not useful to a person in the absence of illness or injury.

**Effective Date of Coverage**

The date your and your dependent's coverage begins under this SPD as noted in your Employer's records.

**Eligibility Class**

One of the three wage-earning levels used by the Benefit Fund to determine the level of benefits to which a member and/or eligible dependents are entitled.

**Eligible**

The state of having met the criteria adopted by the Trustees of the Benefit Fund to determine your enrollment and plan of benefits and Eligibility Class.

**Emergency or Emergency Condition**

The term "Emergency Condition" **(or "Emergency")** refers to a severe medical or behavioral condition, including severe pain, that:

- Comes on suddenly
- Needs immediate medical care
- Leads a person with average knowledge of health and medicine to believe that, without immediate medical care, it could 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 Admission**

An admission to a hospital or treatment facility ordered by a physician within 24 hours of your receiving Emergency Care.

**Emergency Services or Emergency Care**

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.

**Employer**

See Contributing Employer.

**Enrollment Form**

Paperwork you complete and, usually, return to the Benefit Fund to be eligible for or receive benefits. See "Home Care Enrollment and Plan Election Form." Other enrollment forms include the Life Insurance Beneficiary Selection Form and Coordination of Benefits forms.

**ERISA**

The Employee Retirement Income Security Act of 1974, as amended from time to time.

**Executive Director**

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/Investigational Treatments, Services or Other Procedures**

Any treatment, procedure, service, facility, piece of equipment, drug, device or supply that **does not meet one** of the following criteria for use in treating the specific illness or condition:

- 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; or
- Where governmental approval is not required: The treatment or service is demonstrated to be obtainable outside the investigational or experimental setting and is not performed or provided in connection with a clinical trial or investigational protocol.

Note: A treatment, procedure, service, facility, piece of equipment, drug, device or supply will be considered experimental/investigational if it is (i) the subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the U.S.

Food and Drug Administration (FDA) regulations, regardless of whether the trial is subject to FDA oversight; and/or (ii) the subject of a written research or investigational treatment protocol being used by the treating provider or by another provider who is studying the same service. (However, the Fund covers medically necessary routine patient care in approved clinical trials in the same way it covers routine care for members who are not enrolled in clinical trials.)

**Family**

Your children who are eligible to receive benefits from the Benefit Fund, as described in Section I.A.

**FDA (Food and Drug Administration)**

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

**Fiduciary**

A person responsible for exercising discretion with respect to the management or administration of the Plan and Plan assets.

**Full Time**

The number of hours worked in a regular workweek, 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 at 498 Seventh Avenue in New York City, through which benefits are provided.

**Generic Prescription Drug**

A prescription drug with the same dosage, safety, strength, quality, performance and intended use as the brand-name product. It is defined as therapeutically equivalent by the FDA and is considered to be as effective as the brand-name product.

**Habilitative Services**

Healthcare services that help you keep, learn or improve skills and functioning for daily living.

**Health Benefits ID Card**

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

**Health Center**

Part of the Member Choice Home Care Select Plan. You choose a Health Center to be your “medical home” for primary care. The Primary Care Physician you see at your Health Center coordinates your healthcare needs with specialists, diagnostic facilities and other healthcare services provided in the same hospital network.

**Home Care Enrollment and**

**Plan Election Form**

The form used to provide the 1199SEIU Family of Funds' Eligibility Department with the personal and employment information needed to determine your benefits and process your claims.

**Home Care Trustees**

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

**Hospital**

An institution that meets **all** of the following requirements:

- 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 complete electronic medical records on all patients;
- Has bylaws in effect with respect to its medical staff;
- Has a hospital utilization review plan in effect;
- Is licensed by the federal government and by the state in which the hospital is located; and
- Has accreditation under the Joint Commission.

The term "hospital" **does not include** an institution or part of an institution that is used mainly as a/an:

- Rest or nursing facility;
- Facility for the aged, the chronically ill, convalescents or people with alcohol or drug use disorder;
- Facility providing custodial, psychiatric or rehabilitative care; or
- Educational facility

**Illness**

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

**Infertility**

A disease, condition or status characterized by any of the following:

- The inability to achieve a successful pregnancy after 12 months of regular, unprotected sexual intercourse or, for a female who is 35 years of age or older, after six months of regular, unprotected sexual intercourse
- The need for medical intervention in order to achieve a successful pregnancy based on either partner's reproductive organs or known etiology suggestive of impaired reproductive ability
- The need for medical intervention to preserve fertility where planned medical treatment results in iatrogenic infertility

**Injury**

An accidental bodily injury that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable, unforeseeable consequences of a voluntary act by a person. An act or event must be definite as to time and place.

