

# 1199SEIU

## National Benefit Fund for Home Care Employees



## *Our Benefits*

Summary Plan Description  
of Your Health and Welfare Benefits





This booklet serves as both a Summary Plan Description and Plan Document (“SPD”) for participants in the 1199SEIU National Benefit Fund for Home Care Employees employed in the metropolitan New York City area and other areas covered by this 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 (“NBF–Home Care” or “Fund”), a sub-Fund of the 1199SEIU Benefit and Pension Funds, which has established a separate Home Care Trustee board. No individual or entity, other than the Trustees (including any duly authorized board, committee or designee thereof) has any authority to interpret the provisions of this Plan Document or to make any promises to you about the Plan.

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

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

No employee has or will have a vested or non-forfeitable right to receive benefits under the Plan.

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

This SPD and any amendments are your 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 office staff will be glad to help you. Since telephone conversations and other oral statements can easily be misunderstood, they cannot be relied upon if they are in conflict with what is stated in this Plan Document.

The Fund believes it is a “Grandfathered Health Plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted in 2010. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for an external review process for claims appeals. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan can be directed to the Plan Administrator at (646) 473-9200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

June 2015

**Dear 1199SEIU Home Care Member:**

The Benefit Fund cares about you.

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

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

**It is important that you read the entire SPD so that you know:**

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

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

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

Enjoy the benefits of your new benefit plan.

**The Board of Trustees**

## **NEED HELP WITH THE SUMMARY 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, you can get assistance by writing the Benefit Fund at:

**330 West 42nd Street  
New York, NY 10036**

**Or calling (646) 473-9200.**

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

## **¿NECESITA AYUDA CON LA DESCRIPCIÓN ABREVIADA DEL PLAN?**

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

**330 West 42nd Street  
New York, NY 10036**

**O llamando al (646) 473-9200.**

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

## 你的摘要說明計畫需要幫助嗎？

這本小冊子是關於1199SEIU國家福利基金會給家庭護理雇員使用這些福利的政策和程序之摘要。如果你對該語言是不清楚的，你可以透過寫信至基金會以得到援助：

330 西 42街  
紐約，紐約 10036

或請撥打 (646) 473-9200。

基金會的辦公時間是星期一至星期五上午8點至下午 6點。

## ВАМ ЧТО-ТО НЕПОНЯТНО В КРАТКОМ ОПИСАНИИ ПЛАНА?

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

**330 West 42nd Street  
New York, NY 10036**

**или позвонив по телефону: (646) 473-9200.**

Офис Фонда открыт с 8:00 до 18:00, с понедельника по пятницу.

---

# TABLE OF CONTENTS

Preface .....	1
Letter from the Board of Trustees .....	3
<b>OVERVIEW OF YOUR BENEFITS .....</b>	<b>11</b>
<b>SECTION I – ELIGIBILITY .....</b>	<b>21</b>
I. A Who Is Eligible .....	23
I. B When Your Coverage Begins .....	24
I. C Enrolling in the Benefit Fund .....	27
I. D Maximum Benefits .....	29
I. E Your Health Benefits ID Card .....	30
I. F Coordinating Your Benefits .....	31
I. G When Others Are Responsible for Your Illness or Injury .....	34
I. H When You Are on Workers’ Compensation Leave .....	37
I. I Losing Eligibility .....	38
I. J Regaining Eligibility .....	40
I. K How You Can Extend Eligibility .....	41
I. L How to Resolve Questions Concerning Eligibility for Benefits .....	49
<b>SECTION II – HEALTH BENEFITS .....</b>	<b>51</b>
II. A Participating Providers .....	55
II. B Using Your Benefits Wisely .....	59
II. C Hospital Care and Hospice Care .....	63
II. D Emergency Department Visits .....	67
II. E Program for Behavioral Health: Mental Health and Alcohol/Substance Abuse .....	69
II. F Surgery and Anesthesia .....	71
II. G Maternity Care .....	74
II. H Medical Services .....	76
II. I Services Requiring Prior Authorization .....	80



II. J	Vision Care and Hearing Aids . . . . .	83
II. K	Dental Benefits. . . . .	85
II. L	Prescription Drugs . . . . .	87
<b>SECTION III – DISABILITY BENEFITS . . . . .</b>		<b>93</b>
<b>SECTION IV – LIFE INSURANCE BENEFIT . . . . .</b>		<b>95</b>
<b>SECTION V – OTHER BENEFITS . . . . .</b>		<b>101</b>
V. A	Social Services. . . . .	103
<b>SECTION VI – RETIREE HEALTH BENEFITS . . . . .</b>		<b>105</b>
<b>SECTION VII – GETTING YOUR BENEFITS . . . . .</b>		<b>107</b>
VII. A	Getting Your Healthcare Benefits. . . . .	109
VII. B	Your Rights Are Protected — Appeals Procedure . . . . .	114
VII. C	When Benefits May Be Suspended, Withheld or Denied . . . . .	118
VII. D	What Is Not Covered . . . . .	119
VII. E	Additional Provisions . . . . .	121
<b>SECTION VIII – GENERAL INFORMATION. . . . .</b>		<b>123</b>
VIII. A	Your ERISA Rights . . . . .	124
VIII. B	Plan Amendment, Modification and Termination. . . . .	127
VIII. C	Authority of the Plan Administrator . . . . .	128
VIII. D	Information on Your Plan . . . . .	129
<b>SECTION IX – DEFINITIONS . . . . .</b>		<b>133</b>

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

### ***Refer to the Definitions Section***

The Definitions section (Section IX) lists the terms used in this SPD and explains how they are defined by the Benefit Fund.

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

If you have any further questions, please call our Benefit Fund’s Member Services Department at (646) 473-9200.

## 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”).

The Benefit Fund is a “grandfathered” plan that provides “minimum essential coverage” and exceeds the “minimum value” standard, as defined by the Patient Protection and Affordable Care Act (the “Affordable Care Act”).

**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. It exists only to provide you, other 1199SEIU members and your families with quality Health and Welfare Benefits. It also means that 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 that the Benefit Fund is run by an equal number of Trustees appointed by **1199SEIU** and by **Employers** who make payments to the Benefit Fund on behalf of their workers.

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

**Grandfathered** is a term created under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted in 2010. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for an external review process for claims appeals. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan can be directed to the Plan Administrator at (646) 473-9200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

**Minimum essential coverage** is healthcare 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 offered Employer-sponsored coverage that provides minimum value and that's affordable won't be eligible for a premium tax credit for coverage through the Health Insurance Marketplace.



## **OVERVIEW OF YOUR BENEFITS**

## IMPORTANT PHONE NUMBERS

### **Member Services Department**

(646) 473-9200

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

### **Call the Following Phone Numbers to Protect Your Benefits:**

- 1199SEIU CareReview Program  
(for prior approval of hospital stays) (800) 227-9360
- Ambulatory/Outpatient Surgery  
Pre-Certification Program  
(646) 473-9200
- Program for Behavioral Health  
(646) 473-6900

### **Medical Benefits**

Members will be asked to decide whether they wish to receive their benefits through the Member Choice Home Care Select Plan or through the Panel Provider Plan. While the benefits provided by the Fund are similar, the co-payments that you may pay will differ.

**You can also visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org) for forms, directories and other information. From our website, you can also click on “My Account” and create your own personal information account to check your eligibility, find out whether a claim has been paid, change your address or update other information.**

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

**The Benefit Fund believes that it is a “Grandfathered Health Plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”).**

# OVERVIEW OF YOUR BENEFITS

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

**Effective January 1, 2016, your dependent children, as defined by the Plan Administrator, will be eligible for the same benefits as you, other than life insurance.**

BENEFIT	COVERAGE	COMMENTS
<p><b>Hospital Care</b></p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Up to 365 days per year</li> <li>• Semi-private room and board</li> <li>• Acute care for Medically Necessary services</li> <li>• Inpatient admissions</li> <li>• Outpatient or ambulatory facilities</li> <li>• Observation care and services</li> <li>• Up to 30 days per year for inpatient physical rehabilitation in an acute care facility. Benefits are not provided for care in a nursing home or skilled nursing facility.</li> </ul>	<p><i>Benefits are not provided for care in a nursing home or skilled nursing facility.</i></p> <p><i>Call 1199SEIU CareReview at (800) 227-9360 before going to the hospital or within 48 hours of an Emergency admission.</i></p> <p><i>Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.</i></p>

BENEFIT	COVERAGE	COMMENTS
<b>Hospice Care</b>	<ul style="list-style-type: none"> <li>Up to 210 days of Medicare-certified hospice care per lifetime in a hospice center, hospital, skilled nursing facility or at home</li> </ul>	
<b>Emergency Department Visits</b>	<ul style="list-style-type: none"> <li>This benefit is for the hospital's charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered, depending on eligibility, as described in Section II.H of this SPD.</li> <li>Use of the Emergency Department must be <b>for an Emergency within 72 hours</b> of an accident/injury or sudden and serious illness</li> <li>Observation Care and Services (see Section II.C)</li> <li>Benefit Fund pays negotiated or reasonable rate</li> </ul>	<p><i>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.</i></p>



BENEFIT	COVERAGE	COMMENTS
<b>Program for Behavioral Health</b>	<p><b>Mental Health</b></p> <ul style="list-style-type: none"> <li>• Outpatient treatment</li> <li>• Intensive Outpatient Programs (IOP)</li> <li>• Inpatient Care</li> <li>• Partial Hospitalization Programs (PHP)</li> </ul> <p><b>Alcohol/Substance Abuse</b></p> <ul style="list-style-type: none"> <li>• Inpatient detoxification and rehabilitation</li> <li>• Intensive Outpatient Programs (IOP)</li> <li>• Outpatient treatment</li> </ul>	<p><i>Call 1199SEIU CareReview at (800) 227-9360, to pre-certify inpatient treatment.</i></p> <p><i>To pre-certify PHP and IOP services, call the Fund at (646) 473-6868.</i></p> <p><i>Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.</i></p>
<b>Surgery</b>	<ul style="list-style-type: none"> <li>• Inpatient or outpatient (ambulatory) surgery</li> <li>• Benefits based on the Fund's allowance for the surgical procedure</li> <li>• Participating Surgeons bill the Benefit Fund directly and accept the Fund's payment as payment in full</li> </ul>	<p><i>Call 1199SEIU CareReview at (800) 227-9360 before having non-Emergency surgery.</i></p>
<b>Anesthesia</b>	<ul style="list-style-type: none"> <li>• Benefits based on the Fund's Schedule of Allowances</li> </ul>	
<b>Maternity Care</b>	<ul style="list-style-type: none"> <li>• An allowance which includes all prenatal and postnatal visits and delivery charges</li> <li>• Hospital Benefit for the mother</li> <li>• Hospital Benefit for the newborn, if the mother is you</li> </ul>	<p><i>Call the Wellness Department at (646) 473-8962 to register for the Prenatal Program.</i></p> <p><i>Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.</i></p>

BENEFIT	COVERAGE	COMMENTS
<b>Medical Services</b>	<ul style="list-style-type: none"> <li>• Treatment in a doctor’s office, clinic, hospital, Emergency Department or your home</li> <li>• Certain screenings and immunizations</li> <li>• X-rays and laboratory tests</li> <li>• Hospice care</li> <li>• Durable medical equipment and appliances</li> <li>• Dermatology: up to 20 treatments per year</li> <li>• Chiropractic: up to 12 treatments per year</li> <li>• Podiatry: up to 15 treatments per year for routine care</li> <li>• Allergy: up to 20 treatments per year, including diagnostic testing</li> <li>• Physical/Occupational/ Speech therapy: up to 25 visits per discipline per year</li> <li>• Ambulance services</li> <li>• Participating Providers bill the Benefit Fund directly and accept the Fund’s payment as payment in full</li> </ul>	<p><i>Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan.</i></p> <p><i>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.</i></p>

BENEFIT	COVERAGE	COMMENTS
<b>Medical Services Requiring Prior Authorization</b>	<ul style="list-style-type: none"> <li>• Home health care</li> <li>• Non-Emergency ambulance services</li> <li>• Durable medical equipment and appliances</li> <li>• Medical supplies</li> <li>• Specific medications, including specialty drugs</li> <li>• MRI, MRA, PET and CAT scans and certain nuclear cardiology procedures</li> <li>• Molecular and genomic testing</li> <li>• Ambulatory surgery or inpatient admissions</li> <li>• Partial Hospitalization Programs (PHP) for mental health</li> <li>• Intensive Outpatient Programs (IOP) for mental health and alcohol/ substance abuse</li> <li>• Certain home infusion drugs administered on an outpatient basis</li> </ul>	<p><i>Call the Prior Authorization Department at (646) 473-9200 for prior approval for services except Emergency ambulance and the services listed below.</i></p> <p><i>Call (888) 910-1199 for prior approval of radiology tests.</i></p> <p><i>Call eviCore (formerly CareCore) at (844) 840-1199 for prior approval of molecular and genomic testing.</i></p> <p><i>Call 1199SEIU CareReview at (800) 227-9360 for prior approval of ambulatory surgery or inpatient admissions.</i></p> <p><i>To pre-certify PHP and IOP services, call the Fund at (646) 473-6868.</i></p> <p><i>Call Care Continuum at (877) 273-2122 for prior approval of certain home infusion drugs administered on an outpatient basis.</i></p>
<b>Vision Care</b>	<ul style="list-style-type: none"> <li>• One eye exam every two years</li> <li>• One pair of glasses or contact lenses every two years</li> </ul>	

