



# 1199SEIU

NATIONAL BENEFIT FUND

**FOR ROCHESTER AREA MEMBERS**

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## ***OUR BENEFITS***

**SUMMARY PLAN**

**DESCRIPTION**

**OF YOUR HEALTH AND**

**WELFARE BENEFITS**

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**HOME | TABLE OF CONTENTS**

# LANGUAGE ASSISTANCE SERVICES

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

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

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

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

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

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

**ערוויסעס פון אפצאל רופט ענען פארהאן פאר אייך שפראך הילף, אויפמערקזאם: אויב איר רעדט אידיש, (646) 473-9200.**

**লক্ষ্য করুন:** যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নথি রাখায় ভাষা সহায়তা পরামিতি উপলব্ধ আছে। ফোন করুন ১ (646) 473-9200.

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

**نإف ءةءللل ركذآ ئدحتت تنك اذا! فظو حلم لكل رفاوتت ءىوغللل ءدعاسملا تامدخ مءرب لصتا. (646) 473-9200.**

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

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

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

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

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

This booklet serves as both a Summary Plan Description and Plan Document (“SPD”) for participants in the 1199SEIU National Benefit Fund employed in the Rochester area.

The Plan is administered by the Board of Trustees (the “Trustees”) of the 1199SEIU National Benefit Fund for Health and Human Service Employees. No individual or entity, other than the Trustees (including any duly authorized designee thereof) has any authority to interpret the provisions of this Plan Document or to make any promises to you about the Plan.

The Trustees reserve the right to amend, modify, discontinue or terminate all or part of this Plan for any reason and at any time when, in their judgment, it is appropriate to do so. These changes may be made by formal amendments to the Plan, resolutions of the Board of Trustees, actions by the Trustees when not in session by telephone or in writing, and/or any other methods allowed for Trustee actions.

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

The Trustees (including 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 decision.

This SPD and the Benefit Fund staff 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 staff will be glad to help you.

Because telephone conversations and other oral statements can easily be misunderstood, they cannot be relied upon if they are in conflict with what is stated in this Plan Document.

## **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.

If the language is not clear to you, you can get assistance by writing the Benefit Fund at:

**259 Monroe Avenue, Suite 220  
Rochester, NY 14607**

**or calling (585) 244-0830.**

Office hours for the Fund are 9:00 am to 5:00 pm, Monday through Friday.

## **¿NECESITA AYUDA CON EL SUMARIO DE DESCRIPCIÓN DEL PLAN?**

Este folleto es un sumario en inglés de sus derechos y beneficios bajo el Fondo Nacional de Beneficios de la 1199SEIU.

Si usted no entiende este sumario y necesita ayuda, escriba al Fondo:

**259 Monroe Avenue, Suite 220  
Rochester, NY 14607**

**o llame: (585) 244-0830.**

Las horas de oficina del Fondo son de 9:00 am a 5:00 pm de lunes a viernes.

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

January 2018

**Dear 1199SEIU Rochester Area Member:**

Your Benefit Fund provides a wide range of benefits for both full-time and part-time workers. Medical Benefits under the Plan are provided by contract through MVP Health Care. Dental Benefits under this Plan are provided by contract with Excellus BlueCross BlueShield. These benefits are described in this SPD and in information provided to you by MVP and Excellus, respectively. Prescription and Life Insurance Benefits are provided by the Benefit Fund and are described in this SPD.

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

**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.

As you know, healthcare costs have been rising every year. As costs have risen, your Benefit Fund has been looking in new directions and developing programs to provide you with coverage for primary and preventive care.

The Benefit Fund is partnering with MVP Health Care, to arrange for cost-effective medical care to our Rochester area members.

If you have any questions or concerns about any of your benefits or coverage for a specific medical problem, call the Rochester Benefit Fund Office at (585) 244-0830, or call the Benefit Fund's main office at (877) 557-1199. The Benefit Fund staff can answer your questions, refer you to another department or take the information and get back to you later with an answer.

The Benefit Fund cares about you and your family. With your help, your Benefit Fund can continue to provide a comprehensive package of Health and Welfare Benefits in the years ahead for you and your family and other 1199SEIU members and their families.

**The Board of Trustees**

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# TABLE OF CONTENTS

[Preface](#) ..... 1  
[Letter from the Board of Trustees](#) ..... 3  
[Foreword](#) ..... 7

**[OVERVIEW OF YOUR BENEFITS](#) ..... 9**

**[SECTION I – ELIGIBILITY](#) ..... 21**

[I. A Who Is Eligible](#) ..... 24  
[I. B When Your Coverage Begins](#) ..... 27  
[I. C Enrolling in the Benefit Fund](#) ..... 29  
[I. D How to Determine Your Level of Benefits](#) ..... 31  
[I. E Your ID Cards](#) ..... 33  
[I. F Coordinating Your Benefits](#) ..... 34  
[I. G When Others Are Responsible for Your Illness or Injury](#) ..... 37  
[I. H When You Are on Workers’ Compensation Leave](#) ..... 40  
[I. I When Your Benefits Stop](#) ..... 41  
[I. J Continuing Your Coverage](#) ..... 43  
[I. K Your COBRA Rights](#) ..... 45

**[SECTION II – HEALTH BENEFITS](#) ..... 53**

[II. A How Your Health Plan Works](#) ..... 56  
[II. B Getting the Care You Need](#) ..... 58  
[II. C Hospital and Other Facility Services](#) ..... 61  
[II. D Emergency Department Care](#) ..... 66  
[II. E Behavioral Health: Mental Health  
and Alcohol/Substance Abuse](#) ..... 69  
[II. F Medical and Other Health Services](#) ..... 73  
[II. G Vision Care](#) ..... 81  
[II. H Dental Benefits](#) ..... 82  
[II. I Prescription Drugs](#) ..... 86

<b>SECTION III – DISABILITY BENEFITS</b>	<b>93</b>
III. A Your Disability Benefits	95
III. B When You Are on Workers’ Compensation Leave	96
<b>SECTION IV – LIFE INSURANCE BENEFIT</b>	<b>99</b>
IV. A Life Insurance Eligibility	101
IV. B Life Insurance Benefit	103
IV. C Accidental Death and Dismemberment	104
<b>SECTION V – OTHER BENEFITS</b>	<b>107</b>
V. A Anne Shore Sleep-Away Camp Program	109
V. B Joseph Tauber Scholarship Program	111
V. C Social Services/Member Assistance Program	113
<b>SECTION VI – RETIREE HEALTH BENEFITS</b>	<b>115</b>
<b>SECTION VII – GETTING YOUR BENEFITS</b>	<b>117</b>
VII. A Filing a Claim Form for Medical and Health Benefits	119
VII. B Your Rights Are Protected — Appeals Procedure	125
VII. C When Benefits May Be Suspended, Withheld or Denied	130
VII. D What Is Not Covered	131
VII. E Additional Provisions	135
<b>SECTION VIII – GENERAL INFORMATION</b>	<b>137</b>
VIII. A Your ERISA Rights	138
VIII. B Plan Amendment, Modification and Termination	142
VIII. C Authority of the Plan Administrator	143
VIII. D Information on Your Plan	144
<b>SECTION IX – DEFINITIONS</b>	<b>151</b>

## **NEED TO KNOW WHAT “FAMILY” MEANS IN THIS SPD?**

### ***Refer to 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 “spouse,” “family,” “Contributing Employer,” etc. For example, “family” as used in this SPD refers only to your spouse or your children who are eligible for benefits from this Benefit Fund.

If you have any further questions, please call the Rochester Benefit Fund Office at (585) 244-0830.



## YOUR BENEFIT FUND

The 1199SEIU National Benefit Fund is a grandfathered, 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. Wage Class I, II and III Benefits are “grandfathered” plans that provide “minimum essential coverage” and exceed the “minimum value” standard, as those terms are defined by the Patient Protection and Affordable Care Act (the “Affordable Care Act”). For Rochester members, MVP Health Care is a third-party administrator of the 1199SEIU National Benefit Fund.

**Grandfathered under the Affordable Care Act** means that this plan can preserve certain basic health coverage that was already in effect when that law was enacted in 2010, and may not include certain new consumer protections 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.

**Self-funded** means all of the money your Employer pays to the Benefit Fund on your behalf goes directly to providing your benefits. The Benefit Fund does not exist to make profits, like an insurance company does. It exists only to provide you, 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.

**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.

## **YOUR EMPLOYER PAYS FOR YOUR BENEFITS**

Your Union contract — the Collective Bargaining Agreement between your Employer and 1199SEIU — requires that your Employer make payments to the Benefit Fund on your behalf for Health and Welfare Benefits.

The cost of your benefits is paid through “contributions” to the Benefit Fund by your Employer. These payments are called contributions because they go into a large pool of money used to pay for all the benefits for all Rochester 1199SEIU members and their families covered by the Plan. Your benefits are solely paid out of contributions and other income from Rochester Contributing Employers, and not from contributions from other Employers.

Your Union dues are paid to 1199SEIU to cover the cost of running the Union — not to the Benefit Fund to cover the cost of providing Health and Welfare Benefits.



## **OVERVIEW OF YOUR BENEFITS**

## **IMPORTANT PHONE NUMBERS**

### **Rochester Benefit Fund Office**

(585) 244-0830

For questions about eligibility, Coordination of Benefits, your 1199SEIU Health Benefits ID card, Prescription and Life Insurance Benefits.

### **MVP Health Care**

(585) 325-3113 or (800) 767-1678

For questions about your 1199SEIU National Benefit Fund/MVP Health Care ID card, Medical and other Health Benefits.

You can also visit the MVP website at [www.MVPHealthCare.com](http://www.MVPHealthCare.com).

### **Excellus BlueCross BlueShield**

(800) 724-1675

For questions about your Dental Benefits.

### **1199SEIU National Benefit Fund**

(877) 557-1199

For questions about the Member Assistance Program, and for camp and scholarship information.

**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 account to check your eligibility, change your address or update other information.**

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

**The Fund believes it is a “Grandfathered Health Plan” under 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.

LEGEND	
<b>Member</b> – You, the member	<b>Children</b> – Your children, if eligible
<b>Spouse</b> – Your spouse, if eligible	<b>Family</b> – You, your spouse and your children, if eligible

See Section I.A of this SPD to determine if you, your spouse and/or your children are eligible for benefits.

**NOTE:** If you use a non-Participating Provider, the Fund will pay 50% of the Allowed Amount and you may be responsible for the difference between this amount and the amount charged by your provider.

BENEFIT COVERAGE	WAGE CLASS		
	I	II	III
<b>MVP Health Care Coverage and Co-payments* for Participating Providers</b>			
<b>PHYSICIAN SERVICES</b>	Family	Family	Member Only
<ul style="list-style-type: none"> <li>• <b>Primary Care Physician Office Visit (includes in-office injections, immunizations, tests)</b> <ul style="list-style-type: none"> <li>» Member pays \$10 per visit</li> </ul> </li> <li>• <b>Preventive Care Screenings</b> <ul style="list-style-type: none"> <li>» Member pays \$25 per screening</li> </ul> </li> <li>• <b>Well-child Visit for Dependent Children</b> <ul style="list-style-type: none"> <li>» Covered 100% for children ages 0–5</li> <li>» \$10 co-pay for children age 6 and older</li> </ul> </li> </ul>			

\* These are current co-payments. Co-payments subject to change.

\*\* If you use a non-Participating Provider, the Benefit Fund will pay 50% of the Allowed Amount and you may be responsible for the difference between this amount and the amount charged by your provider.

BENEFIT COVERAGE	WAGE CLASS		
	I	II	III

MVP Health Care Coverage and Co-payments* for Participating Providers	I	II	III
<b>PHYSICIAN SERVICES (continued)</b>	Family	Family	Member Only
<ul style="list-style-type: none"> <li>• <b>Specialist Office Visit (includes in-office injections, tests)</b> <ul style="list-style-type: none"> <li>» Member pays \$23.50 per visit</li> </ul> </li> <li>• <b>Diagnostic Testing (in-office, outpatient or Ambulatory Surgery Unit setting)</b> <ul style="list-style-type: none"> <li>» Member pays \$25 per test/X-ray</li> <li>» Member pays \$0 for lab/blood work</li> </ul> </li> <li>• <b>Inpatient Surgery (anesthesia included)</b> <ul style="list-style-type: none"> <li>» If approved by MVP Health Care, member pays \$0</li> <li>» Transplants and bariatric surgery are covered in-network only</li> </ul> </li> <li>• <b>Care by Physician in a Hospital</b> <ul style="list-style-type: none"> <li>» Member pays \$0 as long as hospital stay is approved by MVP Health Care</li> </ul> </li> </ul>			

<b>HOSPITAL SERVICES</b>	Family	Family	Member Only
<ul style="list-style-type: none"> <li>• <b>Inpatient (this benefit is for the hospital's charge for the use of the facility only)</b> <ul style="list-style-type: none"> <li>» Member pays \$0 for Medically Necessary acute care</li> <li>» Wage Class III covered for Medically Necessary services up to 300 days per year. First 120 days paid at 100% of the Allowed Amount; days 121–300 paid at 50% of the Allowed Amount.**</li> <li>» Observation care and services</li> </ul> </li> </ul>			

\* These are current co-payments. Co-payments subject to change.