**Leave**

A job-protected leave of absence (i.e., a period during which you are not working) from your place of employment.

**Legal Separation**

A marital status whereby spouses, while remaining legally married, have chosen to live separate lives physically and economically, as determined in the sole discretion of the Trustees, and as evidenced by, but not limited to, such circumstances as the following: living separate and apart from each other; maintaining separate legal residences and/or separate finances; having custody arrangements for children; or formally dividing joint legal property, assets and responsibilities.

**Legally Separated**

See Legal Separation.

**Level of Benefit**

The Eligibility Classification (Eligibility Class I or Eligibility Class II) used to determine the specific package of benefits to which you and your covered children are entitled.

**Lien Acknowledgment**

A form that describes and acknowledges the Benefit Fund's right to recover up to the amount it has paid or will pay for expenses relating to any claims you or your beneficiary may have against any person or entity responsible for an illness, accident or injury, including illness, accident or injury resulting from medical malpractice, as described in Section I.G.

**Lien Determination**

A determination that one or more of your claims for benefits is not covered because it is an expense resulting from an illness, accident or injury caused by the conduct of a third party, including expenses for treatment related to an illness, accident or injury that resulted from medical malpractice.

**Life Insurance**

A Plan-sponsored Amalgamated Life Insurance Company policy for the purpose of providing payments to beneficiaries designated by the employee in the event of the death of the employee as described in Section IV of this SPD and in the Certificate of Coverage (a discrete policy).

**LPN**

A licensed practical or vocational nurse.

**Maternity Care**

Includes prenatal and postnatal care, as well as care required by childbirth and miscarriages.

**Medically Necessary**

Services or supplies that are determined by the Plan Administrator to be required for appropriate healthcare and rendered at the appropriate level of care to identify or treat a pregnancy, non-occupational illness or non-occupational injury that a doctor has diagnosed or reasonably suspects. To be Medically Necessary, the Plan Administrator must determine, in its sole discretion, that the services or supplies:

- Are not considered Experimental/ Investigational or Unproven (see the definitions in this section);
- Are consistent with the diagnosis and treatment of the patient's condition;
- Are in accordance with the standards of accepted medical practice;
- Are not solely for the convenience of the patient, caregiver, physician and/or supplier;
- Are performed at a level of care not greater than required for the patient's condition;
- Will result in a measurable and ongoing improvement in the patient's health. For example, if the maximum therapeutic benefit has been met, then Medical Necessity cannot be established;
- 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; and
- Are advanced therapies that have only been rendered after more conservative medical treatments have been attempted without therapeutic improvement.

**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**

1. An employee who is working for a Contributing Employer on whose behalf payments to the Benefit Fund are required in the contract specified by the Trustees.
2. An employee who formerly worked for a Contributing Employer and who is covered for certain benefits is a member only with respect to those benefits provided to their class of former members.

**Mental Health Benefits**

Services for illnesses typically treated by psychiatrists, psychologists or other

licensed therapists using psychotherapy and/or psychotropic drugs.

**Minimum Full-time Household Income**

250% of the federal poverty level, or such other threshold as set by the Trustees or their designees.

**Network Administrator**

An outside company or administrator retained by the Plan to carry out administrative functions such as processing claims, hearing appeals or leasing provider networks.

**Network Provider**

See Participating Provider.

**Newly Organized**

Those employees in a bargaining unit when 1199SEIU United Healthcare Workers East concludes a Union contract, which, for the first time, requires payment to the National Benefit Fund for employees in that bargaining unit. It **does not include** employees covered under expired contracts, which are subsequently renewed or extended, or employees joining a bargaining unit after coverage under the Plan for employees in such a unit has been negotiated.

**Non-panel or Non-participating Provider**

A duly licensed healthcare professional or other provider who does not have any fee agreement with the Benefit Fund.