BENEFIT	COVERAGE	COMMENTS
<b>Hearing Aids</b>	<ul style="list-style-type: none"> <li>• Once every three years</li> <li>• Call for referrals to a Participating Provider</li> </ul>	<i>Co-payments may apply.</i>
<b>Basic Dental Care</b>	<ul style="list-style-type: none"> <li>• Basic and preventive services through Participating Provider network</li> <li>• Initial/periodic oral exams once every six months</li> <li>• Bitewing X-rays once every six months</li> <li>• Prophylaxis (cleaning), scaling and fluoride once every 6 months</li> <li>• Dental Emergencies</li> <li>• Minor restorative services</li> <li>• Denture adjustments, repairs and relines</li> </ul>	<i>If you do not use a Participating DentCare Provider, you will be responsible for all charges. Call DentCare (formerly Healthplex) at (800) 468-0600 to find a provider convenient to you.</i>
<b>Major Dental Care</b>	<ul style="list-style-type: none"> <li>• Major restorative work through Participating Providers</li> <li>• Oral surgery</li> <li>• Crowns, bridges, dentures and periodontal care once every 60-month period</li> </ul>	<i>Co-payments apply. Call DentCare (formerly Healthplex) at (800) 468-0600 for additional information.</i>

BENEFIT	COVERAGE	COMMENTS
<b>Prescription Drugs</b>	<ul style="list-style-type: none"> <li>• FDA-approved prescription medications</li> <li>• No co-payments if you are enrolled in the Member Choice Home Care Select Plan; no deductible when you use generic drugs and preferred drugs if available</li> <li>• Co-payments for brand and generic drugs if you are <b>not</b> enrolled in the Member Choice Home Care Select Plan; no deductible when you use generic drugs and preferred drugs if available</li> <li>• Use Participating Pharmacies</li> <li>• Mandatory Maintenance Drug Access Program for chronic conditions — <i>The 90-Day Rx Solution</i></li> <li>• Prior authorization needed for certain medications</li> <li>• Please refer to “What Is Not Covered” in Section II.L</li> </ul>	
<b>Life Insurance</b>	<ul style="list-style-type: none"> <li>• A benefit of \$10,000</li> </ul>	<i>Life Insurance Benefit is for the member only.</i>
<b>Accidental Death &amp; Dismemberment</b>	<ul style="list-style-type: none"> <li>• For accidental death or injury</li> <li>• Equal to, or one half of, your life insurance (based upon your loss)</li> </ul>	<i>Accidental Death &amp; Dismemberment Benefit is for the member only.</i>

BENEFIT	COVERAGE	COMMENTS
<b>Social Services</b>	<ul style="list-style-type: none"> <li>• Member Assistance Program</li> <li>• Citizenship Program</li> <li>• Earned Income Tax Credit Assistance Program</li> <li>• Financial Wellness Program</li> <li>• Weekly Legal Clinic</li> </ul>	



## SECTION I – ELIGIBILITY

- A. Who Is Eligible
- B. When Your Coverage Begins
- C. Enrolling in the Benefit Fund
- D. Maximum Benefits
- E. Your Health Benefits ID Card
- 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 (FMLA)
  - Coverage While Taking Uniformed Services Leave
  - Your COBRA Rights
- L. How to Resolve Questions Concerning Eligibility for Benefits

## ELIGIBILITY RESOURCE GUIDE

### WHERE TO CALL

**Member Services Department**  
**(646) 473-9200**

**[www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org)**

Call Member Services to:

- Check whether you are eligible to receive benefits;
- Find out your benefit level;
- Request any forms;
- Update the information on your **Home Care Plan Election Form** (address, phone number, etc.);
- Notify the Benefit Fund when you change Employers;
- Report any errors on your Health Benefits ID card;
- Notify the Benefit Fund when you're on Workers' Compensation, Disability or FMLA leave; or
- Get the answers to any of your questions.

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

Call the COBRA Department to:

- Apply for COBRA continuation coverage; or
- Get more information on COBRA.

### PRE-EXISTING CONDITIONS

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.

### REMINDERS

- You must enroll in the Benefit Fund to be eligible for benefits.
- Check the information on your Health Benefits ID card and notify the Fund of any incorrect information immediately.
- Fill out all forms completely and attach all the documents required. Otherwise, your claim may be delayed or your benefits denied.
- Notify the Benefit Fund of any change of address, phone number, etc.
- Notify the Benefit Fund when you change Employers in order for your coverage to continue.
- To protect your benefits, contact the Fund immediately if you are not working due to a Workers' Compensation, Disability 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.



---

# SECTION I. A

## WHO IS ELIGIBLE

Effective January 1, 2016, your dependent children, as defined by the Plan Administrator, will be eligible for the same benefits as you, other than life insurance.

### YOU

You are eligible to participate in the 1199SEIU National Benefit Fund for Home Care Employees if:

- 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 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

Your children are eligible up to their 26th birthday if all the following conditions are met:

- They're your biological children; or

- They're 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 your child's coverage under other benefit plans as requested by the Fund; and
- You are eligible for coverage; and
- You have authorized the required premium deduction.

Your stepchildren, foster children and grandchildren are **not covered** by the Benefit Fund. Children of your spouse cannot be covered by the Benefit Fund unless you are their legally recognized parent or they are legally adopted by or placed for adoption with you.

### 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.

---

# SECTION I. B

## WHEN YOUR COVERAGE BEGINS

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

### **YOU BECOME A PLAN PARTICIPANT BY MEETING THESE ELIGIBILITY REQUIREMENTS:**

**1) You work in a covered job title at a Contributing Employer.**

A “covered job title” is one specified by the Collective Bargaining Agreement among 1199SEIU and the agencies that contribute to the Benefit Fund. Because these can change from time to time, you may receive a list of Contributing Employers and/or covered titles by writing to or calling the Fund.

**AND**

**2) You have completed and submitted a Home Care Plan Election Form, agreeing to pay the required weekly premium by authorizing your Employer to deduct the cost of the premium from your paycheck. This amount will differ if coverage is for you alone, or for you and your dependent children, effective January 1, 2016.**

**AND**

**3) You have become eligible under the “100-hour rule.”**

To become a participant, you must have 100 or more “hours worked” per month for two consecutive calendar months. This two-month period is called the “determination period.” You will then become a participant one calendar month later. This one-month period between the determination period and the date of first eligibility is called the “administrative period.” Participation is always counted from the first day of a month. “Hours worked” only includes the hours that you physically worked for which you were paid by your Employer. Hours worked **DOES NOT** include hours for which you received sick and vacation pay.

**Exception:** If you are hospitalized on the day your eligibility would otherwise start, eligibility for the hospitalized individual does not begin until his or her date of discharge.

The Wellness and Member Assistance Program, Citizenship Program and Earned Income Tax Credit Assistance Program are available to all bargaining unit employees of Contributing Home Care Employers regardless of whether the member meets the 100-hour rule and regardless of whether the member pays 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. However, you can receive no more than the maximum benefit allowed by the Benefit Fund's Schedule of Allowances.

**NOTE:** If you are income-eligible for Medicaid, New York State may pay your weekly premium.

## **EXAMPLES OF THE 100-HOUR RULE**

### **Example #1**

Ms. Hernandez began working for an 1199SEIU-covered agency as a home attendant at the end of August 2014. In September, she worked only 21 hours. In October, she worked 240 hours. In November, she worked 260 hours. By November 30, she had completed the "determination period" — two months in a row with 100 or more hours. After a one-month "administrative period" (December), she will be eligible for benefits on January 1, 2015.

### **Example #2**

Ms. Hernandez began working for an 1199SEIU-covered agency as a home attendant at the end of August 2014. In September, she worked 40 hours. In October, she worked 260 hours. Even though she worked a combined total of 300 hours over two calendar months, she did not complete the "determination period" because she worked only 40 hours in September. If she works at least 100 hours in November, she will be eligible — after a one-month "administrative period" (December) — for benefits beginning on January 1, 2015.

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

Your claims will be processed faster — and you will receive your benefits more quickly — if the Benefit Fund has up-to-date information about you.

You must notify the Fund no more than 30 days from the date of the event when:

- You move;
- You change Employers; or
- There is a change in the status of your dependent children.

Fill out a **Home Care Plan Election Form** and send it to the 1199SEIU Family of Funds' Eligibility Department so that your records can be updated.

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

The 1199SEIU Family of Funds' Eligibility Department collects Home Care Plan Election Forms on behalf of employees and to support the enrollment, disenrollment and payroll deduction functions performed by your Employer. All information appearing on your Home Care Plan Election Form will be transmitted to your Employer and to the Benefit Fund on your behalf. The Benefit Fund will not release your information to any other third party, except where necessary for the administration and operation of the Benefit Fund, or otherwise required by law.

**NOTE:** If you have designated your spouse as your life insurance beneficiary, your divorce will automatically revoke that designation upon notification to the Benefit Fund.

---

# SECTION I. C

## ENROLLING IN THE BENEFIT FUND

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

You must fill out a **Home Care Plan Election Form** and send it to the Benefit Fund before you will be eligible for benefits.

You can get a Home Care Plan Election Form from your Employer, the Union or from the 1199SEIU Family of Funds' Eligibility Department by calling the Member Services Department at (646) 473-9200, or by clicking on "My Account" when visiting the website at **[www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org)**.

The Home Care Plan Election Form 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 of your eligible children; and
- Information on other insurance coverage.

### Sign and date the Home Care Plan Election Form and:

1. Include copies of a birth certificate for you and your eligible children to be covered.
2. Send the Home Care Plan Election Form and any related documents to the 1199SEIU Family of Funds' Eligibility Department immediately.

You must elect coverage during the open enrollment or special enrollment periods. The Eligibility Department will not be able to process your Home Care Plan Election Form if you do not include all the information and documents required. That means you will not be eligible to receive benefits. Once your Home Care Plan Election Form has 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).

### LET THE BENEFIT FUND KNOW OF ANY CHANGES

Your claims will be processed faster — and you will receive your benefits more quickly — if the Benefit Fund has up-to-date information on you and your family.

You must notify the Benefit Fund no more than 30 days from the date of the event 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;
- You change Employers; or
- You want to change your beneficiary.
- Fill out a **Home Care Plan Election Form** and send it to the 1199SEIU Family of Funds' Eligibility Department so that your records can be updated.

Remember to send copies of all the documents needed by the Benefit Fund, including:

- Birth certificate(s);
- Adoption papers; and
- Any other documents required by the Benefit Fund.

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

The 1199SEIU Family of Funds' Eligibility Department collects Home Care Plan Election Forms on behalf of employees and to support the enrollment, disenrollment and payroll deduction functions performed by your Employer. All information appearing on your Home Care Plan Election Form will be transmitted to your Employer and to the Benefit Fund on your behalf. The Benefit Fund will not release your information to any other third party, except where necessary for the administration and operation of the Benefit Fund, or otherwise required by law.

**NOTE:** If you have designated your spouse as your life insurance beneficiary, your divorce will automatically revoke that designation upon notification to the Fund.

**NOTE ABOUT NEWBORN**

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

---

## **SECTION I. D**

### **MAXIMUM BENEFITS**

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

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

---

## SECTION I. E

# YOUR HEALTH BENEFITS ID CARD

If you are eligible for benefits and have enrolled in the Benefit Fund, you will receive a Health Benefits ID card.

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

- You did not receive your card;
- Your card is lost or stolen; or
- Your name is not listed correctly.

**NOTE:** If you are no longer eligible for benefits, you may not use your Health Benefits ID card. If you do, you will be personally responsible for all charges.

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

If you suspect that someone is using a Health Benefits ID card fraudulently, call the Benefit 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 health coverage by “coordinating” benefits.

Here’s how it works:

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

If the Benefit Fund is:

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

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

The coverage that has been in place the longest will be your primary insurer. However, if you are enrolled in a plan where coverage is limited to services provided by in-network providers only, you **must use that insurance first**.

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

If the Benefit Fund is the secondary coverage, we will provide only for those benefits that are not provided by the primary plan.