\*\* If you use a non-Participating Provider, the Benefit Fund will pay 50% of the Allowed Amount and you may be responsible for the difference between this amount and the amount charged by your provider.

BENEFIT COVERAGE MVP Health Care Coverage and Co-payments* for Participating Providers	WAGE CLASS		
	I	II	III

<b>HOSPITAL SERVICES (continued)</b>	Family	Family	Member Only
<ul style="list-style-type: none"> <li>• <b>Emergency Department Visit</b> <ul style="list-style-type: none"> <li>» Member pays \$50 if not admitted to the hospital. Member pays \$0 if admitted to the hospital.</li> <li>» Use of the Emergency Department must be <b>for an Emergency and within 72 hours</b> of an accident/injury or the onset of a sudden and serious illness</li> <li>» If your condition is not an Emergency, you will be responsible for all charges in excess of the Allowed Amount**</li> </ul> </li> <li>• <b>Urgent Care Visit</b> <ul style="list-style-type: none"> <li>» Member pays \$25 per visit</li> </ul> </li> </ul>			

<b>HOSPICE CARE</b>	Family	Family	Member Only
<ul style="list-style-type: none"> <li>• <b>Services in a Medicare-certified hospice program in a hospice center, hospital or at home</b></li> </ul>			

<b>MATERNITY CARE</b>	Family	Family	Member Only
<ul style="list-style-type: none"> <li>• <b>Prenatal Office Care</b> <ul style="list-style-type: none"> <li>» Member pays \$10 per visit</li> </ul> </li> <li>• <b>Inpatient Hospital Care/Delivery</b> <ul style="list-style-type: none"> <li>» Member pays \$0</li> </ul> </li> <li>• <b>Postnatal Care</b> <ul style="list-style-type: none"> <li>» Member pays \$0</li> </ul> </li> </ul>			

\* *These are current co-payments. Co-payments subject to change.*

\*\* *If you use a non-Participating Provider, the Benefit Fund will pay 50% of the Allowed Amount and you may be responsible for the difference between this amount and the amount charged by your provider.*

BENEFIT COVERAGE MVP Health Care Coverage and Co-payments* for Participating Providers	WAGE CLASS		
	I	II	III

<b>MENTAL HEALTH</b>	Family	Family	Member Only
<ul style="list-style-type: none"> <li>• <b>Inpatient Treatment</b> <ul style="list-style-type: none"> <li>» <b>Wage Class I and II:</b> <ul style="list-style-type: none"> <li>- Member pays \$0 for Medically Necessary acute inpatient services</li> </ul> </li> <li>» <b>Wage Class III:</b> <ul style="list-style-type: none"> <li>- Covered for Medically Necessary services up to 300 days per year. First 120 days paid at 100% of the Allowed Amount; days 121–300 paid at 50% of the Allowed Amount.**</li> </ul> </li> </ul> </li> <li>• <b>Outpatient Treatment</b> <ul style="list-style-type: none"> <li>» Member pays \$10 for all outpatient visits. Member can call MVP Health Care’s Behavioral Health Member Line at (800) 568-0458 for a list of Participating Providers.</li> </ul> </li> </ul>			

<b>ALCOHOL AND SUBSTANCE ABUSE</b>	Family	Family	Member Only
<ul style="list-style-type: none"> <li>• <b>Inpatient Detoxification</b> <ul style="list-style-type: none"> <li>» <b>Wage Class I and II:</b> <ul style="list-style-type: none"> <li>- Member pays \$0 for Medically Necessary acute inpatient services</li> </ul> </li> <li>» <b>Wage Class III:</b> <ul style="list-style-type: none"> <li>- Covered for Medically Necessary services up to 300 days per year. First 120 days paid at 100% of the Allowed Amount; days 121–300 paid at 50% of the Allowed Amount.**</li> </ul> </li> </ul> </li> </ul>			

\* *These are current co-payments. Co-payments subject to change.*

\*\* *If you use a non-Participating Provider, the Benefit Fund will pay 50% of the Allowed Amount and you may be responsible for the difference between this amount and the amount charged by your provider.*



BENEFIT COVERAGE	WAGE CLASS		
	I	II	III

MVP Health Care Coverage and Co-payments* for Participating Providers	I	II	III
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**ALCOHOL AND SUBSTANCE ABUSE (continued)**      Family      Family      Member Only

- **Outpatient Treatment**
  - » Member pays \$10 for all outpatient visits. Member can call MVP Health Care’s Behavioral Health Member Line at (800) 568-0458 for a list of Participating Providers.

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MEDICAL SERVICES	Family	Family	Member Only
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- **Laboratory (in hospital or freestanding lab)**
  - » Member pays \$0 per visit
- **Podiatry (available for diabetics only)**
  - » Member pays \$23.50 per visit
- **Chiropractic**
  - » Member pays 20% of the Allowed Amount;\*\* up to 24 visits per calendar year

Not Covered
- **Chemotherapy and Radiation**
  - » Covered in full
- **Radiology (in hospital or freestanding unit)**
  - » Member pays \$25 per test
- **Speech, Physical and Occupational Therapy**
  - » Member pays \$23.50 per visit; coverage is limited to a combined 25 visits per calendar year
- **Ambulance**
  - » Member pays 20% of the Allowed Amount\*\* for Medically Necessary transport

Not Covered

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\* These are current co-payments. Co-payments subject to change.

\*\* If you use a non-Participating Provider, the Benefit Fund will pay 50% of the Allowed Amount and you may be responsible for the difference between this amount and the amount charged by your provider.

BENEFIT COVERAGE MVP Health Care Coverage and Co-payments* for Participating Providers	WAGE CLASS		
	I	II	III

<b>MEDICAL SERVICES (continued)</b>	Family	Family	Member Only
<ul style="list-style-type: none"> <li>• <b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>» Member pays 20% of the Allowed Amount**</li> </ul> </li> <li>• <b>Diabetic Supplies</b> <ul style="list-style-type: none"> <li>» When accessed through a Participating MVP Provider, member pays 20% of the Allowed Amount**</li> <li>» When accessed through a Participating Pharmacy, member pays \$4 co-pay</li> </ul> </li> <li>• <b>Hearing Aids</b> <ul style="list-style-type: none"> <li>» Member pays 20% of the Allowed Amount**</li> <li>» Two hearing aids every 36 months</li> </ul> </li> <li>• <b>Home Health Care</b> <ul style="list-style-type: none"> <li>» Member pays 20% of the Allowed Amount** when care is pre-approved by MVP Health Care</li> </ul> </li> <li>• <b>Internal Prosthetic Devices</b> <ul style="list-style-type: none"> <li>» Member pays 20% of the Allowed Amount**</li> </ul> </li> </ul>			Not Covered

<b>VISION CARE</b>	Family	Family	Member Only
<ul style="list-style-type: none"> <li>• <b>Eye Exam for Disease or Injury</b> <ul style="list-style-type: none"> <li>» Member pays \$23.50 per visit</li> </ul> </li> </ul>			

\* These are current co-payments. Co-payments subject to change.

\*\* If you use a non-Participating Provider, the Benefit Fund will pay 50% of the Allowed Amount and you may be responsible for the difference between this amount and the amount charged by your provider.

BENEFIT COVERAGE MVP Health Care Coverage and Co-payments* for Participating Providers	WAGE CLASS		
	I	II	III

<b>VISION CARE (continued)</b>	Family	Family	Member Only
<ul style="list-style-type: none"> <li>• Eye Exam with Refraction, Once per Member Every Two Years (no referral necessary)               <ul style="list-style-type: none"> <li>» Member pays \$23.50 per visit</li> </ul> </li> <li>• Allowance Toward One Pair of Glasses or One Order of Contact Lenses Every Two Years               <ul style="list-style-type: none"> <li>» \$60 allowance every two years</li> </ul> </li> </ul>			

<b>DENTAL CARE</b>	Family	Not Covered	Not Covered
<ul style="list-style-type: none"> <li>• You or your dentist will be reimbursed according to Excellus BlueCross BlueShield's Schedule of Allowances, up to a maximum benefit of \$2,000 per person per year (excluding preventive care and essential oral pediatric services). Additional lifetime maximum of \$2,000 for orthodontic services for children up to age 19.</li> </ul>			

<b>PRESCRIPTION DRUGS</b>	Family	Not Covered	Not Covered
<ul style="list-style-type: none"> <li>• FDA-approved prescription medications</li> <li>• Use generic and preferred drugs where available               <ul style="list-style-type: none"> <li>» Member pays \$4 co-pay</li> </ul> </li> <li>• Differential if your doctor prescribes a drug that is not preferred</li> <li>• Use Participating Pharmacies</li> <li>• Mandatory Maintenance Drug Access Program for chronic conditions — <i>The 1199SEIU 90-Day Rx Solution</i></li> </ul>			

\* These are current co-payments. Co-payments subject to change.

\*\* If you use a non-Participating Provider, the Benefit Fund will pay 50% of the Allowed Amount and you may be responsible for the difference between this amount and the amount charged by your provider.

BENEFIT COVERAGE MVP Health Care Coverage and Co-payments* for Participating Providers	WAGE CLASS		
	I	II	III

<b>PRESCRIPTION DRUGS (continued)</b>	Family	Not Covered	Not Covered
<ul style="list-style-type: none"> <li>• Prior Authorization needed for certain medications</li> <li>• Please refer to “What Is Not Covered” in Section II.I</li> </ul>			

<b>DISABILITY</b>	Member Only	Member Only	Member Only
<ul style="list-style-type: none"> <li>• This benefit is administered by your Employer under the Benefit Fund’s definition of Disability</li> <li>• Member must notify the Rochester Office to maintain health coverage for up to 26 weeks. Follow the same procedure if you are receiving Workers’ Compensation.</li> </ul>			

<b>LIFE INSURANCE</b>	Member Only	Member Only	Member Only
<ul style="list-style-type: none"> <li>• First year maximum of \$1,250</li> <li>• After first year, based on your Wage Class and annual rate of pay, up to \$15,000</li> </ul>			

<b>ACCIDENTAL DEATH &amp; DISMEMBERMENT</b>	Member Only	Member Only	Member Only
<ul style="list-style-type: none"> <li>• For accidental death or injury</li> <li>• Equal to, or one-half of, your life insurance, depending on the loss suffered</li> </ul>			

<b>ANNE SHORE SLEEP-AWAY CAMP PROGRAM</b>	Children Only	Not Covered	Not Covered
<ul style="list-style-type: none"> <li>• For children 9 to 15 years old</li> <li>• Summer sleep-away camp program provided at no cost to you, except registration fee</li> </ul>			

\* *These are current co-payments. Co-payments subject to change.*

\*\* *If you use a non-Participating Provider, the Benefit Fund will pay 50% of the Allowed Amount and you may be responsible for the difference between this amount and the amount charged by your provider.*

BENEFIT COVERAGE MVP Health Care Coverage and Co-payments* for Participating Providers	WAGE CLASS		
	I	II	III

<b>JOSEPH TAUBER SCHOLARSHIP PROGRAM</b>	Children Only	Not Covered	Not Covered
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- Provided to eligible children of members
- Scholarships provided to attend accredited schools after high school

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<b>SOCIAL SERVICES</b>	Family	Family	Family
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- Member Assistance Program

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\* *These are current co-payments. Co-payments subject to change.*

\*\* *If you use a non-Participating Provider, the Benefit Fund will pay 50% of the Allowed Amount and you may be responsible for the difference between this amount and the amount charged by your provider.*





## SECTION I – ELIGIBILITY

- A. Who Is Eligible
- B. When Your Coverage Begins
- C. Enrolling in the Benefit Fund
- D. How to Determine Your Level of Benefits
- E. Your ID Cards
- F. Coordinating Your Benefits
- G. When Others Are Responsible for Your Illness or Injury
- H. When You Are on Workers' Compensation Leave
- I. When Your Benefits Stop
- J. Continuing Your Coverage
  - While Taking Family and Medical Leave (FMLA)
  - While Taking Uniformed Services Leave
- K. Your COBRA Rights

### WHERE TO CALL

**Rochester Benefit Fund Office**  
**1199SEIU Upstate**  
**259 Monroe Avenue, Suite 220**  
**Rochester, NY 14607**  
**(585) 244-0830**

Call the Rochester Benefit Fund Office to:

- Check whether you are eligible to receive benefits;
- Find out your benefit level;
- Request any forms;
- Update the information on your **Enrollment Form** (address, telephone number, dependents, etc.);
- Notify the Benefit Fund when you change Employers;
- Notify the Benefit Fund when you're on Workers' Compensation, Disability or FMLA leave; or
- Get the answers to any of your questions.