**Non-urgent Admission**

An inpatient admission that is not an Emergency Admission or an Urgent Admission.

**Occupational (Work-related) Illness, Injury or Disease**

An abnormal condition or disorder arising out of employment conditions, including a workplace accident, or employment conditions that are a distinctive feature of the worker's job.

**Orthodontic Treatment**

Any medical or dental service or supply furnished to prevent, diagnose or correct a misalignment of the teeth, bite or jaws or jaw joint relationship, whether or not for the purpose of relieving pain.

The following are not considered orthodontic treatment:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

**Outpatient Observation Care and Services**

A set of specific, clinically appropriate services that 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 24-48 hours or less.

**Over-the-Counter**

Any medication that is customarily and legally purchased without a prescription.

**Panel Doctor or Panel Provider**

See Participating Provider.

**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.

**Participant**

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

**Participating Pharmacy**

A licensed, registered Pharmacy that has signed an agreement with the Benefit Fund's pharmacy benefit manager.

**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 Benefit Fund, or with a network with which the Benefit Fund has a contract, to charge no more than the Benefit Fund's Schedule of Allowances.

**Permanently Disabled**

A designation for a person with an inability to perform any gainful employment prior to age 65 as certified by the granting of a Social Security Disability Award from the Social Security Administration.

**Pharmacy**

An establishment where prescription drugs are legally dispensed. Includes a retail pharmacy, mail-order pharmacy and specialty pharmacy.

**Physician**

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

**Plan**

The benefits and rules and regulations pertaining to the 1199SEIU National Benefit Fund for Home Care Employees for the various levels of

benefits as adopted and interpreted by the Trustees, as well as the official documents, such as the Trust Agreement and this SPD, including its preface, in which those benefits and rules and regulations are described.

**Plan Administrator**

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 they have been licensed.

**Pre-certification**

Prior Authorization for inpatient hospital admission.

**Preferred Brand-name Drugs**

Brand-name drugs included in the Benefit Fund's Preferred Drug List.

**Preferred Drugs**

Generic alternatives to brand-name drugs.

**Primary Care Dentist**

Often referred to as a "general dentist," a primary care dentist is the first point of contact for dental care. They provide comprehensive oral services like routine checkups, cleanings and treatment of common dental issues. They also refer patients to specialists when needed.

**Primary Care Physician (or Doctor)**

The doctor having primary responsibility for your medical care. You choose your own Primary Care Doctor in accordance with the 1199SEIU Benefit Fund guidelines, subject to the doctor's acceptance. A Primary Care Doctor generally practices in the area of family medicine, internal medicine or pediatrics.

**Prior Authorization or Prior Approval**

Required Benefit Fund approval for a treatment plan prior to receiving services or supplies. This review process evaluates the Medical Necessity and appropriateness of a proposed service or care. This includes, but is not limited to, some dental claims; certain home care services or treatment; admissions and intermediate care for mental health or alcohol/substance use disorder; admissions for physical rehabilitation; certain prescription drugs; and all non-Emergency hospital admissions and surgical procedures.Prior Authorization **does not include** an eligibility determination or a review of a Non-participating Provider's charges. There may be certain penalties, as described in this SPD, if you fail to obtain Prior Authorization.

**Psychiatric Social Worker**

A person licensed by the appropriate department of the state to practice within the psychiatric social work profession for which they have been licensed.

**Psychologist**

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

**Referral**

A written or electronic authorization made by your Primary Care Doctor to direct you to a specialist for Medically Necessary services or supplies covered under the Plan.

**Rehabilitation Facility**

A facility, or a distinct part of a facility, that provides rehabilitative services, meets all applicable licensing or certification standards established by the jurisdiction where it is located and makes charges for its services.

**Rehabilitative Services**

Healthcare services that help you keep, get back or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt or disabled.

**Retired Member or Retiree**

A person who is currently receiving a pension from the 1199SEIU Home Care Employees Pension Fund.

**Retrospective Review**

Administrative Review of a request that occurs after services have been provided to you. Such reviews are meant to determine if the provided services were Medically Necessary Covered Services and whether and to what extent benefits are payable.

**RN**

A registered nurse.

**Schedule**

A list of items covered and/or amounts paid.