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

The total amount paid shall not be more than the Trustees determine as the maximum allowable cost for the Medically Necessary care provided or 100% of the actual expenses, whichever is less.

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

When your spouse or 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 your **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 the Benefit Fund and another Employer-sponsored plan (excluding parent coverage), your child's plan is the **primary** payer.

When submitting a claim for your child's care, you must include a statement from that plan showing what action they have 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 his or her employment or through his or her spouse's employment, if any;

- The **secondary** payer is the plan of the **parent whose birthday is earliest in the year**; and
- The other parent's plan is the next payer.

### If your child has no coverage, then the birthday rule would work as follows:

The mother's birthday is March 11 and the father's birthday is July 10. Since the mother's birthday is earlier than the father's birthday, her plan is the primary payer for her children's benefits.

## WHEN COVERED BY AN IN-NETWORK ONLY PLAN

If your children are enrolled in the Benefit Fund and in a plan where coverage is primary and is limited to services provided by in-network providers only, **they must use that insurance first.**

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

## WHEN YOU ARE COVERED BY MEDICARE

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

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

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

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

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

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 be enrolled in Medicare Part A and Part B immediately upon completion of the Medicare Coordination Period, and you must maintain Medicare coverage prior to and after your transplant as required by law unless you have verified that the Fund is your primary insurer. The Fund will provide reimbursement for 50% of the standard Medicare Part B Premium for months where the Fund is secondary to Medicare. You are not eligible for this reimbursement for any month in

which the Fund is providing primary coverage. You may file a claim, along with the required documentation, once each quarter to get this benefit.

**NOTE OF CAUTION:** 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.

---

## 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, his or her insurance company, an uninsured motorist fund, no-fault insurance carrier or Workers' Compensation insurance carrier.

**Expenses such as disability, hospital, medical, prescription or other services resulting from such an illness or injury 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 and 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. Further, 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 fully 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, as soon as you receive 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 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 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, 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 Benefits Officer or his or her designee in writing no later than 60 days after the receipt of the appeal denial. If your appeal is denied by the Chief Benefits Officer or his or her 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 that provides for health insurance protection, even if you select coverage under the motor vehicle insurance as secondary.

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

**WHEN MOTOR VEHICLE  
OR NO-FAULT INSURANCE  
DENIES COVERAGE**

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

If the no-fault insurer denies your claim for benefits, you are required to appeal this denial to your no-fault carrier.

You must provide proof to the Fund that you have exhausted the no-fault

appeals process before the Fund will consider payment in accordance with its Schedule of Fees and Allowances.

---

# SECTION I. H

## WHEN YOU ARE ON WORKERS' COMPENSATION LEAVE

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

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

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

However, the Fund will:

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

If you can't go back to work after 26 weeks, your coverage through the Fund will end. However, you can extend your Health Benefits under COBRA continuation coverage (see Section I.K).

### NOTIFY THE BENEFIT FUND

You need to contact the Benefit Fund **within 30 days** when you're not working due to a work-related illness or injury. 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 Fund determines your eligibility for benefits based on wage reports it receives from your Employer. If you haven't received any wages, then your coverage may be suspended because the Fund does not know that you are out on Workers' Compensation leave.

---

# SECTION I. I

## LOSING ELIGIBILITY

### HOW YOU LOSE ELIGIBILITY

You will no longer be eligible for 1199SEIU Benefit Fund benefits if you do not work the required 100 hours per month for two consecutive calendar months. Eligibility ends the first of the month following the month after the second consecutive month in which you work fewer than 100 hours. For example, if you do not work 100 hours in both January and February, your coverage will end April 1st. However, you may be able to extend your coverage. See Section I.K for how you can extend your eligibility for healthcare coverage.

You may also lose your eligibility 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;
- 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 day of the month that you were terminated; 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 fails to make contributions** and is 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 if your Employer does not agree to make contributions at the rate required by the Trustees, then your benefits will be terminated on the 181st day after the expiration of the Collective Bargaining Agreement, unless the Trustees decide otherwise.

### OTHER COVERAGE OPTIONS FOR YOU AND YOUR FAMILY

There may be other coverage options for you and your family. Under the Affordable Care Act, within 60 days from the date your coverage ended or during any open enrollment period, you 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, and you can see what your premium, deductibles 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 from 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 or FMLA leave.

---

# SECTION I. J

## REGAINING ELIGIBILITY

### HOW YOU REGAIN ELIGIBILITY

You may regain eligibility by again working two consecutive calendar months with 100 or more hours worked per month; 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 — 100-HOUR RULE

Ms. Ruiz was a participant in the Benefit Fund through October, but did not work 100 hours in September or October, so her coverage ended November 30. Beginning in November, she was once again working 100 hours per month. By counting November and December as the determination period, and January as the administrative period, she regained her eligibility in February.

---

# SECTION I. K

## 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 work-related illness or injury (see Section I.G). 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 Fund determines your eligibility for benefits based on wage reports it receives from your Employer. If you have not received any wages, then your coverage may be suspended because the Fund does not know that you are out on Workers' Compensation leave.

### **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. Since the issuance of an "award" by New York State may take some time, you want to avoid termination of coverage while you are waiting.

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

If you return to work directly from disability status and begin working the hours required for coverage, you will not have to re-establish eligibility. If your disability coverage expires and you cannot return to work, you may be eligible to obtain or purchase COBRA coverage. See pages 44-48 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 office. She had already worked enough hours to ensure that her eligibility would cover her through the end of May. Her 26-week disability extension will continue coverage through a date in November if her condition persists. To maintain eligibility, she would need to supply the Fund office with evidence of her continued disability, such as paycheck stubs.

## COVERAGE WHILE TAKING FAMILY AND MEDICAL LEAVE (FMLA)

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 for up to 12 weeks, under certain conditions.

You are entitled to an FMLA extension if you 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 mother-in-law or father-in-law);

- When you have a serious health condition that keeps you from doing your job; or
- When your spouse, son, daughter or parent is a military service member and is on or has been called to active duty in support of a contingency operation in cases of “any qualifying exigency.”

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

If you are eligible for FMLA leave for one of the above qualifying family and medical reasons, you may receive up to 12 workweeks of unpaid leave during a 12-month period. During this 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.

If you need to care for your spouse, son, daughter, 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 his or her 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.

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.

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

### **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 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 pages 44–48 for a full explanation of the COBRA coverage provisions.

When you are discharged from service in the uniformed services (not less than honorably), your full eligibility will be reinstated on the day you return to work with a Contributing Employer, provided that you return to work within 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 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 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 two years. Contact the Benefit Fund office 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 uniformed service.

## **YOUR COBRA RIGHTS**

Under the federal law commonly known as COBRA, you have the option of extending your **group health** coverage for a limited period of time in certain instances where 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.

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

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

For more information, contact the Fund's COBRA Department at (646) 473-6815.

If you elect to continue your coverage, you will receive the same health coverage that you were receiving right before you lost your coverage. This may include hospital, medical, surgical, dental, vision and prescription drug coverage. However, note that life insurance is not covered by COBRA continuation coverage. In addition, a child born to 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 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'RE COVERED**

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

### **18 MONTHS COVERAGE – 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; or
- Your employment is terminated for reasons other than gross misconduct on your part.

Being on a Family and Medical Leave of Absence (see page 42) 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 COVERAGE — 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 ceases to be an eligible dependent; or
- You become entitled to Medicare.

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

## **EXTENDED COVERAGE**

### **Second Qualifying Event Extension**

Additional qualifying events can occur while continuation coverage is in effect. If your family experiences another qualifying event while receiving 18 months (or in the case of a Disability 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 stops being eligible as a dependent child;

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 after 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 of COBRA's requirements of both the responsibility to provide and the procedures for providing notice of the second qualifying event.

### **Disability Extension**

If you or your child covered under the Benefit Fund is determined by the Social Security Administration to be disabled, and you notify the Benefit Fund in a timely fashion, you or your children 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 COBRA continuation period

and must last at least until the end of the 18-month period of continuation coverage. **(NOTE:** If the disabled qualified beneficiary is a child born to 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** after the latest of:

- The date of the Social Security Disability determination;
- The date of the qualifying event;
- The date on which the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event; or
- The date on which the qualified beneficiary is informed of both the responsibility to provide and the procedures for providing notice of the Social Security's Disability determination, but before the end of the first 18 months of COBRA continuation coverage.

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

- Your hours or days are reduced;
- Your employment terminates (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.

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

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

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

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

### **OR**

- Mailed to the Fund office and postmarked on or before the end of 60-day period noted above.

If you do not choose COBRA continuation coverage in a timely manner, your group health coverage under the Fund will end as described in Section I.I, and you will lose your right to elect continuation coverage.



There may be other coverage options for you and your family. Under the Affordable Care Act, within 60 days from the date your coverage ended or during any open enrollment period, you 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, and you can see what your premium, deductibles 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 from the date your coverage ended.

## **COST OF COBRA COVERAGE**

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

## **WHEN COBRA COVERAGE ENDS**

Your COBRA continuation coverage may end before the end of the applicable 18-, 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 get coverage under another group health plan that does not include a pre-existing condition clause that applies to you;
- A qualified beneficiary becomes entitled to Medicare; or
- Coverage had been extended for up to 29 months due to a disability and there has been a final determination that the qualified beneficiary is no longer disabled.

COBRA continuation coverage may also be terminated for any reason the Fund would terminate coverage of a participant not receiving continuation coverage (such as fraud).

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

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

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

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

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

If you have any questions about COBRA continuation coverage, please call the Fund at (646) 473-6815.

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

## **CONTINUING YOUR LIFE INSURANCE**

Life insurance is not covered by COBRA continuation coverage.

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

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

---

## **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 underreporting of hours by Employers or misinterpretation. Hours are reported to the Benefit Fund office according to the date of a paycheck rather than the dates that work was actually performed. Often the Fund office can make adjustments upon presentation of evidence from either an Employer (agency) payroll office or upon examination of paycheck stubs presented by the member.

The 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 mail by your Employer to:

Employer Services Unit  
Eligibility Department  
1199SEIU National Benefit Fund for  
Home Care Employees  
330 West 42nd Street, 27th Floor  
New York, NY 10036

This information may also be sent by your Employer via email to [EmployerServices@1199Funds.org](mailto:EmployerServices@1199Funds.org).

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





## SECTION II – HEALTH BENEFITS

- A. Participating Providers
  - Member Choice Home Care Select Network
  - Panel Providers
- B. Using Your Benefits Wisely
  - 1199SEIU CareReview Program
  - Program for Behavioral Health
  - Emergency Departments Are for Emergencies
  - Care Management Program
  - Prenatal Program
  - Wellness Programs
- C. Hospital Care and Hospice Care
- D. Emergency Department Visits
- E. Program for Behavioral Health: Mental Health and Alcohol/ Substance Abuse
- F. Surgery and Anesthesia
  - Ambulatory Surgery
- G. Maternity Care
  - Prenatal Program
- H. Medical Services
  - Doctor Visits
  - Lab and X-Ray
  - What Is Not Covered
- I. Services Requiring Prior Authorization
- J. Vision Care and Hearing Aids
- K. Dental Benefits
- L. Prescription Drugs

# HEALTH BENEFITS RESOURCE GUIDE

## HOW TO REACH THE BENEFIT FUND

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

### WHERE TO CALL

#### For Member Services

Call the Member Services Department at (646) 473-9200 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. The staff will either give you the information you need or refer you to someone who can provide you with the necessary information.

You can also call for:

- A list of Participating Providers or Home Care Select Networks in your area;
- A list of Member Choice network hospitals;
- A list of Participating Pharmacies in your area; or
- A list of preferred drugs, also known as a Preferred Drug List (PDL).

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

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

#### For Prior Authorization

Call **(646) 473-9200** for prior authorization if:

- You have questions about the treatment your doctor is recommending;
- You require home care services;
- You require certain diagnostic tests; or
- You need prior authorization for certain medications, including specialty drugs.

Call Care Continuum at (877) 273-2122 if you require certain home infusion drugs administered on an outpatient basis.

#### For Inpatient Hospital Stays (including Behavioral Health)

Call the **1199SEIU CareReview Program at (800) 227-9360**:

- To pre-certify your hospital stay **before** going to the hospital for non-Emergency care;
- To notify the Fund within two business days of an Emergency admission; or
- To pre-certify inpatient behavioral health treatment (mental health or alcohol/ substance abuse treatment).

## HEALTH BENEFITS RESOURCE GUIDE

### For the 24-Hour Health Helpline

Call **(866) 935-1199** to reach the Health Helpline 24 hours a day, 7 days a week, with any health questions you may have.

### For the Prenatal Program

Call **(646) 473-8962** to register with the Benefit Fund's Prenatal Program.