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

### NO PRE-EXISTING CONDITION EXCLUSIONS

The Benefit Fund has no pre-existing conditions 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 ID cards and notify the Benefit 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, dependents, etc.
- Notify the Benefit Fund when you change Employers, in order for your coverage to continue.
- File a **Disability Certification Form** every year that your child is disabled and eligible to receive benefits after age 26 (see Section I.A).
- To protect your benefits, contact the Benefit 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.

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# SECTION I. A

## WHO IS ELIGIBLE

### YOU

You are eligible to participate in the Benefit Fund 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 SPOUSE

Your **spouse** may be eligible if:

- You and your spouse are legally married; and
- You are eligible for family coverage, based on your Wage Class (see Section I.D); and
- You have provided documents as requested by the Benefit Fund.

If you and your spouse are legally divorced or legally separated, your spouse cannot enroll in the Benefit Fund.

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

## **IMPORTANT INFORMATION**

Changes within your family that relate to eligibility must be reported to the Benefit Fund immediately and in no case more than 30 days from the date of the event. Such changes include:

- Separation, divorce or death of a spouse; or
- Change in status of your dependent children.

Benefit Fund coverage of a spouse ends upon legal separation or divorce, except to the extent your spouse purchases COBRA continuation coverage (see Section I.K).

## **QUALIFIED MEDICAL CHILD SUPPORT ORDER**

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

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

## YOUR CHILDREN

Your **children** are eligible up to their 26th birthday if all of 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 family coverage, based on your Wage Class (see Section I.D).

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.

## CHILDREN WITH DISABILITIES

If your child is disabled, as described below, coverage for your child may continue after age 26 if all of the following additional conditions are met:

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

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

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# SECTION I. B

## WHEN YOUR COVERAGE BEGINS

### IF YOU ARE A NEW EMPLOYEE

You can start receiving benefits from the Benefit Fund after:

- You are hired by a Contributing Employer already participating in the Benefit Fund;
- You have enrolled in the Benefit Fund; and
- You have completed the waiting period specific to your Employer and your Employer has been obligated to make contributions to the Benefit Fund based on your employment for at least 30 consecutive days (however, in no event can the waiting period exceed the limit permitted by the Affordable Care Act).

### IF YOU ARE A NEWLY ORGANIZED EMPLOYEE

Your coverage begins after:

- Your Employer becomes a Contributing Employer participating in the Benefit Fund;
- You have enrolled in the Benefit Fund; and
- Your Employer has made at least 30 consecutive days of contributions to the Benefit Fund based on your employment.

### IF YOU CHANGE JOBS OR RETURN TO WORK AFTER A LEAVE

If you stop working for one Contributing Employer and begin working for another Contributing Employer or return to work for a Contributing Employer after an unpaid leave of absence:

- **Within 45 days**, you will have no break in your coverage;
- **After 45 days but within six months**, your benefits will start 30 days after you have been working for your new Contributing Employer; or
- **After six months**, you must meet the same requirements as a new employee.

**NOTE:** You must let the Benefit Fund know that you have changed Employers or returned to work from a leave in order for your coverage to begin again.

## **IF YOU HAVE FAMILY COVERAGE**

Coverage for your spouse and/or your children starts at the same time your coverage begins if:

- They are eligible to receive benefits; and
- Your benefit level is Wage Class I or Wage Class II (see Section I.D).

**NOTE:** You are eligible for Disability Benefits from your Employer after four consecutive weeks of employment with a Contributing Employer, as required by the New York State Disability Law.

However, eligibility for all other benefits will begin as described in Section I.B.

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# SECTION I. C

## ENROLLING IN THE BENEFIT FUND

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

You must fill out an **Enrollment Form** and send it to the Rochester Office of the 1199SEIU Family of Funds' Eligibility Department before you will be eligible for benefits.

To enroll in the Benefit Fund:

1. Get an Enrollment Form from the Benefit Fund office, by calling the Rochester Benefit Fund Office at (585) 244-0830 or by clicking on "My Account" when visiting our website at **[www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org)**; and
2. Completely fill out the form (including the beneficiary section).

The Enrollment Form will ask for information about you and your family, including:

- Your name;
- Your address;
- Your Social Security number;
- Your birth date;
- Your marital status;
- The names, birth dates and Social Security numbers of each member of your family;
- The name and address of your designated life insurance beneficiary;
- Your spouse's Employer; and

- Information on other insurance coverage.

### Sign and date the Enrollment Form, and:

1. Include copies of a birth certificate for you, your spouse and your eligible children to be covered, and a marriage certificate if you are enrolling your spouse.
2. Send the Enrollment Form and any related documents to the Rochester Office of the 1199SEIU Family of Funds' Eligibility Department.

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

## 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 are divorced or legally separated;
- You have a new baby;
- Your child reaches age 26;
- A family member covered by the Benefit Fund dies;
- You want to change your beneficiary;
- You change Employers; or
- You stop working for a Contributing Employer.

Fill out an **Enrollment Change Form** and send it to the Rochester Office of the 1199SEIU Family of Funds' Eligibility Department so that your records can be updated. You must notify the Fund **within 60 days** if you stop working or you get divorced, or you or your spouse (if you get divorced) risk losing your rights to continued coverage. See Sections I.J and I.K.

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

- Birth certificate(s) if you are adding your child(ren);

- Adoption papers if you are adding your child(ren);
- A marriage certificate if you are adding your spouse;
- Your separation or divorce papers if you are separated or divorced; and
- Any other documents required by the Benefit Fund.

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

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



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## SECTION I. D

# HOW TO DETERMINE YOUR LEVEL OF BENEFITS

### THE BENEFITS YOU RECEIVE ARE BASED ON YOUR WAGES

The Benefit Fund has three levels of benefits called “Wage Classes.” Your Wage Class is based on:

- The wages you earn; and
- The minimum full-time wage specified in the Collective Bargaining Agreement with your Employer (“minimum full-time wage”).

If you work **full time**, your benefit level is generally **Wage Class I**.

If you work **part time**, your benefit level is:

- **Wage Class I** if you earn 100% of the minimum full-time wage; or
- **Wage Class II** if you earn at least 60%, but less than 100%, of the minimum full-time wage; or
- **Wage Class III** if you earn less than 60% of the minimum full-time wage.

**See page 11 for an Overview of Wage Class I, II and III Benefits.**

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

Your earnings from all Contributing Employers are combined to determine your Wage Class and eligibility for benefits.

However, you can receive no more than the maximum benefit allowed by the Benefit Fund’s Schedule of Allowances.

### HOW YOUR WAGE CLASS IS CALCULATED

Your Employer reports your weekly earnings to the Benefit Fund. To determine your Wage Class, the Benefit Fund averages your weekly earnings over a 16-week testing period. Your Average Weekly Earnings are then compared to wage levels stated in the Collective Bargaining Agreement with your Employer.

If there is a change in your Wage Class, your Wage Class will be immediately adjusted, retroactive to the date of the earnings period submitted by your Employer.

**YOUR WAGE CLASS DETERMINES WHO IS ELIGIBLE . . .**

If you are in Wage Class I or Wage Class II, you are eligible for family coverage. This means that you, your spouse and your children, if eligible, can receive benefits from the Benefit Fund.

If you are in Wage Class III, only you (the member) can receive benefits. Your spouse and your children are not eligible for coverage from the Benefit Fund.

**. . . AND WHAT BENEFITS ARE COVERED**

Your Wage Class determines which benefits you and/or your spouse and children can receive from the Benefit Fund.

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# SECTION I. E

## YOUR ID CARDS

If you are eligible for benefits and have enrolled in the Benefit Fund, you will receive one or more ID cards:

- **An 1199SEIU Health Benefits ID card** for Prescription Benefits if you are in Wage Class I
- **An Excellus ID card** for Dental Benefits if you are in Wage Class I
- **An 1199SEIU National Benefit Fund/MVP Health Care ID card** for Health Benefits

Call MVP Health Care at (585) 325-3113 or (800) 767-1678 if you have any problems with your ID card(s), including if:

- You do not receive your card(s);
- Your name is not listed correctly; or
- Your spouse's and/or children's name(s) are not listed correctly.

If your card is lost or stolen, call the Rochester Benefit Fund Office at (585) 244-0830.

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

Your ID card(s) are for use by you and your eligible dependents only. To help safeguard your identity, please use the unique ID number that is included on your card(s) rather than your Social Security number when communicating with the Benefit Fund. You should not allow anyone else to use your ID card(s) to obtain Benefit Fund benefits. If you do, the Benefit Fund will deny payment and you may be personally responsible to the provider for the charges. If the Benefit Fund has already paid for these benefits, you will have to reimburse the Benefit Fund. The Benefit Fund may deny benefits to you and your eligible dependents and/or may initiate civil or criminal actions against you until you repay the Benefit Fund. If you suspect someone is using an 1199SEIU Health Benefits ID card fraudulently, call the Benefit Fund's Fraud and Abuse Hotline at (646) 473-6148.

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# SECTION I. F

## COORDINATING YOUR BENEFITS

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

Here's how it works:

- 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 SPD.
- **Secondary**, it will pay the balance of your claim up to its Schedule of Allowances in accordance with the rules set forth in this SPD 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 payer. However, if you are enrolled in a plan

where coverage is limited to services provided by in-network providers only, **you must use that coverage first.**

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

### WHEN YOU ARE COVERED BY MORE THAN ONE EMPLOYER PARTICIPATING IN THE BENEFIT FUND OR WHEN YOU AND YOUR SPOUSE ARE BOTH COVERED BY THE BENEFIT FUND

Each of you may claim the other and your children as dependents.

### 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 spouse’s care:**

- Your spouse’s plan is the **primary** payer.
- The Benefit Fund is your spouse’s **secondary** payer.

**For your child’s care:**

- When your child is covered by another Employer-sponsored plan (excluding parent coverage), your child’s plan is the **primary** payer.

When submitting a claim for your spouse’s or your child’s care, you must include a statement from your spouse’s or child’s plan showing what action it has taken.

**IF BENEFIT COVERAGE CAN BE OBTAINED THROUGH YOUR SPOUSE’S EMPLOYER, OR IF YOUR SPOUSE IS SELF-EMPLOYED**

Your spouse must:

- Enroll in that Employer’s benefit plan; or
- Purchase health coverage if self-employed, as defined by the Plan Administrator; and
- Pay any premiums required by that plan to maintain this coverage.

**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 earlier 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.

In the case of a divorce or separation, these rules will continue to apply, except where a court order requires otherwise.

**WHEN COVERED BY AN IN-NETWORK ONLY PLAN**

If your spouse and/or your children are enrolled in a plan where coverage is limited to services provided by in-network providers only, **they must use that coverage first.**

The Benefit Fund may provide benefits for charges related to a co-payment

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

## **WHEN YOU ARE COVERED BY MEDICARE**

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

However, you or your spouse 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 Benefit Fund pays benefits for your covered expenses, you may submit a claim for any unpaid balances to Medicare to be considered.

## **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. To get this benefit, you must file a claim form with the Benefit Fund once each quarter but no later than two years after the premium payment.

**NOTE OF CAUTION: Members or spouses 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.**

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# 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, a no-fault insurance carrier or a Workers' Compensation insurance carrier. **Expenses, such as disability, hospital, medical, prescription or other services resulting from such an illness or injury caused by the conduct of a third party, are *not* covered by this Plan.**

However, the Plan Administrator recognizes that often the responsibility for illness or injuries 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 which 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 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 that the Benefit Fund has an independent right to bring a lawsuit in connection with such an illness or injury in your name and also has a right to intervene in any such action brought by you.