**Schedule of Allowances**

List of fees for each service allowed or paid by the Plan, as established by the Trustees. The Centers for Medicare & Medicaid Services' rules for bundling payments apply.

**Semi-private Room Rate**

The room and board charge that an institution applies to the most beds in its semi-private rooms, that is, rooms with two or more beds.

**Skilled Nursing Facility**

A facility that provides medical and nursing care and is recognized as such by Medicare.

**Skilled Nursing Services**

Services that meet **all** of the following requirements:

- The services require medical or paramedical training;
- The services are rendered by a registered nurse or licensed practical nurse within the scope of their license; and
- The services are not custodial.

**Smart Cycle**

Progyny's benefit currency for fertility treatment. Progyny bundles all services necessary for a treatment cycle into this unit of currency versus a dollar maximum. Everything needed for a comprehensive fertility treatment is contained within the Smart Cycle, including all necessary diagnostic testing and the latest technology (such a PGT-A, ICSI, etc.). Each treatment or service is valued as a portion of a Smart Cycle. Individuals can utilize their Smart Cycles for whichever treatments they and their physician determine to be necessary until they exhaust their Smart Cycle balance.

**Specialist**

A physician licensed by the appropriate department of the state to practice within the generally accepted medical or surgical sub-specialty for which they have been licensed.

**Specialty Care**

Healthcare services or supplies that require the services of a Specialist.

**Specialty Care Drugs**

Prescription drugs, typically high-cost, that require special handling, storage, monitoring and/or routes of administration.

**Stay**

A full-time inpatient confinement for which a room and board charge is made.

**Substance or Alcohol Use Disorder**

A physical or psychological dependency, or both, on a controlled substance or alcohol agent. This term **does not include** conditions not attributable to a mental disorder that are a focus of attention or treatment, an addiction to nicotine products or food or caffeine intoxication.

**Surgeon**

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

**Surgery Center**

A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards;
- Is set up, equipped and run to provide general surgery;
- Is directed by a staff of Physicians (at least one of them must be on the premises when surgery is performed and during the recovery period);
- Has at least one certified anesthesiologist onsite when surgery requiring general or spinal anesthesia is performed and during the recovery period;
- Does not have a place for patients to stay overnight;
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by a registered nurse; and
- Is equipped and has trained staff to handle Emergency Conditions.

**Telehealth**

A consultation, exam or visit between you and a Provider who is performing a clinical medical or behavioral health service outside an in-person setting. Telehealth (or telemedicine) services can be provided by:

- Two-way audiovisual teleconferencing;
- Telephone calls; or
- Any other method permitted by state law.

**Terminally Ill (Hospice Care)**

A medical prognosis of six months or fewer to live.

**Totally Disabled**

See Permanently Disabled.

**Trust Agreement**

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

**Trustees**

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

**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.

**Unproven Treatments, Services or Other Procedures**

A treatment, procedure, facility, piece of equipment, drug, device or supply ("service/treatment") that **does not**

meet each of the following criteria for use in treating the condition being reviewed, regardless of any governmental approval:

1. There is reliable scientific evidence, including but not limited to published peer-reviewed evidence-based studies and literature meeting nationally recognized requirements demonstrating that the service/treatment:
    - Improves net health outcomes by having a measurable, reproducible positive effect on health outcomes attainable under the usual conditions of professional practice; and
    - Is safe and effective, or the beneficial effect on health outcomes outweighs any potential risk or harmful effects.
2. The service has been endorsed by national medical bodies, societies or panels regarding the efficacy and rationale for use.

**Urgent Admission**

A hospital admission by a Physician due to:

- The onset of or change in an illness;
- The diagnosis of an illness; or
- An injury.

The condition, while not needing an Emergency Admission, is severe enough to require confinement as an inpatient in a Hospital within two weeks of the date the need for the confinement becomes apparent.

**Urgent Condition**

A sudden illness, injury or condition that meets **all** of the following requirements:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition that would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the Emergency Department of a Hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your Physician becomes reasonably available.

**You or Your**

Refers to the member, as an individual, and/or to the member's dependents, individually or together, depending on the context in which it is used. This definition applies regardless of the term's capitalization.

**NOTES:** _____

**NOTES:** _____

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