### For the Program for Behavioral Health (Mental Health and Alcohol/Substance Abuse)

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

### For the Dental Program

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

### REMINDERS

- If you use a Non-Participating Provider, you can be billed the difference between the Benefit Fund's allowance and whatever the provider normally charges, which could result in a significant cost to you. Also, a Non-Participating Provider that appeals a benefit denial cannot file a lawsuit on your behalf more than five years from the date of service.
- Call 1199SEIU CareReview **before** your hospital stay 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**. If it is an Emergency, your Emergency Department visit must be **within 72 hours of an injury or the onset of a sudden and serious illness**.
- Show your 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 Health Benefits ID card to the pharmacist when you have a prescription filled.
- Register with the Benefit Fund's Prenatal Program.
- Call the Benefit Fund for services and supplies requiring prior authorization.

You can also visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org) for forms, directories and other information.

## **QUALITY CARE ASSESSMENT**

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



---

## SECTION II. A

# PARTICIPATING PROVIDERS

### GETTING THE CARE YOU NEED

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

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

You can choose any doctor, hospital or other healthcare provider that you want for your care. But if you use a Non-Participating (or Non-Panel) 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 that appeals a benefit denial cannot file a lawsuit on your behalf more than five 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** by calling (646) 473-7160, and to notify you of what your out-of-pocket expenses will be.

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

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

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

The Fund reviews providers’ practice patterns and credentials. However, the Fund is not responsible for the decisions and actions of individual providers.

## **MEMBER CHOICE HOME CARE SELECT (MCHCS)**

### **Access to Comprehensive Care**

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

You can choose from more than 100 Health Centers that are **conveniently located near your work or your home** throughout New York City. You can **receive comprehensive care at no cost to you** for medical care or prescriptions as long as you use your selected Health Center for all of your primary care needs. And, there are **no claim forms 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. Call the Benefit Fund’s Member Services Department at (646) 473-9200 for the list of Health Centers, or visit our website at **[www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org)**.
2. Complete a **Plan Election Form** during designated open enrollment periods 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 Plan Election Form to the Fund.

**NOTE:** If you select the MCHCS option, your eligible dependents must also elect MCHCS, and must use the same Health Center as you.

### **Special Rules:**

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

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

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

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

### **How It Works**

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

If you have a special medical problem, talk to your primary care doctor first.

Your doctor can determine whether you need to be referred to a specialist.

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

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

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

## **PANEL PROVIDERS**

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

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

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

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

For the names of Participating Doctors and other healthcare providers in your area, call the Fund at (646) 473-9200 or visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).

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

The Benefit Fund has designated certain labs (including Member Choice hospital-based labs), certain radiology facilities and certain DME vendors as "preferred." You must use these providers to avoid out-of-pocket costs. If your doctor wants you to have lab or radiology tests, please contact the Fund at (646) 473-9200 or visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org) for the listing and locations of these laboratory and radiology facilities.

## **WHEN YOU USE NON-PARTICIPATING PROVIDERS**

You can go to any doctor or hospital you choose. But if you use a Non-Participating (or Non-Panel) 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 that appeals a benefit denial cannot file a lawsuit on your behalf more than five 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** by calling (646) 473-7160, and to notify you of what your out-of-pocket expenses will be.

---

## SECTION II. B

### USING YOUR BENEFITS WISELY

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

#### 1199SEIU CAREREVIEW PROGRAM (800) 227-9360

If you need to go to the hospital or require ambulatory or outpatient surgery, you must contact the 1199SEIU CareReview Program:

- To pre-certify your hospital stay **before** going to the hospital for non-Emergency care;
- To pre-certify your hospital stay **within two business days** of an Emergency admission;
- To pre-certify inpatient mental health or alcohol/substance abuse treatment;
- To pre-certify inpatient physical rehabilitation in an acute care facility; or
- To pre-certify 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.

#### PROTECT YOUR BENEFITS

##### If You Use an Emergency Department for Non-Emergency Care

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

You will be responsible for the difference between some of the Benefit Fund's payments and the actual cost of the care you receive in the Emergency Department — resulting in a high out-of-pocket cost to you.

##### Questions?

If you have any questions, call the Fund's Member Services Department at (646) 473-9200. The staff can help you understand what procedures you need to follow in order to protect your benefits.

## **PROGRAM FOR BEHAVIORAL HEALTH**

### **Mental Health and Alcohol/Substance Abuse**

The Benefit Fund has a special program to help you get behavioral healthcare. **All calls and treatment information are kept strictly confidential. To pre-certify Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP) services, call the Benefit Fund at (646) 473-6868.**

Remember to call **1199SEIU CareReview at (800) 227-9360** before going to the hospital for inpatient care.

### **EMERGENCY DEPARTMENTS ARE FOR EMERGENCIES**

A hospital Emergency Department should be used only in case of a **legitimate medical Emergency**. To be considered an Emergency, your Emergency Department visit must occur **within 72 hours of an injury or the onset of a sudden and serious illness**.

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

### **CARE MANAGEMENT PROGRAM**

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

If you require ongoing medical treatment from a catastrophic or severe illness or injury, including after-hospital care, the Care Management ("CM") staff may consult with the doctor or hospital during the planning of Medically Necessary and appropriate care. CM aims to coordinate your care under the terms of our Plan to 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 you. This will help ensure that requested services are the most appropriate for the illness or injury and are provided at the most cost-effective level of care.

The review process can be:

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

## **PRENATAL PROGRAM – HAVING A HEALTHY BABY**

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

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

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

Call (646) 473-8962 to register for the Benefit Fund's Prenatal Program.

## **WELLNESS PROGRAMS**

You have access to a 24-Hour Health Helpline that you can call with any health questions. You can reach the Health Helpline at (866) 935-1199.

For more information or to find worksite programs, health fairs, workshops or other wellness events near you provided by Worksite Medical Services P.C., call the Benefit Fund at (646) 473-9200 or visit [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).

## **PREFERRED LABORATORY FACILITIES**

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

If you require lab work:

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

Contact the Fund or visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org) for a listing and locations of these facilities.

## **PREFERRED RADIOLOGY (X-RAY) FACILITIES**

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

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

## **PREFERRED DURABLE MEDICAL EQUIPMENT (DME) VENDORS**

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

## **CERTAIN OUTPATIENT MOLECULAR AND GENOMIC LABORATORY PROCEDURES (GENETIC TESTING)**

A list of outpatient laboratory genetic tests that require prior approval can be found on the Benefit Fund's website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org) under the "For Providers" tab. If your doctor prescribes one of these tests, your doctor or the laboratory must call (844) 840-1199 for prior approval. In addition, prior approval may be requested by your provider by logging into the "Ordering Provider Login" at [www.CareCoreNational.com](http://www.CareCoreNational.com).

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



---

## SECTION II. C

# HOSPITAL CARE AND HOSPICE CARE

### 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 of this SPD
- Up to 365 days per year
- Acute care that is Medically Necessary
- Semi-private room and board
- Observation care and services
- Up to 30 days per year for inpatient physical rehabilitation in an acute care facility
- Benefits are not provided for care in a sub-acute nursing home or skilled nursing facility
- Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan

Call the 1199SEIU CareReview Program at (800) 227-9360 before going to the hospital or within two 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 during a calendar year in a semi-private room in a hospital if Medically Necessary to treat your medical condition.

If you need hospital care:

- Call the 1199SEIU CareReview Program at (800) 227-9360; and
- Show your Health Benefits ID card when you get to the hospital. Even though you are covered for up to 365 days per year, most people do not have to stay in the hospital for more than a few days.

The Benefit Fund reviews hospital admissions. Based on this review, the Plan Administrator determines the number of days the Fund will pay for a given admission based on the diagnoses when you are admitted and discharged. Your doctor may consult with the Fund's Medical Advisor or 1199SEIU CareReview if your doctor feels a longer hospital stay is needed. If you choose a private room, you will have to pay the difference between the charges for a private room and the average charges for a semi-private room.

**If you require services from a surgeon or an anesthesiologist, check to make sure they are Participating**

**Providers. Even when you go to a Participating Hospital, the doctors and anesthesiologists that provide services in the facility may not be participating and may charge above the Benefit Fund's allowance.**

## **CARE COVERED**

Inpatient Hospital Benefits cover reasonable payments billed by the hospital for the Medically Necessary acute care customarily provided to patients with your medical condition. These may include:

- Room and board, including special diets;
- Use of operating and cystoscopic rooms and equipment;
- Lab work that is needed for the diagnosis and treatment of the condition for which you are in the hospital, including pre-admission testing within seven days of the admission;
- X-rays that are needed for the diagnosis and treatment of the condition for which you are in the hospital, including pre-admission testing within seven days of admission;
- Use of cardiographic equipment;
- 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; or

- Recovery room charges for care immediately following an operation.

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

## **INPATIENT ACUTE REHABILITATION**

You are covered for up to **30 days per calendar year** in a 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 the Fund's Medical Advisor before the Fund will agree to provide benefits for any rehabilitation care.

## **ELECTIVE/SCHEDULED ADMISSIONS**

Before you go to the hospital, remember to call the 1199SEIU CareReview Program 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 inpatient treatment or if he or she is 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 Medically Necessary services rendered outside of the country. The member must provide proof of payment, an itemized bill and other pertinent information, which may include a copy of the member's passport or airline tickets and a certified translation, if requested by the Fund.

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

## **WHAT IS NOT COVERED**

The Benefit Fund will not pay for:

- Custodial care or sub-acute care in a hospital or any other institution;
- Care or service in a nursing home, skilled nursing facility, rest home or convalescent home;
- Hospitalization covered under federal, state or other laws except where otherwise required by law;
- Rest cures;
- Blood for transfusions;
- Admissions for cosmetic services;
- Personal or comfort items;
- Private rooms;
- Services related to a claim filed under Workers' Compensation;
- Services that are not Medically Necessary;

- Services that are not pre-approved in accordance with the terms of the Plan; and
- All general exclusions listed in Section VII.D.

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

## **PAYMENT TO A HOSPITAL**

The Benefit Fund has negotiated rates with many hospitals in the New York area. These are called "Participating Hospitals."

When you go to a Participating Hospital for Medically Necessary care, the Fund will pay the hospital directly for all services. You will have no out-of-pocket costs.

If you go to a hospital that is not a Participating Hospital for an elective admission, the Fund will pay only what it determines is the Schedule of Allowances at a comparable Participating Hospital for the services provided. You may be responsible for large out-of-pocket costs for the balance of the hospital bill and/or for other services.

## 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 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 bridging 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, which 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 to care for you for up to eight hours a day;
- Physical and occupational therapy;
- Consultation or case management services by a physician;
- Psychological counseling; or

- Respite care. This is care received during a period of time when your family or usual caretaker cannot attend to your needs.

### LIMITATIONS

Unless specified above, **not covered** under this benefit are charges for:

- Daily room and board charges over the semi-private room rate;
- Bereavement counseling;
- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling, including estate planning and the drafting of a will; and
- Homemaker or caretaker services. These are services that are not solely related to your care. These include, but are not limited to, sitter or companion services, transportation or maintenance of your residence.

---

## 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 of this SPD.
- Use of the Emergency Department must be within 72 hours of an accident/injury or sudden and serious illness to be considered Emergency care
- 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 New York area. If you go to the Emergency Department of a Participating Hospital, you will have no out-of-pocket costs for the hospital's charge for the use of the facility.

#### EMERGENCY DEPARTMENTS ARE FOR EMERGENCIES

A hospital Emergency Department should be used only in the case of a **legitimate medical emergency**. To be considered an Emergency, your Emergency Department visit must meet the definition of Emergency (see Section IX) and must occur **within 72 hours of an injury or the onset of a sudden and serious illness**.

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

When you go to the Emergency Department:

1. Show your Health Benefits ID card. The 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 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, a clinic or through the use of an urgent care center that may be conveniently located near where you live. These centers are generally open seven days per week and have extended hours. For non-Emergency treatment, you will be responsible for the difference between some of the Benefit Fund's payments 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 you need to go to the Emergency Department:

1. Call your doctor first — he or she may be able to recommend treatment over the phone, have you go to the doctor's office or go to the hospital.
2. If your doctor's office is closed, call your doctor's Emergency (after hours) number.

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

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

---

# SECTION II. E

## PROGRAM FOR BEHAVIORAL HEALTH: MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE

### BENEFIT BRIEF

#### Inpatient Mental Health

- Medically Necessary services, which may include inpatient days and Partial Hospitalization Programs

#### Inpatient Alcohol/Substance Abuse

- Medically Necessary services for inpatient detoxification and rehabilitation

#### Outpatient Mental Health and Alcohol/Substance Abuse

- Outpatient visits and Intensive Outpatient Programs

### GET THE HELP YOU NEED

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

If you need help, call the Program at (646) 473-6900.