If you receive payments from or on behalf of the party responsible for an illness or injury, you agree that the Benefit Fund must be repaid immediately, up to the amount of the payments that the Benefit Fund advanced to you or on your behalf. The Benefit Fund's right to recover its advanced benefit payments comes before you can recover any payments you may have made. You must repay the Benefit Fund regardless of whether the total amount of the recovery is less than the actual loss and even if the party does not admit responsibility, itemize the payments or identify payments as medical expenses. You cannot reduce the amount of the Benefit Fund's payments to pay for attorney's 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 illness or injury. 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 Medical 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 Medical 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.



## **WHEN MOTOR VEHICLE OR NO-FAULT INSURANCE PROVIDES COVERAGE**

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

### **This Plan is *secondary* to:**

- Coverage provided under any “no-fault” provision of any motor vehicle insurance statute or similar statute; and
- Coverage provided under motor vehicle insurance, which provides for health insurance protection, even if you (your spouse and/or your covered children) 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 Benefit Fund that you have exhausted the no-fault appeals process before the Benefit Fund will consider payment in accordance with its Schedule of Allowances.

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# 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 through 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 Benefit Fund for yourself and your family. If you need help or advice concerning your Workers' Compensation claim, call the Rochester Benefit Fund Office at (585) 244-0830.

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

However, the Benefit Fund will continue to cover you and your family 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 Benefit 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 Rochester Benefit Fund Office at (585) 244-0830 to find out which forms need to be filed with the Benefit Fund.

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

**For more information, see Section III.B.**

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# SECTION I. I

## WHEN YOUR BENEFITS STOP

**If you are no longer employed by a Contributing Employer, if you stop working or if your Employer is not obligated to make payments to the Benefit Fund on your behalf:**

Your benefits end 30 days after the last day on which your Employer is required to make contributions to the Benefit Fund\* on your behalf, unless your benefits are continued as described in Section I.J. However, if you or your spouse are covered by Medicare as of the last day that your Employer is required to make contributions to the Benefit Fund on your behalf, then there shall be no 30-day extension for active member benefits that are otherwise covered by Medicare, and therefore, such benefits end immediately on that last day.

*\* This may include contributions based on severance or other wages paid to you, such as vacation, etc.*

**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 continue your coverage through other sources.

**If the Collective Bargaining Agreement between your Employer and 1199SEIU expires, and:**

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

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

**IF YOU ARE ON DISABILITY OR WORKERS' COMPENSATION LEAVE THROUGH YOUR EMPLOYER**

Unless you return to work *immediately*, all of your benefits will end:

- On the last day of your Disability Benefits, up to a maximum of 26 weeks within a 52-week period; or
- On the last day of your Workers' Compensation Benefits, up to a maximum of 26 weeks within a 52-week period.

If you are unable to return to work after your Disability leave or after 26 weeks of Workers' Compensation leave, call the Rochester Benefit Fund Office at (585) 244-0830. See Section I.K for more information on COBRA continuation coverage.

## **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 and your family can buy health coverage through the Health Insurance Marketplace, **which could be a lower-cost option**. In the Marketplace, you could be eligible for a tax subsidy that lowers your monthly premiums right away, and you can see what your premiums and out-of-pocket costs will be before you make a decision to enroll. You may also be eligible for COBRA continuation coverage. Being eligible for COBRA does not limit your eligibility for coverage or for a tax subsidy through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days from the date when your coverage ended.

## **WHEN YOU RETURN TO WORK**

If you stop working for one Contributing Employer and begin working for another Contributing Employer, or return to work for a Contributing Employer after an unpaid leave of absence:

- **Within 45 days**, you will have no break in your coverage;
- **After 45 days but within six months**, your benefits will start 30 days after you have been working for your new Contributing Employer; or
- **After six months**, you must meet the same requirements as a new employee.

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

## **UPON YOUR DEATH**

Upon your death, your spouse and eligible children will continue to receive benefits:

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

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

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# SECTION I. J

## CONTINUING YOUR COVERAGE

### WHILE TAKING FAMILY AND MEDICAL LEAVE

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

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

- The birth of your child and to care for the baby within one year of birth;
- When you adopt a child or become a foster parent within one year of placement;
- When you need to care for your spouse, your child or your parent who has a serious health condition (but not your 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 case of “any qualifying exigency.”

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 qualifying family and medical reasons listed in this section, you may receive up to 12 workweeks of unpaid leave during a 12-month period.

If you need to care for your spouse, son, daughter, parent or “next of kin” in the Armed Forces (current service members or current 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.

If you return to work with the required number of hours or more hours in your first full month after your FMLA leave ends, there is no lapse in coverage. To be eligible for continued benefit coverage during your FMLA leave, your Employer must notify the Benefit Fund that you have been approved for FMLA leave.

**NOTE:** Your Employer — not the Benefit 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 leave ends. If you do not return to work, you may owe your Employer for the costs that were paid on your behalf over any period of time where coverage was extended solely on the basis of your FMLA leave.

### **WHILE TAKING UNIFORMED SERVICES LEAVE**

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

If you take a leave of absence under USERRA, healthcare coverage under the Plan will be continued for up to 30 days of active duty. If active duty continues for 31 days or more, coverage may be continued at your election and at your expense for up to 24 months (or such other period of time required by law). See Section I.K for a full explanation of the COBRA 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 Rochester Benefit Fund Office at (585) 244-0830 if you have any questions regarding coverage during a military leave.

The Benefit 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.

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# SECTION I. K

## YOUR COBRA RIGHTS

Under the federal law commonly known as COBRA, you, your spouse and your children 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 Benefit Fund because of a qualifying event.

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

This section summarizes your rights and obligations regarding COBRA continuation coverage. You and your spouse should read it carefully. For more information, contact the Rochester Benefit Fund Office at (585) 244-0830.

If you elect to continue your coverage, you, your spouse and/or your eligible children will receive the same health coverage that you were receiving right before you lost your coverage. This may include hospital, medical, surgical, dental, vision and prescription drug coverage. However, note that life insurance is not covered by COBRA continuation coverage. A child born to you or placed for adoption with

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

### WHEN AND HOW LONG YOU'RE COVERED

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

### 18 MONTHS COVERAGE — YOU, YOUR SPOUSE, YOUR ELIGIBLE CHILDREN

You, your spouse 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 Wage Class; or
- Your employment terminates for reasons other than gross misconduct on your part.

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

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

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

### **36 MONTHS COVERAGE — YOUR SPOUSE**

Under certain circumstances, your spouse may have the right to elect COBRA continuation coverage for a **maximum of 36 months**. These include a loss of coverage because:

- You die;
- You and your spouse become divorced or legally separated; or
- You become entitled to Medicare.

Under federal law, you or your spouse is responsible for notifying the Benefit Fund within 60 days after the

date your spouse loses (or would lose) coverage.

### **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 federal law, you or your child is 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 COBRA 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 spouse and 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 spouse and any children receiving COBRA continuation coverage if:

- You die;
- You become entitled to Medicare;
- You get divorced or legally separated; 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, your spouse or a 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, your spouse and your eligible 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 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 you or adopted by you during the initial 18-month continuation period, the child must be determined to be disabled during the first 60 days after the child was born or adopted.)

The Disability extension is available only if you notify the Benefit Fund of the Social Security Disability determination **within 60 days** after the later of:

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

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

Under the law, you, your spouse or your children are responsible for notifying the Benefit Fund **within 60 days** if:

- You and your spouse become divorced or legally separated; or
- Your child is no longer an eligible dependent.

**You** must notify the Benefit Fund at (877) 557-1199 or at PO Box 1036, New York, NY 10108-1036 **within 60 days** after the later of:

- The date of the qualifying event;
- The date on which the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event; or
- The date on which the qualified beneficiary is informed of both the responsibility to provide and the procedures for providing notice of a qualifying event.

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

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

## **INFORMING YOU OF YOUR RIGHTS**

After the Benefit Fund is notified of your qualifying event, you will receive information on your COBRA rights. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

- You would have lost your Benefit Fund coverage, including extensions; or
- You are notified by the Benefit 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 Benefit Fund office on or before the 60-day period noted in Section I.K; or
- Mailed to the Benefit Fund office at PO Box 1036, New York, NY 10108-1036 and postmarked on or before the 60-day period noted in Section I.K.

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

Even if you decide not to elect COBRA coverage when you qualify, your spouse and each of your children, if eligible, have a right to elect this coverage.

With respect to other health plans, you should also take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's Employer) within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

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

## **COST OF COBRA COVERAGE**

**Each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage.**

## WHEN COBRA COVERAGE ENDS

Your COBRA continuation coverage may end before the end of the applicable 18-, 29- or 36-month coverage period when:

- Your Employer ceases to be a Contributing Employer to the Benefit 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, your spouse or your children get coverage under another group health plan which does not include a pre-existing condition clause that applies to you, your spouse or your children (as applicable);
- 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.

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

Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event.

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 Benefit Fund office within 30 days of any such determination.

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 contact the Rochester Benefit Fund Office at (585) 244-0830.

Remember to notify the Benefit Fund immediately if:

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

## **CONTINUING YOUR LIFE INSURANCE**

Life insurance is not covered by COBRA continuation coverage.

To continue your life insurance coverage, you may make payments directly 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 II – HEALTH BENEFITS**

- A. How Your Health Plan Works
- B. Getting the Care You Need
- C. Hospital and Other Facility Services
- D. Emergency Department Care
- E. Behavioral Health: Mental Health and Alcohol/Substance Abuse
- F. Medical and Other Health Services
- G. Vision Care
- H. Dental Benefits
- I. Prescription Drugs

## HEALTH BENEFITS RESOURCE GUIDE

### WHERE TO CALL

#### **Rochester Benefit Fund Office (585) 244-0830**

Call if you have any questions about:

- Eligibility;
- Your 1199SEIU Health Benefits ID card;
- 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.

#### **1199SEIU National Benefit Fund Main Office (877) 557-1199**

(Prescription drug inquiries)

Call for:

- A list of Participating Pharmacies in your area;
- A Preferred Drug List (PDL); or
- Prior Authorization for certain medications.

**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” to access information about your eligibility or make simple updates to your information.**

#### **MVP Health Care (585) 325-3113 or (800) 767-1678**

Call if you have any questions about:

- Your 1199SEIU National Benefit Fund/MVP Health Care ID card;
- Medical Benefits;
- Medical bills; or
- Durable medical equipment.

#### **MVP Health Care Behavioral Health Member Line (800) 568-0458**

Call for:

- Help with a mental health or alcohol/substance abuse problem; or
- To request approval for inpatient behavioral health services.

#### **MVP Health Care 24/7 Nurse Advice Line (585) 325-3113 or (800) 767-1678**

#### **Excellus BlueCross BlueShield (800) 724-1675**

(Dental inquiries)

Call for:

- Dental forms and information; or
- A list of dentists in your area.



### REMINDERS

- If you are in Wage Class I and II, you, your spouse and your children are covered for Health Benefits. If you are in Wage Class III, only you are covered for limited benefits for yourself only.
- Your primary care physician (PCP) is the first one to call or see when you are not feeling well. He or she is best able to help you get the care you need.
- Show your 1199SEIU National Benefit Fund/MVP Health Care ID card when you go to the Emergency Department or when you are admitted to the hospital.
- If you use a non-Participating Provider, you could face high out-of-pocket costs. Before you receive services from a non-Participating Provider, you should ask the provider to find out the total Benefit Fund allowance for the planned service, and to notify you of what your out-of-pocket expenses will be.
- Hospital Emergency Departments should be used 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 accident/injury or the onset of a sudden and serious illness**.
- If your condition is not an Emergency, you will be responsible for all charges.
- Show your 1199SEIU Health Benefits ID card to the pharmacist when you have a prescription filled.

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## SECTION II. A

# HOW YOUR HEALTH PLAN WORKS

Your Benefit Fund provides you and your family with access to a comprehensive medical benefit program. The following information will help you make the best use of this plan.

### THE POINT OF SERVICE PLAN DESIGN (“POS”)

The POS plan design provides two levels of benefits for Covered Services depending on whether you obtain Covered Services from a Participating Provider (“in-network services”) or a non-Participating Provider (“out-of-network services”). You can reduce your out-of-pocket costs by following the requirements for in-network benefits.

### The Provider Network

You have access to a comprehensive network of Participating Physicians, Hospitals, Labs and other facilities, as well as other providers through the MVP Participating Provider Network. You can search for Participating Providers on MVP’s website at [www.MVPHealthCare.com](http://www.MVPHealthCare.com), or contact MVP’s Customer Care Center at (585) 325-3113 or (800) 767-1678.