The Benefit Fund's social workers will discuss your problems and concerns with you and refer you to appropriate resources as needed.

### MENTAL HEALTH BENEFITS

#### Outpatient Care

- Outpatient visits
- Intensive Outpatient Programs

#### Inpatient Care

- Medically Necessary mental health admissions in a hospital
- Partial Hospitalization Programs

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

### ALCOHOL/SUBSTANCE ABUSE BENEFITS

When Medically Necessary, you are covered for diagnosis and treatment of alcoholism or substance abuse.

#### Outpatient Care

- Outpatient visits
- Intensive Outpatient Programs

#### Inpatient Care

- Medically Necessary services for inpatient detoxification and rehabilitation

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

## **PARTIAL HOSPITALIZATION PROGRAMS FOR MENTAL HEALTH AND INTENSIVE OUTPATIENT PROGRAMS FOR MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE**

Partial Hospitalization Programs and Intensive Outpatient Programs provide alternate levels of coordinated care and can prevent hospitalizations and help to 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 need to go to the hospital, you must call 1199SEIU CareReview at (800) 227-9360:

- **Before** going to the hospital if it's not an Emergency; or
- **Within two business days** of an Emergency admission.

If you need hospital care, the 1199SEIU CareReview staff will authorize your hospital stay and may refer you to the Fund for additional follow-up.

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

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



---

## SECTION II. F

# SURGERY AND ANESTHESIA

### BENEFIT BRIEF

#### Surgery and Anesthesia

- Inpatient or outpatient (ambulatory) surgery
- Anesthesia

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

#### SURGERY

You are covered for surgery when performed:

- By a licensed physician or surgeon; and
- In an accredited hospital, ambulatory surgery center or office-based surgery suite.

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

#### 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 Doctor, 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 to notify you of what your out-of-pocket expenses will be.**

For the names of Participating Surgeons in your area, call the Fund's Member Services Department at (646) 473-9200.

#### ASSISTANT SURGEON

The Fund will pay 20% of its allowance for your surgery for an assistant surgeon if:

- No surgical residents were available; and
- The assistant surgeon was Medically Necessary.

#### ANESTHESIA

The amount of reimbursement for anesthesia under the Schedule of Allowances varies depending upon:

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

Coverage includes:

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

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

### **AMBULATORY SURGERY**

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

The Benefit Fund pays for:

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

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

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

The Benefit Fund complies with federal law related to mastectomies. If a member has a mastectomy and then chooses to have breast reconstruction, the Fund (in consultation with the patient and doctor) will provide coverage based upon the Fund's Schedule of Allowances for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy (including lymphedemas).

## WHAT IS NOT COVERED

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

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

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

---

## SECTION II. G

# MATERNITY CARE

### BENEFIT BRIEF

#### Maternity Care

- An allowance which includes all prenatal and postnatal visits and delivery charges
- Hospital Benefit for the mother
- Hospital Benefit for the newborn if the mother is you
- Co-payments may apply if you are not enrolled in the Member Choice Home Care Select Plan

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

#### MATERNITY BENEFITS

Your Maternity Benefit includes:

- An allowance for all prenatal and postnatal visits and delivery charges;
- Anesthesia allowance; and
- A Hospital Benefit for the mother and newborn.

#### FOR YOUR DEPENDENT CHILD

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

- An allowance for all prenatal and postnatal visits and delivery charges; and
- Anesthesia allowance.

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

The Benefit Fund complies with federal law in that:

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

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

## **THE PRENATAL PROGRAM**

### **Having a Healthy Baby**

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

**To participate in the Benefit Fund's Prenatal Program, register by calling (646) 473-8962 or register online at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).**

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

Doctors, labs and other health providers that are part of the **Benefit Fund's Member Choice Home Care Select Plan and Participating Provider Plan accept the Fund's allowance as payment in full.** For more information, see Section II.A.

If you use a **Non-Participating Provider**, you could face high out-of-pocket costs. You may have to pay the difference between the Fund's allowance and 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 to notify you of what your out-of-pocket expenses will be.

#### DOCTOR VISITS

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

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

## MAKING SURE YOU GET THE CARE YOU NEED

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

- **Dermatology:** up to 20 treatments per year;
- **Chiropractic:** up to 12 treatments per year;
- **Podiatry:** up to 15 treatments per year for routine care;
- **Allergy:** up to 20 treatments per year, including diagnostic testing; and
- **Physical/Occupational/Speech Therapy:** up to 25 visits per discipline per year. Habilitation therapies for eligible children are not covered to the extent there is other coverage available from either a government agency or program through a special organization.

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

## PREVENTIVE CARE

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

- **Periodic check-ups**  
Through regular exams, your doctor can detect any problems early, when they are easier to treat.
- Certain screenings and immunizations

## X-RAY AND LABORATORY SERVICES

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

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

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

## PREFERRED LABORATORY FACILITIES

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

- Make sure that your doctor sends your lab samples to a preferred lab; or
- If you need to have your lab work done outside of your doctor's office, take your referral slip from your doctor

to a Patient Care (Drawing) Center from one of the preferred labs.

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

### **PREFERRED RADIOLOGY (X-RAY) FACILITIES**

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

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

### **PREFERRED DURABLE MEDICAL EQUIPMENT (DME) VENDORS**

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

### **CHOOSE A PRIMARY CARE DOCTOR FOR COMPREHENSIVE CARE**

A primary care doctor is an internist, family physician or obstetrician/gynecologist who coordinates your care.

Your primary care doctor gets to know you and your medical history, sees you when you are sick, and provides regular check-ups.

This way, he or she is aware of your overall health and minor problems can be detected before they become serious illnesses.

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

### **HOSPICE CARE**

Coverage for a combined total of up to 210 days in a Medicare-certified hospice program in a hospice center, hospital, skilled nursing facility or at home. See Section II.C for details.

### **AMBULANCE SERVICES**

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.

The Benefit Fund also covers transportation between hospitals if you need specialized care that the first hospital cannot provide.

### **WHAT IS NOT COVERED**

The Benefit Fund does not cover:

- Experimental, unproven or non-FDA-approved treatments, procedures, facilities, equipment, drugs, devices or supplies;
- Treatment that is cosmetic in nature;
- Treatment that is custodial in nature;



- Infertility treatment, including, but not limited to, in vitro fertilization, artificial insemination, embryo storage, cryosterilization and reversal of sterilization;
- Laboratory tests that are not FDA-approved;
- Venipuncture;
- Treatment for illness or injury covered by Workers' Compensation;
- Acupuncture when administered by anyone other than a licensed medical physician;
- Private physicians when care is given in a governmental or municipal hospital;
- Charges in excess of the Fund's Schedule of Allowances;
- Employment or return-to-work physicals;
- Treatments determined to be not Medically Necessary;
- Habilitation therapies for eligible children to the extent there is other coverage available from either a government agency or program or through a special organization;
- Charges related to refractions when performed by an ophthalmologist; and
- All general exclusions listed in Section VII.D.

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

---

# SECTION II. I

## SERVICES REQUIRING PRIOR AUTHORIZATION

### BENEFIT BRIEF

#### Services Requiring Prior Authorization

- Home health care
- Non-Emergency ambulance services
- Durable medical equipment and appliances
- Medical supplies
- Specific medications, including specialty drugs
- Certain diagnostic and radiologic tests
- Certain outpatient molecular and genomic laboratory procedures (genetic testing)
- Ambulatory surgery or inpatient admissions
- Partial Hospitalization Programs (PHP) for mental health
- Intensive Outpatient Programs (IOP) for mental health and alcohol/substance abuse
- Certain home infusion drugs administered on an outpatient basis

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

If you use a **Non-Participating Provider**, you could face high out-of-pocket

costs. You have to pay the difference between the Fund's allowance and whatever the provider normally charges. Prior authorization reviews Medical Necessity of covered services only. 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 to notify you of what your out-of-pocket expenses will be.

#### WHAT IS COVERED

To be covered, services must be:

- Ordered by your physician;
- Medically Necessary to treat your condition in compliance with the Benefit Fund's clinical guidelines, policies, protocols and procedures; and
- Approved **in advance** by the Fund's Prior Authorization Department.

#### PRIOR APPROVAL NEEDED

Call the 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 reviews Medical Necessity of covered services only. Authorization of services **does not** mean a Non-Participating Provider will accept the Benefit Fund's payment as payment in full. Participating Providers accept the Fund's payment as payment in full.

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

## HOME HEALTH CARE

Home health care services will be covered if they are authorized by the Benefit Fund in advance, Medically Necessary and in compliance with the Fund's protocols. Benefits are payable in accordance with the Fund's Schedule of Allowances up to the maximum benefits available.

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

- Intermittent skilled nursing care;
- Intermittent non-skilled care; 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, when authorized by the Fund in advance, Medically Necessary and in compliance with the Fund's protocols.

## NON-EMERGENCY AMBULANCE SERVICE

Transportation between hospitals is covered if you need specialized care that the first hospital cannot provide.

**NOTE:** 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 do not require prior authorization.

## DURABLE MEDICAL EQUIPMENT AND APPLIANCES

The Plan covers rental of standard durable medical equipment (hospital beds, wheelchairs).

Equipment may be bought only if:

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

## MEDICAL SUPPLIES

The Plan covers services and supplies medically needed to treat your illness and which are approved by the Food and Drug Administration (FDA), such as:

- Prostheses;
- Blood and blood processing;
- Dressings;

- Catheters; and
- Oxygen.

## **SPECIFIC MEDICATIONS**

You must get prior approval before benefits can be provided for certain prescriptions, including specialty drugs. Call Care Continuum at (877) 273-2122 if you require certain home infusion drugs administered on an outpatient basis.

The Benefit Fund will periodically publish an updated listing of drugs that require prior authorization.

For a listing of these drugs, contact the Benefit Fund at (646) 473-9200 or visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org). See Section II.L for further details.

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

## **AMBULATORY SURGERY OR INPATIENT ADMISSIONS**

You must get prior approval for hospital and surgery. See Section II.B.

## **CERTAIN DIAGNOSTIC TESTS**

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

By using these facilities, you will avoid out-of-pocket costs. Call (888) 910-1199 for a referral to a preferred radiology facility. All

radiological tests must be performed by a radiologist or a non-radiology provider within the specialty of your particular test.

## **PARTIAL HOSPITALIZATION PROGRAMS FOR MENTAL HEALTH AND INTENSIVE OUTPATIENT PROGRAMS FOR MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE**

Partial Hospitalization Programs and Intensive Outpatient Programs provide alternate levels of coordinated care and can prevent hospitalizations and help to restore maximum function in a clinically appropriate setting. To pre-certify these services, call the Benefit Fund at (646) 473-6868.

## **CERTAIN OUTPATIENT MOLECULAR AND GENOMIC LABORATORY PROCEDURES (GENETIC TESTING)**

A list of outpatient laboratory genetic tests that require prior approval can be found on the Benefit Fund's website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org) under the "For Providers" tab. If your doctor prescribes one of these tests, your doctor or the laboratory must call (844) 840-1199 for prior approval. In addition, prior approval may be requested by your provider by logging into the "Ordering Provider Login" at [www.CareCoreNational.com](http://www.CareCoreNational.com).

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

---

# SECTION II. J

## VISION CARE AND HEARING AIDS

### BENEFIT BRIEF

#### Vision Care

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

#### Hearing Aids

- Once every three years
- 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 using 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 entitlement for benefits or for a referral to a Participating 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 glasses or contact lenses every two years.

#### WHEN YOU NEED VISION CARE

If you need a listing of Participating Optometrists, call the Fund at (646) 473-9200.

#### FILING FOR BENEFITS

Participating Optometrists and Participating Opticians bill the Benefit Fund directly.

If you select frames, lenses or other services that are not included in the Benefit Fund's program with your provider, you may incur out-of-pocket costs.

If you use a Participating Optometrist or Participating Optician, and you incur a large out-of-pocket cost, call the Benefit Fund at (646) 473-9200 before you pay for your exam, glasses or contact lenses.

#### WHAT IS NOT COVERED

The Benefit Fund does not cover:

- Non-prescription sunglasses;
- Scratch resistant and/or ultraviolet treatment;
- Visual training; and
- 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 for a referral to a Participating Provider. Co-payments may apply when using Participating Providers.

If you use a Non-Participating Provider, you can be billed 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 (formerly Healthplex). For questions regarding Dental Benefits, call DentCare at (800) 468-0600.

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

All dental work must be done by a Participating General Dentist or Specialist in the DentCare network. Cleanings may be performed by a licensed dental hygienist supervised by a licensed dentist.

### YOUR PRIMARY CARE DENTAL PROVIDER

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

### BASIC AND PREVENTIVE CARE

You are covered in full for:

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

### MAJOR RESTORATIVE CARE

There is a co-payment for major services including:

- Periodontics (treatment of gum diseases), 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
- Crown and bridgework, including replacement of any existing denture, bridgework, crown or gold restoration, subject to a five-year limitation.

### IN CASE OF EMERGENCY

In case of an Emergency, please contact your primary care dentist. If you cannot reach your primary care dentist and you have an Emergency, call DentCare at (800) 468-0600 for the name of a provider in your area.

## GETTING YOUR BENEFITS

### When Using a Participating Dentist

Participating Dentists send your claim form to and receive payment directly from DentCare. They have agreed to accept the Benefit Fund's allowance as payment in full for many services.

You will have to pay a co-payment directly to the dentist for some services.

If you have to pay a co-payment, it is due at the time services are provided.

### When Using a Non-Participating Dentist

If you use a Non-Participating Dentist, you or your dentist will not be reimbursed unless the services are for Emergency care while outside the DentCare service area. To receive a benefit for out-of-area Emergency care, you will need to pay the bill yourself and send a completed claim form to DentCare for reimbursement. You have to pay any charges not covered by DentCare.

## WHAT IS NOT COVERED

Benefits are not provided for:

- Services provided by a dentist not affiliated with DentCare (unless an Emergency);
- Services, supplies or appliances that are not Medically Necessary based upon DentCare's clinical policies and guidelines;
- Implants and services, supplies, appliances or restorations incurred in connection with implants are

usually not covered by the Benefit Fund unless they meet the Benefit Fund's clinical guidelines and approved protocols;

- Temporary crowns, restorations, dentures or fixed bridgework, night guards, or services that are cosmetic in nature;
- Lost or stolen appliances;
- Treatment of temporomandibular joint (TMJ) disease;
- Any dental treatment inconsistent with the Benefit Fund'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; and
- All general exclusions listed in Section VII.D.

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



---

# SECTION II. L

## PRESCRIPTION DRUGS

### BENEFIT BRIEF

#### Prescription Drugs

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

#### WHAT IS COVERED

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

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

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

#### USING YOUR BENEFITS

To get your prescription:

1. Ask your doctor to prescribe only covered medications, as per the Benefit Fund's prescription programs;
2. Use Participating Pharmacies for short-term medications; and
3. Show your Health Benefits ID card to the pharmacist when you give him or her your prescription.

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

- Mandatory Generic Drug Program;
- Preferred Drug List;
- Mandatory Maintenance Drug Access Program;
- Prior authorization for specified medications;
- Quantity and day supply limitations;
- Step therapy; and
- Use the Specialty Care Pharmacy for injectables and other drugs that require special handling.

## PRESCRIPTION DRUG PROGRAMS

For a complete list of these programs, please call the Benefit Fund at (646) 473-9200 or visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).

### Generic Drugs

Generic drugs are therapeutic alternatives to brand-name drugs. The only major difference is the cost.

By law, a generic drug must contain the same active ingredients in the same quantities and be the same strength as the corresponding brand-name drug.

When your doctor gives you a prescription:

- If there is a generic equivalent for a brand-name drug, you must get the generic drug. Otherwise, you will have to pay the difference in cost between the brand-name drug and the generic equivalent, plus your co-payment if applicable.
- If there is no generic equivalent, your prescription will be filled with the brand-name drug.
- In some situations, your doctor may specify the brand-name drug. In this case, your doctor must submit detailed medical information and supporting documentation to the Benefit Fund's Prescription Review Department to evaluate the clinical reasons why the brand-name drug is necessary.

## PRESCRIPTION DRUG PROGRAMS

### Preferred Drugs

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

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

### Prior Authorization for Specified Medications

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

If your doctor prescribes any of those drugs, contact the Benefit Fund at (646) 473-9200. Some drugs require prior authorization from the Pharmacy Benefit Manager. Visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org) for a comprehensive list and the correct phone number to call.

**NOTE:** You may have to pay the entire cost of the prescription if you don't get prior approval from the Fund. 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 for these medications must be in compliance with the standards and criteria established by the FDA and accepted clinical guidelines for standard of care.

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

## PRESCRIPTION DRUG PROGRAMS

**Personalized Medicine** – A voluntary program for members to help physicians determine which drug and dosage are clinically appropriate.

**Quantity Duration** – Based on FDA-recommended prescribing and safety information, the quantity duration rules help members receive the most clinically effective dosages of medication.

### **Specialty Care**

Members must use the Specialty Care Pharmacy Program for injectables and other drugs that require special handling. Call the Benefit Fund or visit our website at **[www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org)** for a listing 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 preferred brand names.

## **PROTECT YOUR CARD**

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

**If your card is lost or stolen, immediately report it to the 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 visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).**

## USE A PARTICIPATING PHARMACY

For a listing of Participating Pharmacies, call the Benefit Fund's Member Services Department at (646) 473-9200 or visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).

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

1. Pay for your prescription when it is filled;
2. Then visit the Benefit Fund's website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org) or call the Benefit Fund's Member Services Department at (646) 473-9200 for a **Prescription Drug Reimbursement Form (Direct Claim Form)**; and
3. Complete this form and send it along with an itemized paid receipt for your prescription to the address indicated on the form.

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

## FILLING YOUR PRESCRIPTIONS

### For Short-Term Illnesses:

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

### For Chronic Conditions:

#### The Benefit Fund's Mandatory Maintenance Drug Access Program – *The 90-Day Rx Solution*

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

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

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

- Mailing the prescription to the Benefit Fund's mail order pharmacy, where it will normally be delivered within eight days; or
- Taking it to one of the designated Participating Pharmacies.

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

Call the Fund at (646) 473-9200 or visit our website at

**www.1199SEIUBenefits.org** for the locations of pharmacies that participate in the Mandatory Maintenance Drug Access Program, for a mail order form or to determine if the drug you are taking is a maintenance medication.

## **WHAT IS NOT COVERED**

The Benefit Fund does not cover:

- Over-the-counter drugs (except for diabetic supplies);
- Over-the-counter vitamins;
- Non-prescription items, such as bandages or heating pads, even if your physician recommends them;
- Prescriptions for drugs not approved by the FDA for the treatment of your condition;
- Cost differentials for drugs that are not approved through the Fund's Prescription Drug Program;
- Experimental drugs;
- Compound drugs except for reformulations for injection or administration;
- Non-sedating antihistamines;

- Migraine medication in excess of FDA guidelines for strength, quantity and duration;
- Proton pump inhibitors in excess of a 90-day supply or FDA-approved indications by diagnosis;
- Medications for cosmetic purposes;
- Cold and cough prescription products;
- Oral erectile dysfunction agents (except for penile functional rehabilitative therapy for up to six months immediately following prostatic surgery); and
- All general exclusions listed in Section VII.D.

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



## **SECTION III – DISABILITY BENEFITS**

---

# DISABILITY BENEFITS

Disability Benefits are provided through the state.

While you are receiving Disability Benefits, you are still eligible for the same coverage you had before your disability for up to a maximum of 26 weeks within a 52-week period. You must notify the Benefit Fund when you begin to receive Disability Benefits through the state and submit copies of your disability payment stubs to the 1199SEIU Family of Funds' Eligibility Department as proof of your continued disability.

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

**NOTE:** You cannot receive Disability Benefits for any period in which you receive any other compensation, such as pension (except for active members age 70.5 or older who are receiving a Pension Benefit), payments from the Social Security Administration as a result of a Disability Award, sick leave or wages from any other Employer.

## **WHEN YOU RETURN TO WORK**

Remember to let the Benefit Fund know when you return to work after being out on a Disability or Workers' Compensation leave. This will allow the Fund to update its records to reflect that you are once again an active member.





## **SECTION IV – LIFE INSURANCE BENEFIT**

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 Benefit described in this section, effective September 1, 2014. This benefit is for the member only.

## LIFE INSURANCE RESOURCE GUIDE

### WHERE TO CALL

**Member Services Department  
(646) 473-9200**

Call Member Services to:

- Request a form to change a beneficiary; or
- 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 must file a claim for Accidental Death and Dismemberment Benefits **within 31 days** of your death or dismemberment.

**You can also visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).**

## BENEFIT BRIEF

### Life Insurance

- A benefit of \$10,000
- Life Insurance Benefit is for the member only

### Accidental Death and Dismemberment

- For accidental death or injury
- Equal to, or one-half of, your life insurance, depending on the loss suffered
- Accidental Death and Dismemberment Benefit is for the member only

## LIFE INSURANCE BENEFIT

The Benefit Fund will provide life insurance coverage and an Accidental Death and Dismemberment policy (AD&D) for you as long as you are a participant of the Fund.

## ABOUT THE POLICY

The Life Insurance Benefit is \$10,000. If you are covered by the Benefit Fund at the time of your death, the amount (\$10,000) 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 \$10,000 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 from the date of your accident; and
- Occurs while you are employed and covered by the Benefit Fund.

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

Your **Accidental Dismemberment Benefit** is paid to you based upon the following schedule:

- **Half your life insurance amount** for loss of one hand, one foot or the sight in one eye;
- **Equal to your life insurance amount** for 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 in this section.

### **CHOOSING YOUR BENEFICIARY**

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

When you fill out your **Life Insurance Beneficiary Selection Form**, list at least one person as your beneficiary. The form asks for both “primary” and “secondary” beneficiaries. Your life insurance will be paid to your primary beneficiary or split evenly if you have chosen more than one primary beneficiary. Secondary beneficiaries can receive proceeds only if all of the primary beneficiaries are deceased at the time of your death.

### **CHANGING YOUR BENEFICIARY**

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

1. Call the Benefit Fund’s Member Services Department at (646) 473-9200 and ask for a **Life Insurance Beneficiary Selection Form**, or visit our website at **[www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org)**;
2. Fill out the form; and
3. Return it to the Benefit Fund.

The change of beneficiary will not be effective until it’s received by the Benefit Fund office.

**NOTE:** If you have designated your spouse as your beneficiary and you later get divorced, your divorce will automatically revoke that designation upon notification to the Fund. If you do not change your beneficiary thereafter, your Life Insurance Benefit will be paid as if there is no beneficiary (see “If There Is No Beneficiary” below).

### **IF THERE IS NO BENEFICIARY**

If you do not list a beneficiary, your beneficiary dies before your death or the Benefit Fund cannot locate your beneficiary after reasonable efforts, your Life Insurance Benefit and Accidental Death and Dismemberment Benefit is paid to your survivors in the following order:

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

### **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; and
2. Submit a certified original copy of your death certificate and a claim form to the Benefit Fund.

## 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 his or her benefit after your death, that assignment shall be considered irrevocable.

## IF THERE IS A DISPUTE

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

The disputed funds will be deposited into a court-monitored account if necessary.

## EXTENSION OF COVERAGE

**If you become disabled before you reach age 60**, even if you lose your coverage under the Fund, your life insurance will continue 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 the time you stop working; and
- Your condition is recertified by your doctor three months before each anniversary of the start of the disability.

## 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

Accidental Death and Dismemberment Benefits are not available for losses resulting from:

- Acts of war;
- Bodily or mental infirmity;
- Disease or illness of any kind;
- Medical or surgical treatment (except where necessary solely by injury);
- Bacterial infection (except pyogenic infections resulting solely from injury);
- Intentionally self-inflicted injury;
- Suicide or any attempt thereof;
- The use of alcohol or substance abuse;
- 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; or
- Committing or participating in a crime or act that can be prosecuted as a crime.





## **SECTION V – OTHER BENEFITS**

### **A. Social Services and Member Assistance Program**

## OTHER BENEFITS RESOURCE GUIDE

### WHERE TO CALL

#### **Member Assistance Program**

**(646) 473-6900**

Call Member Assistance to:

- Make an appointment to confidentially discuss a personal or family problem; or
- Reach the Program for Behavioral Health.

#### **Citizenship Program**

**(646) 473-9200**

Call Citizenship to:

- Learn about assistance available in applying for United States citizenship.

#### **Earned Income Tax Credit Assistance Program**

**(646) 473-9200**

- Call the Earned Income Tax Credit Assistance Program for tax preparation help.

#### **Financial Wellness Program**

- For information on the Financial Wellness Program, please check our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).

#### **Weekly Legal Clinic**

**(646) 473-6488**

- Provides free legal consultations to eligible members regarding various legal matters. For information on the legal clinic, visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).

**You can also visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).**



---

# SECTION V. A

## SOCIAL SERVICES

### BENEFIT BRIEF

#### Member Assistance Program

- Help and referral for personal and family problems

#### Citizenship Program

- Assistance in applying for United States citizenship

#### Earned Income Tax Credit Assistance Program

- Tax preparation help

#### Financial Wellness Program

- Help with managing credit and financial wellness

#### Weekly Legal Clinic

- Free legal consultations regarding various legal matters

The Member Assistance Program, Citizenship Program and Earned Income Tax Credit Assistance Program are available to all bargaining unit employees of Contributing Home Care Employers regardless of whether the member meets the 100-hour rule and regardless of whether the member pays the required weekly premium.