### In-Network Services

To receive in-network benefits, you must receive services from a MVP Participating Provider. Benefits for some Covered Services are available only when provided by a Participating Provider. These services are marked as “In-Network Only” in bold. If you receive Covered Services other than as described below and in this SPD, the Plan will provide out-of-network benefits, unless otherwise excluded under the terms and conditions of this SPD.

- **In-Network Preventive Care**  
To receive the in-network benefit for preventive care described in this SPD, you must obtain such services from a Participating Provider.
- **In-Network Only Transplant Services/Donor Costs**  
To receive the in-network benefit for transplant services/donor costs, the services must be provided through MVP’s Transplant Network.
- **In-Network Only Bariatric Services**  
To receive the in-network benefit for bariatric services, the services must be provided through MVP’s Bariatric Network.

## **Out-of-Network Services**

If you choose to receive Medically Necessary Covered Services outside of MVP's network of Participating Providers, you can still receive benefits, but at a reduced level of coverage and at higher out-of-pocket costs to you. Most covered out-of-network services are reimbursed at 50% of the Allowable Charge. If the non-Participating Provider's Charge is more than the Allowable Charge under the Plan, you will be responsible for paying 100% of the difference between MVP's Allowable Charges and the non-Participating Provider's Charges in addition to any applicable co-insurance.

Where day and visit limitations are indicated with regard to Covered Services, these contractual limitations apply whether the Covered Service is accessed in-network or out-of-network.

To access your benefits, you should select a primary care physician (PCP) from MVP's network of providers:

- Your PCP is the first one to call or see when you are not feeling well. He or she is best able to help you get the care you need.
- Hospital Emergency Departments should be used only when you have a life-threatening medical Emergency.
- For services that require Prior Authorization, if the provider fails to obtain authorization, then the services will not be covered.

- Through arrangements with other networks, MVP provides for out-of-area access if it is needed for Emergency or urgent care.

## **ABOUT EXCELLUS BLUECROSS BLUESHIELD**

The Benefit Fund has contracted with Excellus BlueCross BlueShield to provide members with the Dental Benefits described in Section II.H. This includes access to a broad range of Participating Dental Providers who accept payment by Excellus as payment in full. Benefits are also provided for out-of-network care, which is provided in accordance with Excellus BlueCross BlueShield's Schedule of Allowances. If you use an out-of-network provider, you may be balanced billed and have out-of-pocket expenses.

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## SECTION II. B

# GETTING THE CARE YOU NEED

There is no paperwork with MVP Health Care when you show your 1199SEIU National Benefit Fund/MVP Health Care ID card to your primary care physician or a specialist to whom you have been referred. MVP Health Care handles all your claims to make it easier for you.

When you use Participating Providers, you pay a small co-payment for primary care physician office visits (such as a family practitioner, internist, obstetrician/gynecologist or pediatrician) and for specialist office visits (such as a cardiologist or podiatrist). Well-child visits are covered in full through age five.

For a brief summary of your benefits, refer to the “Overview of Your Benefits” at the beginning of the SPD.

### OUT-OF-AREA COVERAGE

When you travel outside the MVP service area, you are covered for all urgent care or Emergency medical services.

Urgent care is any medical service that cannot be put off without causing harm.

An Emergency is a sudden illness or injury that cannot be put off without causing severe damage or death (see Section II.D – Emergency Department Care). If you have an Emergency while outside the Rochester area, go directly to the nearest hospital.

Please remember to call MVP at (585) 325-3113 or (800) 767-1678 **within two business days** of an Emergency admission.

### UTILIZATION MANAGEMENT

This Plan requires Prior Notice, Prior Authorization, Concurrent Notice and/ or Concurrent Review by or to MVP before you receive certain Covered Services. All services are subject to Retrospective Review. Approval of services through Prior Authorization or Concurrent Review is not a guarantee of benefits. MVP may deny benefits if there is material misrepresentation or fraud by a member, and as otherwise permitted by law. **Failure to follow these requirements may result in a reduction in benefits.**

### Prior Notice

You must give Prior Notice to MVP before you receive certain Covered Services from an out-of-network provider. When you use an in-network provider, your provider gives Prior Notice. MVP does not review, approve or deny benefits at that time. Your call is necessary for MVP to establish a Concurrent Review schedule.

Prior Notice is required for the following in-network and out-of-network Covered Services:

- All elective inpatient admissions (inpatient admissions that are planned in advance); and
- All surgical procedures except office surgery.

**To give Prior Notice**, you or your provider must contact MVP Health Care at (585) 325-3113 or (800) 767-1678 at least 48 hours before you get certain Covered Services. You or your provider must provide MVP with your name, MVP ID number, your provider's name and address, the services you will be receiving, date(s) of service and your diagnosis.

**It is your responsibility to make sure that Prior Notice is given when using an out-of-network provider.**

**To give Prior Notice for mental health or substance abuse services**, you or your provider must contact MVP at (800) 568-0458. You or your provider must provide MVP with your name, MVP ID number, your provider's name and address, the date(s) that services are requested and your diagnosis.

### **Prior Authorization**

Prior Authorization means the required approval that must be obtained from MVP before you receive certain Covered Services. MVP reviews information about your medical condition and the proposed services in order to determine whether such services are Medically Necessary Covered Services as described in this SPD.

Prior Authorization is required for the following Covered Services:

- Non-Emergency long distance ambulance services;
- Bariatric surgery (must use MVP's Bariatric Network);
- Transplant services (must use MVP's Transplant Network);
- Durable medical equipment, orthotic devices and ostomy supplies;
- High-tech imaging services, including CT scans, MRAs, MRIs, PET scans, MRCs, CTAs and nuclear cardiology;
- Inpatient rehabilitation;
- Partial Hospitalization Programs; and
- Intensive Outpatient Programs

**To request Prior Authorization**, you or your provider must contact MVP's Utilization Management Department at (800) 767-1678. You or your provider must provide MVP with your name, MVP ID number, your provider's name and address, the date(s) that services are requested and your diagnosis.

If the request is urgent, you or your provider must tell MVP and describe the circumstances that make it urgent. You or your provider must contact MVP at least five days before your proposed admission or service date. You or your provider must notify the Fund if your admission or service date changes. **It is your responsibility to make sure that Prior Authorization is given when using an out-of-network provider.**

**To request Prior Authorization for mental health or substance abuse inpatient services,** you or your provider must contact MVP at (800) 568-0458. You or your provider must provide MVP with your name, MVP ID number, your provider's name and address, the date(s) that services are requested and your diagnosis.

### **Urgent Matters**

If the request for Prior Authorization is urgent and you or your provider properly identify to MVP that the request is urgent, and describe the circumstances that make it urgent, MVP will respond.

Generally, cases that are considered urgent are ones that:

- Could, applying the judgment of a prudent layperson with an average knowledge of health and medicine, seriously endanger your life, your health or your ability to regain maximum function; or
- Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately treated without the requested services; or
- A physician with knowledge of your medical condition determines that a Prior Authorization request is urgent.

If all necessary information is received at the time of the Prior Authorization request, MVP will notify you by telephone, and you and your provider in writing, of the determination within 72 hours of MVP's receipt of the request.

If all necessary information is not received at the time of the Prior Authorization request, MVP will notify you and your provider within 24 hours after MVP's receipt of the request, of any missing information that is needed to decide the request. You and your provider will then have 48 hours from the receipt of MVP's notice to provide MVP with the missing information. In such cases, MVP will notify you and your provider, by telephone and in writing, of the determination within 48 hours after: (a) MVP's receipt of the missing information; or (b) the end of your time to provide the missing information, whichever is sooner.

### **Non-urgent Matters**

If all necessary information is received at the time of the Prior Authorization request, MVP will notify you and your provider, in writing, of the determination, within 15 days of MVP's receipt of the request.

If all necessary information is not received at the time of the Prior Authorization request, MVP will notify you and your provider, in writing, of any missing information that is needed to decide the request. You and your provider will then have 45 days from the receipt of MVP's notice to provide MVP with the missing information. In such cases, MVP will notify you and your provider, in writing, of the determination within 15 days after: (a) MVP's receipt of the missing information; or (b) the end of your time to provide the missing information, whichever is sooner.

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## SECTION II. C

# HOSPITAL AND OTHER FACILITY SERVICES

### BENEFIT BRIEF

#### Hospital Care

- This benefit is for the hospital's charge for the use of its facility only. Hospital Benefits include semi-private room and board for Medically Necessary acute care.
- All other services are usually provided by the hospital
- A private room is provided only if Medically Necessary. If you stay in a private room for any reason other than Medical Necessity, you must pay the difference in cost between a private room and a semi-private room.
- If you are admitted to a non-contracting hospital other than on an Emergency basis, you may have out-of-pocket expenses
- Maternity care in the hospital is covered and hospital care for your newborn is also covered

Wage Class I (Family): Covered for 365 days per year

Wage Class II (Family): Covered for 365 days per year

Wage Class III (Member Only): Covered for Medically Necessary services up to 300 days per year. First 120 days paid at 100% of the Allowed Amount; days 121–300 paid at 50% of the Allowed Amount.

#### Hospice Care

- Services in a Medicare-certified hospice program in a hospice center, hospital or at home

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered if you need to go to the hospital. If you are in Wage Class III, only you are covered for this benefit.

**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. **Acute care** may include preventive, curative, rehabilitative or palliative care, whose primary purpose is to improve health and whose effectiveness depends on time-sensitive and rapid intervention.

- Show your 1199SEIU National Benefit Fund/MVP Health Care ID card when you go to the hospital.

## **WHAT IS COVERED**

This Plan covers the following services:

### **Autologous Blood**

Available if you require a major surgical procedure to be performed where blood replacement is frequently necessary. Limited to the cost of the actual donation procedure.

### **Inpatient Physical Rehabilitation Care**

Available when such services are Medically Necessary and are acute services provided by a facility licensed to provide inpatient physical rehabilitation services or by a unit of a hospital designated as providing such services. Benefits are not provided for care in a sub-acute setting such as a nursing home or skilled nursing facility.

## **Inpatient Hospital Services**

The following are available if you are receiving acute services as a registered inpatient in a hospital and are under the care of a licensed physician:

- Semi-private room;
- Board and general nursing services;
- Use of operating, recovery, delivery, endoscopic and treatment rooms and equipment;
- Use of intensive care or special care units and equipment;
- Dressings and casts;
- Diagnostic services, supplies and equipment;
- Therapeutic services;
- Equipment and supplies in connection with oxygen, anesthesia and pathology services;
- Laboratory services;
- Medical and surgical supplies; and
- Therapy services.

### **Hospice Services**

Hospice means an organization engaged in providing services to terminally ill persons. It is federally certified to provide hospice services or accredited as a hospice by the Joint Commission. Also included are hospice organizations certified in accordance with Article 40 of the New York Public Health Law; or if the hospice is located outside of the State of New York, under a similar certification process required by the state in which the hospice organization is located.



The Plan will provide benefits for hospice services that include home care and outpatient services provided by the hospice, including drugs and medical supplies, once per each member's lifetime, under the following conditions:

- A licensed physician certifies, and MVP agrees, that your life expectancy is six months or less;
- The hospice services are supervised by a licensed provider under a written hospice care plan; and
- The hospice services are provided by a hospice in a hospital or home setting.

### **Hospital Outpatient Cardiac Rehabilitation Care**

Available when such services are acute services and are provided by a hospital or facility.

### **Outpatient Hospital Services**

Tests given to you before your admission to a hospital (pre-admission testing) will be covered if:

- Your physician has ordered the tests;
- An operating room and inpatient bed at the hospital have been reserved prior to performance of the tests;
- Surgery occurs within seven days of the tests; and
- You are physically present at the hospital for the tests.

### **Outpatient Therapeutic Services**

- **Radiation Therapy**

The use of X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes for the treatment of disease.

- **Chemotherapy and Cancer Hormone Therapy**

The prevention of the development, growth or multiplication of malignant diseases by chemical or biological agents, and includes growth cell stimulating factor injections taken as part of a chemotherapy regimen.

- **Dialysis**

The removal of waste materials when a member has acute kidney failure or chronic, irreversible kidney deficiency, and the use of equipment and disposable medical supplies. Benefits for dialysis will continue until you become eligible for Medicare.

- **Infusion Therapy**

The treatment of disease by injection of curative agents.

- **Inhalation Therapy**

The inhalation of medicine, water vapor and/or gases to treat impaired breathing.

Also covered are items used in and provided by the hospital or facility when performing therapeutic services, such as prescribed drugs, medications, serums, biologicals and vaccines, intravenous preparations and visualizing dyes, and the administration of such items.

## **Outpatient Diagnostic Services**

Services ordered by a physician and used in, or provided by, a hospital or facility to determine a definite condition or disease. These include, but are not limited to, radiology and imaging services, X-rays, ultrasounds, diagnostic nuclear medicine, PET scans, MRIs, CAT scans, electroencephalograms (EEG), electrocardiograms (ECG) and body scans.

## **Gynecological Health Care Services**

Gynecological health care services means preventive and routine reproductive health and gynecological care. Such services include annual screening, cervical cytology screening, contraceptive services, evaluation of breast masses, gynecological dermatological conditions, gynecological oncology, genetic counseling, infertility/endocrinology, urological conditions, evaluation for infertility in patient's spouse, high-risk pregnancy referral to a perinatologist, counseling and treatment of gynecological disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists and the termination of pregnancy. Includes coverage for follow-up services required as a result of problems identified during such visits.

## **Bone Mineral Density Measurements or Tests**

Bone mineral density measurements or tests for members who meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health; provided that, to the extent consistent with such criteria, members qualifying for coverage shall include:

- Members previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- Members with symptoms or conditions indicative of the presence of osteoporosis, or the significant risk of osteoporosis;
- Members on a prescribed drug regimen posing a significant risk of osteoporosis;
- Members with lifestyle factors to such a degree as posing a significant risk of osteoporosis; and
- Members of such age, gender and/or other physiological characteristics, which pose a significant risk for osteoporosis.

## **Renal Dialysis**

Hemodialysis or peritoneal dialysis, when provided in a hospital or freestanding facility which has an operating certificate issued by the New York State Department of Health, in accordance with Article 28 of the New York State Public Health Law or, if provided outside the State of New York, a comparable certificate or license for the state where services are rendered, as follows:

- Dialysis treatment on a walk-in basis if the program is approved by the appropriate governmental authorities. For home treatment, the Plan covers the reasonable rental cost of equipment, plus all appropriate and necessary supplies required for home dialysis treatment when ordered by your physician. Coverage will not include any furniture, electrical or other fixtures or plumbing needed to perform the dialysis treatment at home. For these home and facility-based services to be covered, the treatments must be provided, supervised or arranged by the physician and you must be a registered patient of an MVP-approved kidney disease treatment center.

See Section I.F for a description of how this benefit is coordinated with Medicare.

### **Outpatient Surgery**

Available for hospital and facility charges for surgery. Surgery means generally accepted invasive, operative and cutting procedures. This includes, but is not limited to, specialized instrumentation, endoscopic examinations, correction of fractures and dislocations, and the pre- and post-operative care usually rendered in connection with such procedures.

### **Outpatient High-End Radiology**

The Plan will provide for high-end radiology and diagnostic services, including, but not limited to, outpatient high-end radiology (CAT scans, PET scans, MRIs and nuclear medicine scans). Please contact MVP's Customer Care Center for more information on Prior Authorization requirements at (585) 325-3113 or (800) 767-1678.

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

The Benefit Fund complies with federal law in that:

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

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

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## SECTION II. D

# EMERGENCY DEPARTMENT CARE

### BENEFIT BRIEF

#### Emergency Department Care

- Care needed for an Emergency within 72 hours of an accident/injury or the onset of a sudden and serious illness
- The Benefit Fund pays negotiated rate at a Participating Hospital or a reasonable allowance at a non-Participating Hospital
- If you are admitted to the hospital from the Emergency Department, there is no co-payment. If you are not admitted, there will be a small co-payment.

Wage Class I: Family

Wage Class II: Family

Wage Class III: Member Only

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered for Emergency Department care. If you are in Wage Class III, only you are covered for this benefit.

#### EMERGENCY DEPARTMENTS ARE FOR EMERGENCIES

Emergency services are Medically Necessary services provided in conjunction with an Emergency condition defined as the sudden onset of an acute medical or behavioral condition that reveals 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 or surgical care to result in: (1) placing the health of the person afflicted, or in the case of a behavioral condition, placing the health of such person or others, in serious danger; (2) serious impairment to such person's bodily functions; (3) serious dysfunction of any bodily organ or part of such person; or (4) serious disfigurement of such person.

- There is no co-payment due if you are admitted to the hospital from the Emergency Department.
- If possible, you should notify your primary care physician within 48 hours after receiving Emergency care.

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 accident/injury or the onset of a sudden and serious illness.**

When you go to the Emergency Department, show your 1199SEIU National Benefit Fund/MVP Health Care ID card.

If you go to the Emergency Department in a hospital with which MVP Health Care does not have an Emergency Department contract, you may have out-of-pocket costs. If you have any questions about a bill for Emergency Department treatment, call MVP's Customer Care Center at (585) 325-3113 or (800) 767-1678.

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.

### **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, which 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 aren't sure whether you need to go to the Emergency Department:

1. Call your doctor first. Your doctor may be able to recommend treatment over the phone, have you go to the office or go to the hospital.
2. If your doctor's office is closed, call your doctor's Emergency (after hours) number.
3. If you do not have a primary care doctor or cannot reach your doctor, call MVP Health Care at (585) 325-3113 or (800) 767-1678 during normal business hours.

## **WHAT IS A MEDICAL EMERGENCY?**

Some problems are Emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are Emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds or sudden inability to breathe. There are many other acute conditions that MVP Health Care may determine are medical Emergencies — what they all have in common is the need for quick action. For a complete definition of Emergency, see Section IX.

## **WHAT TO DO IN CASE OF AN EMERGENCY**

### **Emergencies Within/Outside MVP Health Care's Service Area**

Emergencies, as defined in Section IX, do not require Prior Authorization. Even so, you are encouraged to always contact your primary care physician for direction and advice before seeking medical treatment. If, however, you are faced with a situation you are sure is an Emergency, you should go directly to the Emergency Department.

If you are faced with a situation that you are not sure is an Emergency as defined in Section II.D, you should contact your primary care physician first. Your primary care physician will help you determine the most appropriate course of treatment. As your partner in healthcare, your primary care physician needs to be informed of any healthcare services that you receive. You are required to contact your primary care physician to facilitate his or her ability to oversee your healthcare and ensure that you may receive any necessary follow-up treatment in connection with your Emergency Department visit.

### **Urgent Care Within/Outside MVP Health Care's Service Area**

Urgent care is intended to treat minor illness or injury — a sprain, a minor cut or burn, the flu or other ailment that is not quite an Emergency but does require prompt care. It differs from Emergency care, which is designed to treat sudden, serious health problems (for example, a heart attack or stroke). When used correctly, urgent care is an appropriate, convenient and affordable alternative to Emergency care.

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# SECTION II. E

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

### BENEFIT BRIEF

#### Mental Health

- Wage Class I and II: Medically Necessary services
- Wage Class III: Covered for Medically Necessary services up to 300 days per year. First 120 days paid at 100% of the Allowed Amount; days 121–300 paid at 50% of the Allowed Amount.
- Co-payments may apply

#### Alcohol/Substance Abuse

- Wage Class I and II: Medically Necessary services
- Wage Class III: Covered for Medically Necessary services up to 300 days per year. First 120 days paid at 100% of the Allowed Amount; days 121–300 paid at 50% of the Allowed Amount.
- Co-payments may apply

Wage Class I: Family

Wage Class II: Family

Wage Class III: Member Only

#### MENTAL HEALTH BENEFITS

You are required to receive Prior Authorization from MVP before you receive inpatient mental health services. To give Prior Authorization, you or your provider must contact the MVP Behavioral Health Access Center at (800) 568-0458.

A clinical intake specialist can help in selecting a provider, carefully matching you with a provider that meets your specific clinical requirements and is geographically accessible. **For in-network mental health services**, you must pay the applicable co-payment listed on your Summary of Covered Services. **For out-of-network mental health services**, you must pay the applicable co-insurance listed on your Summary of Covered Services. Additionally, if you receive services out of network, you must also pay the difference, if any, between MVP's Allowable Charges and the non-Participating Provider's Charges.

A mental health condition means a condition or disorder involving mental illness that falls under a diagnostic category listed in the mental disorders section of the *International Classification of Diseases (ICD-CM)*, as periodically revised.

Mental health condition does not include:

- Mental retardation, provided however, that we would provide benefits for acute mental health services when other diagnoses are present;
- Learning disorders;
- Motor disorders;
- Communication disorders;
- Dementia, provided however, that we would provide benefits for acute mental health services when other diagnoses are present;
- Partner relational problems;
- Academic problems;
- Religious or spiritual problems; or
- Acculturation problems.

## **MENTAL HEALTH SERVICES**

Benefits are available for the treatment of acute mental health conditions for the following services:

### **Inpatient Services**

Benefits are available for mental health admissions in a hospital, in Partial Hospitalization Programs and in Intensive Outpatient Programs.

For Covered Services accessed within New York State, for purposes of this subsection, “hospital” is defined as the inpatient services of a psychiatric center under the jurisdiction of the office of mental health or other psychiatric inpatient facility in the department; a psychiatric inpatient facility maintained by a political subdivision of the

state for the care or treatment of the mentally ill; a ward, wing, unit or other part of a hospital, as defined in Article 28 of the Public Health Law, operated as part of such hospital for the purpose of providing services for the mentally ill in accordance with an operating certificate issued by the Commissioner of Mental Health; or other facility providing an operating certificate by the Commissioner. For Covered Services accessed outside New York State, comparable legislation will be reviewed. Inpatient mental health services are not covered when provided at a residential treatment facility.

### **Outpatient and Professional Services**

The following benefits are available for outpatient mental health services:

- Outpatient provider visits; and
- Outpatient psychiatric Emergency visits. A “psychiatric Emergency” is defined as a situation in which a person appears to have a mental illness for which immediate observation care and treatment is appropriate and the absence of treatment is likely to result in serious harm to oneself or others.

Benefits shall be paid for the above-mentioned services only when such services are performed and billed by a facility operated by the Office of Mental Health; a facility issued an operating certificate by the Commissioner of Mental Health in accordance with the provisions



of Article 31 of the Mental Hygiene Law; or a psychiatrist, psychologist or properly certified social worker who is certified in accordance with the requirements of Section 4303(n) of the New York State Insurance Law or comparable legislation outside the State of New York.

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

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

### **ALCOHOL/SUBSTANCE ABUSE BENEFITS**

You are required to give Prior Notice and receive Prior Authorization from MVP before you receive inpatient substance use disorder services. To give Prior Notice or request Prior Authorization, you or your provider must contact the MVP Behavioral Health Access Center at (800) 568-0458.

A clinical intake specialist can help in selecting a provider, carefully matching you with a provider that meets your specific clinical requirements and is geographically accessible. **For in-network substance use disorder services,**

you must pay the applicable co-payment listed on your Summary of Covered Services. **For out-of-network substance use disorder services,** you must pay the applicable co-insurance listed on your Summary of Covered Services. Additionally, if you receive services out of network, you must also pay the difference, if any, between MVP's Allowable Charges and the non-Participating Provider's Charges.

A substance abuse condition means a condition or disorder involving alcohol or substance abuse that falls as listed in the mental disorders section of the *International Classification of Diseases (ICD-CM)*, as periodically revised. Substance abuse condition does not include:

- Caffeine-related disorders

### **ALCOHOL/SUBSTANCE ABUSE SERVICES**

Your Plan provides benefits for acute substance abuse conditions for the following services:

#### **Inpatient Services**

Benefits are available for inpatient substance abuse treatment, including:

- Intensive Outpatient Programs; and
- Active treatment for detoxification needed because of alcohol dependence or substance dependence.

Within New York State, care must be received from an Office of Alcoholism

and Substance Abuse Services (OASAS) certified facility. Outside New York State, care must be received in a facility whose alcoholism and/or substance abuse treatment program has been approved by the Joint Commission.

### **Outpatient and Professional Services**

The diagnosis and treatment of alcoholism and/or substance abuse provided at a facility or practitioner's office. Provided the person in need of treatment is a member under this Plan, benefits are also available for family counseling visits. These family counseling visits are eligible for coverage even if the person in need of treatment has not yet begun that treatment. Benefits for family counseling are limited to one visit per day.

Within New York State, coverage is limited to facilities certified by the Office of Alcoholism and Substance Abuse Services or licensed by such Office as outpatient clinics or medically supervised ambulatory substance abuse programs or multidisciplinary group practices approved by MVP. In other states, coverage is limited to those facilities accredited by the Joint Commission as alcoholism or chemical dependence substance abuse treatment programs.