### MEMBER ASSISTANCE PROGRAM

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

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

- Getting help for an alcohol or substance abuse problem;
- Getting decent housing;
- Dealing with pressure from creditors;
- Dealing with domestic violence; and
- Many more problems.

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

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

### CITIZENSHIP PROGRAM

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

## **EARNED INCOME TAX CREDIT ASSISTANCE PROGRAM**

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

## **FINANCIAL WELLNESS PROGRAM**

For information on the Financial Wellness Program, please visit our website at **[www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org)**.

## **WEEKLY LEGAL CLINIC**

Provides free legal consultations to eligible members regarding various legal matters. For information on the legal clinic, please visit our website at **[www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org)** or call (646) 473-6488.



## **SECTION VI – RETIREE HEALTH BENEFITS**

The 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 — Appeals Procedure
- C. When Benefits May Be Suspended, Withheld or Denied
- D. What Is Not Covered
- E. Additional Provisions

## RESOURCE GUIDE

### WHERE TO CALL

**Member Services Department  
(646) 473-9200**

Call Member Services if:

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

**You can also visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).**

---

# SECTION VII. A

## GETTING YOUR HEALTHCARE BENEFITS

### PAYMENT INFORMATION FOR PARTICIPATING PROVIDERS

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

### POST-SERVICE CLAIMS

#### Filing a Claim

A request for payment or reimbursement for benefits is called a “post-service care claim” or a “claim,” which may be submitted to the Benefit Fund in either electronic or paper form.

The Fund needs to receive a claim so that:

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

#### If You Use a Participating Provider

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

#### If You Use a Non-Participating Provider

You may need to submit a claim form to the Benefit Fund. If your provider does not have a claim form, you may obtain one by calling our Member Services Department at (646) 473-9200. You can also obtain a claim form from the “Forms and Other Resources” section of our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org). To expedite processing, your claim form should be submitted to the PO Box indicated on your claim 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. This way, you are giving the Fund your consent to have the payment sent to your doctor, hospital or healthcare provider. However, the Fund will only pay a claim according to the Schedule of Allowances. You may be responsible for any charges over the 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.

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

You will need to submit a claim form to the Benefit Fund. If your provider does not have a claim form, you may obtain one by calling our Member Services Department at (646) 473-9200.

You can also obtain a claim form from the “Forms and Other Resources” section of our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org). Submit this form with the bill from your provider to the PO Box indicated on your claim form, and make sure the bill lists the amount you have paid. The Fund will only pay a claim according to the Schedule of Allowances. You may be responsible for any charges over the Fund’s allowance.

### **If You Receive an Overpayment**

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 Very Important to File Your Claim with the Benefit Fund Promptly**

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

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

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

### **INITIAL CLAIM DECISION FOR POST SERVICE CLAIMS**

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

## **REQUESTS FOR BENEFITS OTHER THAN POST-SERVICE PAYMENT CLAIMS**

### **Initial Benefit Decision**

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

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

### **Pre-Service Care Requests**

Pre-Service Care Requests are requests for those benefits that require Fund approval — “pre-certification” or “prior authorization” — before treatment. These include, for example, requests to pre-certify a hospital stay or an ambulatory/outpatient surgery (see Section II.B) or to authorize home nursing care or durable medical

equipment (see Section II.I). In the case of requests for hospital stays or ambulatory/outpatient surgery, the Benefit Fund will have 1199SEIU CareReview, a contracted Fund Agent, review your request.

### **Concurrent Care Requests**

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

### **Urgent Care Requests**

Certain Pre-Service Care or Concurrent Care Requests involve situations that have to be decided quickly because using the usual timeframes for decision-making could: (i) seriously jeopardize the life or health of the patient; or (ii) in the opinion of the treating physician with knowledge of the medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment being requested. These Requests for Benefits are treated as Urgent Care Requests and include those situations commonly treated as Emergencies.

These claims may be filed by phone or fax. See Section II.I for requests involving hospitalization or outpatient/ambulatory surgery; see Section VII.B for all other requests.

## **TIMEFRAMES FOR INITIAL BENEFIT DECISIONS**

The Plan Administrator will provide a written decision on your initial Request for Benefits. If your request is denied, you will receive an explanation of why your benefits have been denied (or reduced) and the specific provisions of the Plan on which the decision was based. If an Urgent Care Request is denied, this information may be provided orally. A written notification will be given to you no later than three days after this oral notification.

### **Pre-Service Care Requests**

You or your authorized representative will be notified of the Plan Administrator's (or 1199SEIU CareReview's) approval or denial of your Request for Benefits no later than 15 days from the date the 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 after it is filed. You will then have 45 days to provide any additional information requested of you by the Plan Administrator (or 1199SEIU

CareReview). The period for making the benefit decision will be tolled (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. 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**

You or your authorized representative generally will be notified of the Plan Administrator's denial of your Request for Benefits sufficiently in advance of the reduction or termination of benefits to allow you to appeal and obtain a decision before the benefit is reduced or terminated (assuming that your request was filed before the end of the course of treatment for which the extension is being sought). If the request to extend the course of treatment or the number of treatments involves urgent care, the Plan Administrator will notify you of its decision, whether adverse or not, within 24 hours after receiving the request, provided that the request is made to the 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 on a timely basis, the initial decision on your Request for Benefits will be made based on the information available to the Plan Administrator.

## **Urgent Care Requests**

You or your authorized representative will be notified of the Plan Administrator's approval or denial of your request as soon as possible, but in no event, later than 72 hours after the Plan Administrator has received the request. If your request is incomplete, you will be notified within 24 hours. You or your authorized representative will then have 48 hours to provide the necessary information, and the Plan Administrator will notify you of its decision within 48 hours of receiving the additional information (or from the time the information was due). If you fail to provide the additional information on a timely basis, the initial decision on your Request for Benefits will be made based on the information available to the Plan Administrator.

---

## SECTION VII. B

# YOUR RIGHTS ARE PROTECTED — APPEALS PROCEDURE

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

### 1ST STEP – ADMINISTRATIVE REVIEW OF ADVERSE DECISION

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

**NOTE:** All claims by you, your beneficiaries or third parties against the Fund are subject to the Claims and Appeals Procedure. No lawsuits may be filed until all steps of these procedures have been completed and the benefits requested have been denied in whole or in part. No lawsuits may be filed by providers as your assignee after five years from the date of service. All lawsuits must be filed in a federal court in New York City.

### 2ND STEP – 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 after the 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.

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 third, final appeal to the Appeals Committee of the Board of Trustees. Such requests must be filed within 60 days after the receipt of the denial notice. Your request for a review must be in writing unless your claim involves urgent care,

in which case the request may be made orally. If your appeal is denied by the Appeals Committee, and you disagree with that decision, you still have the right to file a suit under ERISA only 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 of 1199SEIU CareReview shall be final and binding on all parties. If the Administrative Review by 1199SEIU CareReview results in a denial of your Request for Benefits, you have the right to file 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 or accident/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.

### **All Other Claims or Requests for Benefits**

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

## **WHAT YOU ARE ENTITLED TO**

In connection with your right to appeal, you:

- Are entitled to submit written comments, documents, records or any other matter relevant to your claim;
- Are entitled to receive, at your request and free of charge, reasonable access to, and copies of, all relevant documents, records and other information that was relied on in deciding your claim for benefits;
- Will be given a review that takes into account all comments, documents, records and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit decision;
- Will be provided with the 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;
- Are entitled to have your claim reviewed by a healthcare professional retained by the Plan, if the denial was based on a medical judgment; this individual may not have participated in the initial denial;
- Are entitled to a review that is conducted by a named fiduciary of the Plan who is not the person

who made the benefit decision, and who does not work for that person; and

- Are entitled to authorize a representative to appeal on your behalf, subject to the limitations described below.

**WHAT YOUR PROVIDER IS ENTITLED TO**

Non-Participating Providers do not have an independent right to appeal an adverse benefit decision. If you assign your right to benefit payments to a Non-Participating

Provider and authorize that provider to appeal on your behalf, the provider will “stand in your shoes” in the appeal, and will have no greater rights than you have as a participant appealing under the terms of this Plan. A Non-Participating Provider that appeals as an authorized assignee can only file a lawsuit on your behalf in a federal court in New York City and cannot file the lawsuit more than five years from the date of service. No other rights conferred under the terms of this Plan or ERISA may be transferred or assigned.

<b>HOW TO REQUEST AN ADMINISTRATIVE REVIEW OR AN APPEAL TO THE APPEALS COMMITTEE OF THE BOARD OF TRUSTEES</b>	
<p><b>Requests for Administrative Review of urgent care for hospitalization or ambulatory/outpatient procedures can be directed to 1199SEIU CareReview at:</b></p> <ul style="list-style-type: none"> <li>• Phone: (800) 227-9360</li> <li>• Fax (Medical): (866) 623-5793</li> <li>• Fax (Behavioral Health): (952) 996-2836</li> </ul>	<p><b>Requests for Administrative Review of non-urgent hospitalization or ambulatory/outpatient procedures should be sent to:</b></p> <p>1199SEIU CareReview Program CareAllies 1777 Sentry Park West Dublin Hall, 4th Floor Blue Bell, PA 19422</p>
<p><b>Requests for other Administrative Reviews and appeals should be sent to:</b></p> <p>1199SEIU National Benefit Fund for Home Care Employees Claim Appeals PO Box 646 New York, NY 10108-0646</p>	<p><b>Requests involving urgent care can be made by:</b></p> <ul style="list-style-type: none"> <li>• Phone: (646) 473-7446</li> <li>• Fax: (646) 473-7447</li> </ul>

In the case of an Urgent Care Request, you are entitled to a fast review process in which all necessary information, including the Benefit Fund’s benefit decision on review, shall be sent to you by telephone, facsimile or other available expeditious methods.

## **TIMEFRAMES FOR ADMINISTRATIVE REVIEW AND APPEAL**

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

- **Pre-Service Care Requests** – Not later than 15 days after your request for a review is received.
- **Post-Service Care Claims** – Not later than 30 days after your request for a review is received.
- **Urgent Care 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 Appeals Committee of the Board of Trustees does not exceed 72 hours after your request for a review is received.
- **Concurrent Care Requests** – An appeal of a Concurrent Care Request will be treated as either an Urgent Care Request, a Pre-Service Request or a Post-Service Claim, depending on the facts.

The decision of the Appeals Committee shall be final and binding on all parties, subject to your right to file a suit only in a federal court in New York City, under ERISA and the terms of this Plan.

---

## **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 material it needs to process your claim for benefits.**

The Fund may be unable to process your claim if you:

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

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

- That you were not entitled to receive;
- For claims that you would otherwise be entitled to until full restitution (which may include interest and expenses incurred by the Fund) has been made for any fraudulent claims that were paid by the Fund; 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 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 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, the Benefit Fund does not cover the following charges:

- Charges in excess of the Fund's Schedule of Allowances
- Charges for services provided and supplies or appliances used before you became eligible for Fund coverage
- Charges for services covered under any mandatory automobile or no-fault policy
- Charges associated with any work-related accidental injuries or diseases that are covered under Workers' Compensation or comparable law
- Charges for care resulting from an act of war
- To the extent permitted by law, charges related to an illness or accident/injury that was deliberately self-inflicted, except where such illness or accident/injury is attributable to a mental condition or that resulted from the person committing an illegal act
- Charges for services or materials that do not meet the Fund's standards of professionally recognized quality
- Charges that would not have been made if no coverage existed or charges that you were not required to pay. For example, the Fund will not pay for services provided by members of your immediate family.
- Charges made by your provider for broken appointments
- Charges for in-hospital services that can be performed on an ambulatory or outpatient basis
- Charges for procedures, treatments, services, supplies or drugs for cosmetic purposes, except to remedy a condition that results from an accidental injury that occurred while covered by the Fund
- Charges for experimental or unproven procedures, services, treatments, supplies, devices, drugs, etc. (see definition of "Experimental" in Section IX)
- Charges for services, treatments and supplies covered under any other insurance coverage or plan, or under a plan or law of any government agency or program, unless there is a legal obligation to pay
- Charges for services that are not FDA approved for a particular condition

- Charges that are unreasonable, excessive or beyond a provider's normal billing rate or beyond his or her scope or specialty
- Charges for services that are not covered by the Fund, even if the service is Medically Necessary
- Charges for services that are not Medically Necessary (see Section VIII.C)
- Charges related to interest, late charges, finance charges, court or other legal costs
- Charges related to programs for smoking cessation, weight reduction, stress management and other similar programs that are not provided by a licensed medical physician or not Medically Necessary
- Charges for infertility treatment, including, but not limited to, in vitro fertilization, artificial insemination, embryo storage, cryosterilization and reversal of sterilization
- Charges for claims submitted more than 12 months after the date of service
- Charges related to an illness or accident/injury resulting from the conduct of another person, where payment for those charges is the legal responsibility of another person, firm, corporation, insurance company, payer, uninsured motorist fund, no-fault insurance carrier or other entity
- Charges for services that are custodial in nature
- Charges for services in excess of or not in compliance with the Fund's guidelines, policies or procedures
- Charges that are not itemized
- Charges for over-the-counter, personal, comfort or convenience items, such as bandages or heating pads (even if your physician recommends them)
- Charges for services that are not pre-approved in accordance with the terms of the Plan
- Charges for claims containing misrepresentations or false, incomplete or misleading information
- Charges for invalid and/or obsolete CPT or HCPCS codes

---

## SECTION VII. E

### ADDITIONAL PROVISIONS

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

Payments shall not be made to a person who is:

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

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

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

No legal action may be brought against the Benefit Fund or the Trustees by providers as your assignee after five years from the date of service.