### **BEHAVIORAL HEALTH SERVICES**

If you experience an Emergency related to your mental health, you should go to the Emergency Department for an evaluation. If you are admitted, MVP Health Care will be notified.

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## SECTION II. F

# MEDICAL AND OTHER HEALTH SERVICES

### BENEFIT BRIEF

#### Medical and Other Health Services

- Use MVP Health Care providers to avoid large out-of-pocket expense
- Small co-payments

Wage Class I: Family

Wage Class II: Family

Wage Class III: Member Only

See the “Overview of Your Benefits” at the beginning of the SPD.

#### IMPORTANT INFORMATION

If you use a non-Participating Provider, you could face high out-of-pocket costs. Before you receive services from a non-Participating Provider, you should ask the provider to find out the total Benefit Fund allowance for the planned service, and to notify you of what your out-of-pocket expenses will be.

#### OUTPATIENT SERVICES

For preventive care services, you must pay the applicable co-payment or co-insurance listed on your Summary of Covered Services, if applicable.

#### Adult Routine Physical and Immunizations

Physicals and immunizations (including flu shots) for covered persons when provided by a Participating Provider.

#### Diagnostic Screening for Prostate Cancer

Screening performed in the outpatient department of a Participating Hospital, Participating Facility or Participating Provider’s office subject to the following limits:

- Standard diagnostic testing, including a digital rectal examination and a prostate-specific antigen (PSA) test, at any age for men having a prior history of prostate cancer; and
- An annual standard diagnostic examination, including a digital rectal examination and a prostate-specific antigen (PSA) test, for men age 50 and older who are not symptomatic and for men age 40 and older with a family history of prostate cancer or other prostate cancer risk factors.

## Well-child Care

For dependent children from the date of birth to attainment of age 19. Well-child care means an initial newborn check-up in the hospital and well-child visits. Well-child visits include a medical history, a complete physical examination, developmental assessment, anticipatory guidance and laboratory tests ordered at the time of the visit. Such laboratory tests must be performed in the office or in a clinical laboratory. All well-child visits must be provided in accordance with the standards and frequency schedule of the American Academy of Pediatrics. Well-child care also includes immunizations, against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, hemophilus influenza type B, hepatitis B and other necessary immunizations, except immunizations required due to travel outside of the United States. Services not described here and services which exceed the frequency levels described here are not covered under the well-child care benefit.

## Well-woman Care

- **Mammography Screenings**  
Mammography screening for occult breast cancer (cancer in which the site of the primary or original tumor cannot be found) performed in a Participating Facility or Participating Provider's office, is subject to the following limits:
  - » Upon the recommendation of a Participating Physician, at any age if a member has a prior

history of breast cancer or whose mother, sister or daughter has a prior history of breast cancer

- » A single baseline mammogram for members age 35 to 39 years of age
- » An annual mammogram for members age 40 and older
- **Primary and Preventive Obstetric and Gynecologic Services**  
Primary and preventive obstetric and gynecologic services from a qualified provider of such services for no fewer than two examinations annually for such services or to any care related to pregnancy. Coverage includes follow-up services required as a result of such annual examinations.
- **Cervical Cancer Screenings**  
Annual cervical cytology screening performed in the outpatient department of a Participating Hospital, Participating Facility or in a Participating Provider's office. This includes an annual pelvic examination, pap smear and diagnostic services in connection with evaluating the pap smear.

## Chiropractic Services

Available if Medically Necessary and provided by a licensed chiropractor. Chiropractic services means services to detect or correct by manual or mechanical means, including structural imbalance, distortion or subluxations (when one or more of the bones of your spine move out of position and create

pressure on, or irritate spinal nerves) in the human body for the purpose of removing nerve interference and the effects of that, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column. Covered for a maximum of 24 visits per calendar year. No referral is required. Those in Wage Class III are not eligible for this benefit.

### **Vision Benefit**

Routine eye exams are covered once every two years, subject to a co-payment. No referral is needed. Eye exams for disease or injury are covered when Medically Necessary, subject to a co-payment.

### **Physical/Occupational/Speech Therapy Services**

Available up to 25 combined visits per year when such services are acute services provided by a provider or in the outpatient department of a hospital or a facility. Speech therapy for children with developmental delay is covered through age 5.

### **Podiatry Care**

Available for diabetics only. Routine foot care not covered.

### **Allergy Injections**

The repeated administration of specific allergens to patients for the purpose of providing protection against the allergic symptoms and inflammatory reactions associated with natural exposure to the allergens.

### **Allergy Testing**

Testing needed to confirm the presence of specific antibodies. Standard methods of testing with proven efficacy are covered when medically indicated and performed by a licensed professional.

### **Anesthesia Services**

Available when provided by a provider in connection with Covered Services.

### **Breast Cancer Care**

The Plan will provide benefits for mastectomy and treatment of physical complications of mastectomy such as lymphedema, lymph node dissection or lumpectomy for the treatment of breast cancer. Following a covered mastectomy, the Plan will provide benefits for all stages of reconstruction of the breast on which the mastectomy was performed. The Plan will also provide benefits for surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined appropriate by your provider, in consultation with you. The Plan will also provide benefits for breast prostheses required as a result of covered breast cancer care.

### **Laboratory Services, X-Rays and Medical Diagnostic Services**

Available when provided in a hospital, provider's office or other facility.

### **Chemotherapy and Radiation**

See description under "Outpatient Therapeutic Services" in Section II.C.

## **Physician Consultations in Office**

Inpatient or office consultations by providers when requested by your attending physician for the evaluation of your condition.

## **Physician Inpatient Hospital Visits**

Visits in conjunction with a Medically Necessary admission.

## **Physician Office Visits**

Available for the examination, diagnosis and treatment of an injury, illness or condition and laboratory services provided at the time of such visit. Coverage includes injections given during a covered office visit, including desensitization treatments to alleviate allergies.

## **SURGERY AND ANESTHESIA**

### **Bariatric Surgery**

Only when such surgery is performed at a hospital participating in MVP's Bariatric Network.

### **Breast Reconstruction**

Inpatient and outpatient services for the reconstruction of the breast on which a mastectomy was performed, and surgery and reconstruction of the other breast to produce a symmetrical appearance. These services will be performed in the manner that your attending physician, in consultation with you, determines is appropriate.

### **Office Surgery**

Surgery and surgical care rendered in a provider's office.

## **Multiple Surgical Procedures**

Charges for multiple surgical procedures will be a covered expense subject to the following provision. If more than one eligible surgical procedure is performed at the same time, the Plan's reimbursement will be based on the full Allowable Charge for the primary procedure. The Plan's reimbursement for additional procedures may be reduced to one-half of the Allowable Charge for the additional procedures.

## **Assistant Surgeon's Charges**

If the services of an assistant surgeon are determined to be Medically Necessary, the Plan's reimbursement for the assistant surgeon's Covered Charge will be limited to 20% of the Allowable Charge for the surgical procedure.

## **HOME HEALTH CARE**

A home health agency means an organization licensed or certified by Medicare to operate as a home health agency or certified under Article 36 of the New York Public Health Law, or if outside the State of New York, certified under a similar certification process required by the state where services are provided. Those in Wage Class III are not eligible for this benefit.

Available when Medically Necessary for the following home health agency services:

- Part-time or intermittent nursing care by or under the supervision of a registered nurse.

- Part-time or intermittent home health aide services, provided that such services consist primarily of caring for the patient and do not include custodial care.
- Therapy services if provided by home health agency personnel. This means acute services, limited to physical therapy, occupational therapy and speech therapy.
- Supplies and drugs prescribed by a provider and laboratory services, to the same extent that laboratory services would have been covered if you were an inpatient at a hospital.

The Plan will provide benefits for home health agency services if:

- The services are supervised by a licensed physician under a written treatment plan;
- The services are provided by a home health agency;
- Without these services, you would need to be admitted to a hospital; and
- You or your designated representative consent in writing to the treatment plan.

## HEARING AIDS

Hearing aids are covered when they are determined to be Medically Necessary. Coverage is available for two hearing aids every 36 months. Hearing exams for diagnosing, prescribing and fitting of hearing aids also are covered. Each hearing aid and exam is subject to a co-payment. Those in Wage Class III are not eligible for this benefit.

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

The Benefit Fund complies with federal law related to mastectomies.

If a member or dependent has a mastectomy and then chooses to have breast reconstruction, the Benefit Fund (in consultation with the patient and doctor) will provide coverage based upon the Benefit 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).

## **TREATMENT OF ALCOHOLISM AND DRUG ADDICTION**

You may receive outpatient visits for diagnosis and rehabilitation of alcohol and drug abuse. Each visit is subject to a co-payment.

## **MEDICAL SERVICES WHILE HOSPITALIZED**

You are entitled to the necessary services of health professionals during any covered hospitalization.

## **SERVICES IN YOUR HOME**

You may receive home visits by a health professional if your primary care physician determines that such a visit is Medically Necessary. Home visits by a physician may be subject to a co-payment.

You may receive home health visits when:

- They have been approved by MVP; and
- MVP determines that without home health visits you would require hospitalization.

The coverage for home health visits includes all medicines, medical supplies and dressings used in connection with home health services.

Home health visits include part-time or intermittent nursing care, home health aide services and physical, occupational and speech therapy services if you would have received these services if you were hospitalized.

Services in your home are subject to a co-payment. Those in Wage Class III are not eligible for this benefit.

## **PROSTHETIC DEVICES**

You are covered for Medically Necessary prosthetic devices and any replacements, unless otherwise limited or excluded in this Plan. Your first pair of contact lenses following cataract surgery is covered. Replacement of external breast prostheses will not be covered more than once every two calendar years. Custom prosthetics will not be covered if a standard device exists, unless a custom device is Medically Necessary. Prosthetic devices are subject to co-insurance.

## **AMBULANCE SERVICES**

Emergency ambulance services are airborne and non-airborne ambulance services to a hospital, when used for an Emergency medical condition. Coverage is only for transportation to the nearest appropriate facility. Ambulance Services Benefits are not covered if you could have safely ridden in a private car, whether or not one was available.

Those in Wage Class III are not eligible for this benefit.

## **SECOND SURGICAL OPINION**

Coverage is available for second surgical opinions when your provider has made a recommendation on the need for covered elective surgery



(surgery planned in advance). You are not required to have a second surgical opinion. The second opinion must be given by a board-certified specialist who examines you and who, by reason of his or her specialty, is competent to consider the proposed surgery.

Coverage is also available for a second medical opinion from a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer, recurrence of cancer or a recommendation of a course of treatment for cancer.

## **DURABLE MEDICAL EQUIPMENT (DME), INTERNAL PROSTHETICS, ORTHOTICS, MEDICAL SUPPLIES**

To be covered, durable medical equipment must:

- Be a covered service;
- Be Medically Necessary;
- Meet Medicare guidelines;
- Be prescribed by a Participating Physician; and
- Be approved by MVP Health Care.

Those in Wage Class III are not eligible for this benefit.

### **Diabetic Supplies**

Includes blood glucose monitors, test strips and control solutions, urine testing strips, insulin, lancets and automatic lancing devices, insulin cartridges for the visually impaired, insulin syringes and injection aids, and insulin pump supplies

including, but not limited to, infusion sets and reservoirs. Are covered under a separate pharmacy benefit.

### **Disposable Medical Supplies**

Supplies that are primarily and customarily used only for a medical purpose, including, but not limited to, sterile bandages, cleansing solution and catheter supplies. These supplies will be appropriate for use in the home and are meant to be discarded after usage.

### **Durable Medical Equipment**

Benefits for the purchase, rental, repair or replacement of durable medical equipment authorized by a provider and obtained from a provider. The option of whether to rent or purchase authorized durable medical equipment is at the sole discretion of the Plan and is subject to any applicable co-payment.

### **Orthotics**

The Plan will provide benefits for orthotics provided in a provider's office.

### **Foot Orthotics**

The Plan will provide benefits for foot orthotics when Medically Necessary only for qualifying diabetics. Sports orthotics are excluded.

### **Glucose Monitors**

The Plan will provide benefits for durable medical equipment used to monitor blood glucose levels.

## **DENTAL**

MVP Health Care does not cover dental care except for dental services required for the treatment of sound natural teeth due to accidental injury. These services must be provided within 12 months of the accident. These services following accidental injury do not include restoring the injured tooth.

For information on your Dental Benefits, refer to Section II.H.