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 stated 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.

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

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





## **SECTION VIII – GENERAL INFORMATION**

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

---

# SECTION VIII. A

## YOUR ERISA RIGHTS

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

### GETTING INFORMATION

You have the right to:

- Examine, without charge, at the Fund office, all required Benefit Fund documents, including Collective Bargaining Agreements, insurance contracts, detailed annual reports (Form 5500 series) and descriptions;
- Obtain copies of all required Benefit Fund documents, such as copies of the trust, the latest annual report, Summary Plan Description or Summary of Benefits and Coverage by writing to the Plan Administrator at PO Box 2661, New York, NY 10108-2661. The Plan Administrator can make a reasonable charge for copies; and
- Receive a summary of the Fund’s Annual Financial Report. The Plan Administrator is required by law to provide each member with a copy of this Summary Annual Report. Union and Fund periodicals may be used for this purpose.

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

### CONTINUE GROUP HEALTH COVERAGE

- If you lose health coverage for yourself under the Plan as a result of a qualifying event, you may have to pay for continued coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate the exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

## **PRIVACY OF PROTECTED HEALTH INFORMATION**

A federal law — the Health Insurance Portability and Accountability Act (“HIPAA”) — 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 that 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 functions. The Benefit Fund may share enrollment information with the 1199SEIU Family of Funds’ Eligibility Department for enrollment functions. 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. Anyone may request an additional copy of this Notice by contacting the Benefit Fund office 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.

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

If your claim for benefits is entirely or partially denied:

- You must receive a written explanation of the reason for the denial, 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 only in a federal court in New York City.
- In this case, the court may require the Plan Administrator to provide the documents and possibly pay

you up to \$110 a day until you receive the materials, unless the documents were not sent because of reasons beyond the control of the Plan Administrator.

- If you have a claim for benefits 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 appeals procedure (see Section VII.B), if you believe that 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 Benefit Fund's money, or if you are discriminated against for asserting your rights, you may get help from the U.S. Department of Labor, or you 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, the court may require you to pay these costs and fees (for example, if it finds your claim is frivolous).

## **QUESTIONS?**

If you have any questions about:

- Your Fund, contact the Benefit Fund office at (646) 473-9200; or
- Your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest area office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Publications Hotline of the Employee Benefits Security Administration 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 this Plan (including any related documents and underlying policies), at any time and for any reason, by action of the Board of Trustees, or any duly authorized designee of the Board of Trustees, in such manner as may be duly authorized by the Board of Trustees.

Neither you, your beneficiaries or any other person has or will have a vested or nonforfeitable 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;
  - To decide all matters arising in connection with entitlement to benefits, the nature, type, form, amount and duration of benefits, and the operation or administration of the Plan; and
  - To make all factual determinations required to administer, apply, construe and interpret the Plan (and all related Plan documents).
- (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; and
  - (viii) Process and approve or deny benefit claims and rule on any benefit exclusions.

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

- (i) Determine whether any individual is eligible for any benefits under this Plan;
- (ii) Determine the amount of benefits, if any, an individual is entitled to under this Plan;
- (iii) Interpret all of the provisions of this Plan (and all related Plan documents);
- (iv) Interpret all of the terms used in this Plan;

All determinations made by the Plan Administrator (or any duly authorized designee thereof) and/or the Appeals Committee of the Board of Trustees 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 YOUR PLAN

### NAME OF THE PLAN

The 1199SEIU National Benefit Fund  
for Home Care Employees

### TYPE OF PLAN

Taft-Hartley (Union-Employer) Jointly  
Trusted Employee Welfare Benefit Fund

### ADDRESS

Headquarters and Offices:

330 West 42nd Street  
New York, NY 10036

### 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.

You may receive a copy of any  
Collective Bargaining Agreement by  
writing to the Fund Administrator or by  
examining a copy at the Fund office.

You can find out if a particular Employer  
or employee organization is a sponsor  
of the Benefit Fund by writing to the  
Benefit Fund office. The address of the  
sponsor will also be given.

### ACCUMULATION OF ASSETS

The Fund's resources are held in  
checking and savings accounts to pay  
benefits and expenses. Assets are  
also invested by Investment Managers  
appointed by the Home Care Trustees  
to whom the Home Care Trustees have  
delegated this fiduciary duty.

### PLAN YEAR

The Fund's fiscal year is January 1 to  
December 31.

### PLAN ADMINISTRATOR

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

The Trustees may be contacted at:

c/o Executive Director  
1199SEIU National Benefit Fund for  
Home Care Employees  
330 West 42nd Street  
New York, NY 10036

### FOR SERVICE OF LEGAL PROCESS

Legal papers may be served on the  
Fund Trustees or the Fund's counsel.

### IDENTIFICATION NUMBER

Employer Identification Number:  
13-4129368

## HOME CARE TRUSTEES

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

UNION TRUSTEES	
Guadalupe Astacio Organizer 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036	Keith Joseph Vice President 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036
Kwai (David) Ho Vice President 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036	Rona Shapiro Executive Vice President 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036

## EMPLOYER TRUSTEES

James Carey Executive Director R.A.I.N. Home Attendant Services 811 Morris Park Avenue Bronx, NY 10462	Michael Elsas President Cooperative Home Care Associates 400 East Fordham Road, 12th Floor Bronx, NY 10458
Gladys Confident Director Home Care Services for Independent Living, Inc. 2044 Ocean Avenue, Suite B-4 Brooklyn, NY 11230	Ling Ma Director Chinese-American Planning Council Home Attendant Program 1 York Street, 2nd Floor New York, NY 10013
Jay Conolly Vice President, Human Resources Partners In Care 1250 Broadway New York, NY 10001	





## **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**

Plan sponsored by Amalgamated Life Insurance Company under an agreement with the Trustees providing for payments to a beneficiary designated by the employee under the circumstances described in Section IV and in the Certificate of Coverage (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 beneficiary or a provider of services that has received an Assignment of Benefits and your written authorization to appeal on your behalf.

## **Ambulatory Care**

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

## **Assignment of Benefits**

1. The Benefit Fund will pay its allowance to your doctor, laboratory, etc. directly when you request it to

do so by signing 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.

2. See Lien Acknowledgment.

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.

## **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 he or she has 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**

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

## **Concurrent Review**

A review of a request to extend a course of treatment, as services are being provided to you, to determine whether such services continue to be Medically Necessary Covered Services.

## **Contributing Employer**

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

## **Coordination of Benefits**

A method of sharing costs among payers, which sets the order of payment by each. (See Section I.F for more detailed information.)

## **Cosmetic Surgery**

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

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

## **Custodial Care**

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

**Dentist**

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

**Dependent**

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

**Direct Payment**

Payments made on a self-pay basis to continue your life insurance coverage after your benefits have terminated.

**Disabled**

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

**Doctor**

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

**Durable Medical Equipment**

Equipment that can withstand repeated use, is primarily and usually used to serve a medical purpose and is generally not useful to a person in the absence of illness or injury.

**Eligible**

You have met the criteria adopted by the Trustees of the Benefit Fund to determine your enrollment for benefits.

**Eligible Charges**

The maximum amount that the Benefit Fund recognizes as a reasonable charge for the service rendered, as set forth in the Fund's Schedule of Allowances.

**Emergency**

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

stabilization and medical detoxification from drugs or alcohol, that are provided for an Emergency Condition.

### **Employer**

See Contributing Employer.

### **Executive Director**

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

### **Experimental**

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

- If a drug, biological product, device or other item requires governmental approval, that item has completed the required clinical trials and has received final approval from the appropriate governmental regulatory bodies for commercial distribution for use in treating the condition being reviewed;
- The treatment is endorsed by an appropriate medical society;
- There must be scientific evidence, including peer-review literature, demonstrating that the technology improves net health outcomes or offers significant benefit over conventional treatment, in terms of efficacy, safety and reliability;

- The technology/treatment must offer a significant benefit over conventional treatment; or
- The improvement in net health outcome must be attainable under the usual conditions of medical practice.

### **Family**

You and 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 drugs, biologics, vaccines and medical devices.

### **Fiduciary**

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

### **Full Time**

The number of hours worked in a normal 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 located at 330 West 42nd Street in New York City.

## **Habilitation Therapies**

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

## **Health Benefits ID Card**

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

## **Home Care 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 who are responsible for the Plan of Benefits for Home Care employees.

## **Hospital**

An institution that:

- Primarily provides services to diagnose, treat and care for injured, disabled or sick patients by or under the supervision of a doctor;
- Provides 24-hour nursing service with the care given or supervised by a registered professional nurse;
- Maintains clinical records on all patients;

- Has by-laws in effect with respect to its staff of physicians;
- Has a hospital utilization review plan in effect;
- Is licensed by the federal government and by the state in which the hospital is located; and
- Has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

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

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

## **Illness**

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

## **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 which you may have against any person or entity responsible for an illness or accident/injury, including illness or accident/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 or accident/injury caused by the conduct of a third party, including expenses for treatment related to an illness or accident/injury that resulted from medical malpractice.

## **Life Insurance**

Plan sponsored by Amalgamated Life Insurance Company under an agreement with the Trustees 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 and in the Certificate of Coverage.

## **Medically Necessary**

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

- 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, 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**

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.

## **Mental Health Benefits**

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

## **NBF–Home Care**

1199SEIU National Benefit Fund for Home Care Employees

## **Network**

See Participating Provider.

## **Non-Panel or Non-Participating**

A duly licensed healthcare professional or other provider who does not have any fee agreement with the Benefit Fund.

## **Outpatient Observation Care and Services**

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment before a decision can be made regarding whether a patient will require further treatment as a hospital inpatient or if he or she is able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the Emergency Department and who then require a significant period of treatment or monitoring in order to

make a decision concerning their admission or discharge. Generally, observation services are for a period of less than 48 hours and usually less than 24 hours.

## **Over-the-Counter**

Any medication that is customarily and legally purchased without a prescription.

## **Panel Doctor**

See Participating Provider.

## **Participant**

An employee who is working for a Contributing Employer on whose behalf payments to the 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 (PBM).

## **Participating Provider**

A duly licensed health practitioner, such as a dentist, dental specialist, physician, board-certified or board-eligible specialist, podiatrist, chiropractor, psychologist, psychiatric social worker, optician, optometrist or medical supplier, who has signed an agreement with the Benefit Fund or with a network with which the Benefit Fund has a contract.

**Part Time**

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

**Physician**

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

**Plan**

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

**Plan Administrator**

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

**Podiatrist**

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

**Pre-Certification**

See Prior Approval.

**Prior Approval**

A requirement to submit a treatment plan or call the Benefit Fund or its agents 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 or outpatient services or treatment, admissions for mental health or alcohol/substance abuse, admissions for physical rehabilitation, certain prescription drugs, all non-Emergency hospital admissions and surgical procedures. Prior approval 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 approval.

**Prior Authorization**

See Prior Approval.

**Psychiatric Social Worker**

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

**Psychologist**

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

**Retrospective Review**

A review of a request, after services have been provided to you, to determine whether such services were Medically Necessary Covered Services and whether and to what extent benefits are payable.

**Schedule**

A list of items covered and/or amounts paid.

**Schedule of Allowances**

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

**Special Enrollment Period**

A period outside the open enrollment period during which you may enroll yourself and your dependent (i) for 30 days following a loss of eligibility for other group health coverage or the acquisition of a new dependent by birth, adoption or placement for adoption; or (ii) for 60 days following a loss of coverage under Medicaid or CHIP or after becoming eligible for state premium assistance subsidy.

**Surgeon**

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

**Trust Agreement**

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

**Trustees**

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

**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.

**You or Your**

As used in this SPD, the term “You” or “you” (or “Your” 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.











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



**JUNE 2015**