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# SECTION II. G

## VISION CARE

### BENEFIT BRIEF

#### Vision Care

- One eye exam every two years
- Allowance for one pair of glasses or one order of contact lenses every two years
- No referral necessary

Wage Class I: Family

Wage Class II: Family

Wage Class III: Member Only

If you are in Wage Class I or Wage Class II, you, your spouse and your children are covered for vision care. If you are in Wage Class III, only you are covered for this benefit.

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

#### YOUR COVERAGE

This Vision Benefit is not to be confused with medical treatment for diseases of the eye. You are covered for:

- One eye exam every two years; and
- A \$60 allowance every two years toward one pair of glasses or one order of contact lenses.

#### FILING FOR BENEFITS

Participating Optometrists and Opticians bill MVP Health Care directly. A list of

Participating Ophthalmologists and Optometrists is available from MVP Health Care at (585) 325-3113 or (800) 767-1678.

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

If you use a Participating Optometrist or Optician, and you have a large out-of-pocket cost, call the Rochester Benefit Fund Office at (585) 244-0830 before you pay for your exam, glasses or contact lenses.

If you use a non-Participating Provider:

- Send a paid itemized bill to the Benefit Fund; and
- You'll be reimbursed up to the Benefit Fund's allowance.

Certain Participating Vision Care Providers also provide hearing aids. For more information on Hearing Aid Benefits, see Section II.F.

#### WHAT IS NOT COVERED

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

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## SECTION II. H

# DENTAL BENEFITS

### BENEFIT BRIEF

#### Dental Benefits

- Basic Dental Benefits are provided by the Benefit Fund through Excellus BlueCross BlueShield
- 100% of Excellus BlueCross BlueShield's Schedule of Allowances for preventive services. Preventive services and essential oral pediatric services are not subject to an annual maximum.
- 80% of Excellus BlueCross BlueShield's Schedule of Allowances for basic restorative services subject to an annual maximum of \$2,000 per person per year (excluding essential oral pediatric services)
- 50% of Excellus BlueCross BlueShield's Schedule of Allowances for major restorative services subject to an annual maximum of \$2,000 per person per year (excluding essential oral pediatric services)
- Orthodontia lifetime maximum of \$2,000 for children up to age 19

Wage Class I: Family

Wage Class II: Not Covered

Wage Class III: Not Covered

If you are in Wage Class I, you, your spouse and your children are covered for Dental Benefits. If you are in Wage Class II or Wage Class III, you are not covered for this benefit.

Effective January 1, 2011, there is no limit on essential oral pediatric services to the extent required by the Affordable Care Act. Therefore, any reference to a \$2,000 maximum in this section excludes essential oral pediatric services.

Benefits are paid according to Excellus BlueCross BlueShield's Schedule of Allowances up to the maximum benefit of \$2,000 per person per year in total for basic and major restorative services.

The maximum benefit is figured on a calendar year, based on the date of *treatment* — not the date of the payment or when you filed your claim.

All dental work must be done by:

- A licensed dentist; or
- A dental specialist who is a board-certified or board-eligible dentist practicing exclusively in the field of periodontics or orthodontics.
- Cleanings may be performed by a licensed dental hygienist supervised by a licensed dentist.

## PREVENTIVE SERVICES

You, your spouse and your children are covered for the following, which is not included in the annual maximum of \$2,000:

- Examinations twice per calendar year;
- Prophylaxis (cleaning) twice per calendar year;
- Fluoride treatments twice per calendar year up to age 16;
- Full mouth/panorex X-rays once every 36 months;
- Bitewing X-rays up to a combination of four in any calendar year;
- Space maintainers covered up to age 16; and
- Emergency palliative treatment.

## BASIC RESTORATIVE SERVICES

You, your spouse and your children are covered for the following up to the annual maximum of \$2,000:

- Fillings;
- Simple extraction oral surgery;
- Oral surgery;
- Endodontics (treatment of the tooth's nervous system);
- Periodontal surgery once per quadrant every 36 months;
- Periodontal scaling and root planing; and
- Periodontal maintenance following surgery twice per calendar year.

## MAJOR RESTORATIVE SERVICES

You, your spouse and your children are covered for the following up to the annual maximum of \$2,000. Unless otherwise indicated, these services are eligible for replacement every five years:

- Removable prosthetics (dentures);
- Fixed prosthetics;
- Inlays/Onlays/Crowns and bridgework, including replacement of any existing denture, bridgework, crown or gold restoration once every five years;
- Relines/rebases; and
- Implants — eligible for replacement every 10 years.

## ORTHODONTIC SERVICES

- Orthodontics (treatment and appliances to correct teeth irregularities) once in a lifetime for children up to age 19;
- Benefits start when the appliances are inserted and continue for a maximum of **24 consecutive months** for active treatment and a maximum of **eight months** of retention visits during the 12-month period following active treatment; and
- Benefits up to a maximum of \$2,000 per lifetime. No more than 50% of the maximum will be paid in any calendar year.

## IN CASE OF EMERGENCY

If you need Emergency treatment in your dentist's office, Prior Authorization is not required.

However, you must file the following information with Excellus BlueCross BlueShield **within 30 days** of the date of your treatment:

- A completed claim form; and
- The appropriate X-rays.

## EMERGENCY TREATMENT OF NON-EMERGENCY CONDITIONS CAN BE COSTLY TO YOU

If you use the Emergency Department for *non-Emergency treatment*, Excellus BlueCross BlueShield will not pay any more than it would for non-Emergency treatment in your dentist's office.

The allowance for non-Emergency treatment is much lower than the cost of an Emergency Department visit, resulting in a **large out-of-pocket cost** to you.

## GETTING YOUR BENEFITS

### When Using a Participating Dentist

Participating Dentists send your claim form to and receive payment directly from Excellus BlueCross BlueShield and have agreed to accept the allowance as payment in full.

### You will have to pay:

- Twenty percent (20%) of the allowance for basic restorative services and 50% of the allowance for major restorative care; and

- All charges over the maximum benefit of \$2,000 per year for basic and major restorative services.

**Do not** make any other payments to a Participating Dentist without verifying them with Excellus BlueCross BlueShield.

### When Using a Non-Participating Dentist

If you use a non-Participating Dentist, you or your dentist will be reimbursed up to the Schedule of Allowances subject to the annual maximum.

Payment will be no more than the allowance or the provider's charge, whichever is less, and you may have to pay the difference between the Excellus BlueCross BlueShield payment and your dentist's charge.

To receive your benefits, you can:

- Ask your provider to submit a claim form to Excellus BlueCross BlueShield. They will pay your dentist directly, and you may be subject to balance billing; or
- Pay the bill yourself and send a completed claim form to Excellus BlueCross BlueShield for reimbursement. You have to pay any charges not covered under the Schedule of Allowances.

### Multiple Services or Multiple Dentists

Your care is paid according to the Schedule of Allowances, unless a maximum amount is specified for a particular combination of dental services.

The Benefit Fund will make payments as if your treatment were performed by a single dentist if:

- You use more than one dentist during the course of your treatment; or
- More than one dentist provides services for the same procedure.

## DENTAL EVALUATIONS

Before, during or after your dental treatment, you may be required to be examined by an independent dental consultant.

This evaluation protects both you and the Benefit Fund and is provided at no cost to you. If you do not agree to the exam, your benefits may be reduced or denied.

## ADDITIONAL LIMITATIONS

Excellus BlueCross BlueShield will pay up to its Schedule of Allowances for:

- Services performed in foreign countries only if there was an Emergency
- Services which must be clearly described and performed by a licensed dentist
- Treatment of temporomandibular joint (TMJ) disorder, limited to the following services:
  - » Lateral skull/facial bone X-ray;
  - » Injections into the joint by an oral surgeon;
  - » TMJ X-ray;
  - » Approved prosthesis as required; and

» Reduction of subluxation by an oral surgeon.

- Surgical repair by an oral surgeon
- Maryland-type bridges covered only for replacement of anterior teeth, with anterior teeth as abutments

## WHAT IS NOT COVERED

Benefits are not provided for:

- Lost or stolen appliances;
- Services, supplies or appliances received in connection with implants and periodontal splinting;
- Services, supplies or appliances which are not Medically Necessary;
- Temporary crowns, restorations, dentures or fixed bridgework, night guards or services that are cosmetic in nature;
- The start of orthodontic treatment for those who are 19 years of age and older;
- Treatment provided by someone other than a dentist (except for cleanings performed by a licensed dental hygienist under the supervision of a dentist); and
- All general exclusions listed in Section VII.D.

Call Excellus BlueCross BlueShield at (800) 724-1675 for more information, or visit the Benefit Fund's website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).

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# SECTION II. I

## PRESCRIPTION DRUGS

### BENEFIT BRIEF

#### Prescription Drugs

- Coverage of FDA-approved prescription medications for FDA-approved indications, except plan exclusions
- \$4 co-payment when you purchase generic and preferred brand drugs where available
- If your doctor prescribes a drug that is not preferred, you will have to pay the difference
- Use Participating Pharmacies
- Mandatory Maintenance Drug Access Program
- Prior Authorization needed for certain medications

- You must comply with the Benefit Fund’s prescription programs, including Prior Authorization where required. For a complete list of these programs, call the Benefit Fund office at (585) 244-0830 or visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).
- \$4 co-payment for preferred diabetic supplies at Participating Pharmacies for Wage Class I members. Twenty percent (20%) co-payment for diabetic supplies at Participating DME Vendors through Medical Benefit for Wage Class II and Wage Class III members.

Wage Class I: Family

Wage Class II: Not Covered

Wage Class III: Not Covered

If you are in Wage Class I, you, your spouse and your children are covered for prescription drugs. If you are in Wage Class II or Wage Class III, you are not covered for this benefit.

#### WHAT IS COVERED

The Benefit 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 licensed pharmacist.



Benefits for prescriptions for FDA-approved drugs that are not approved for treatment of your condition must be submitted to the Benefit 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:

- Ask your doctor to prescribe only covered medications and generics whenever possible, as per the Benefit Fund's prescription programs;
- Use Participating Pharmacies for short-term medications; and
- Show your 1199SEIU Health Benefits ID card to the pharmacist when you give him or her your prescription.

Other than the co-payments described in this section, there are no out-of-pocket costs for your prescriptions if you comply with the Benefit Fund's prescription programs:

- Mandatory Generic Drug Program;
- Preferred Drug List;
- Mandatory Maintenance Drug Access Program;
- Prior Authorization for certain medications;
- Quantity and day supply limitations;
- Step therapy; and

- Use the Specialty Care Pharmacy for injectables and other drugs that require special handling.

## PROTECT YOUR CARD

Your 1199SEIU 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 Rochester Benefit Fund Office at (585) 244-0830. If you think someone is fraudulently using a Health Benefits ID card, call the Benefit 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 list of Participating Pharmacies, call the Benefit Fund's Member Services Department at (877) 557-1199 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 for a **Prescription Drug Reimbursement Claim 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:

Use the Benefit Fund's Mandatory Maintenance Drug Access Program, *The 1199SEIU 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 Benefit Fund's Mandatory Maintenance Drug Access Program, *The 1199SEIU 90-Day Rx Solution*.

This program requires that you order medications you take on an ongoing basis in 90-day supplies.

**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 to you at your choice of location within eight days; or

- Taking it to one of the designated Participating Pharmacies where it will be filled at the pharmacy.

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

Call the Benefit Fund at (877) 557-1199 or visit our website at [www.1199SEIUBenefits.org](http://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 that you are taking is a maintenance medication.

## PRESCRIPTION DRUG PROGRAMS

For a complete list of these programs, please call the Benefit Fund at (877) 557-1199 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. Most importantly, they must meet the same FDA standards for safety and effectiveness.

When your doctor gives you a prescription:

- If there is a generic equivalent for a brand-name drug, you must get the generic drug. Otherwise, you will have to pay the difference in cost between the brand-name drug and the generic equivalent.
- If there is no generic equivalent, your prescription will be filled with the brand-name drug.
- In rare situations, your doctor may want you to take 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.

### PREFERRED DRUGS

The Benefit 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 preferred, you will have to pay the difference in cost between the preferred drug and the non-preferred drug.

If you would like a copy of the PDL, please call the Benefit Fund at (877) 557-1199 or visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).

## PRESCRIPTION DRUG PROGRAMS

### PRIOR AUTHORIZATION FOR SPECIFIED MEDICATIONS

You must get Prior Approval before benefits can be provided for prescriptions filled with certain medications. The Benefit Fund will periodically publish an updated list of which drugs require Prior Authorization.

If your doctor prescribes any of those drugs, contact the Prior Authorization Department of the Benefit Fund at (877) 557-1199.

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 Benefit Fund. These claims will not be reimbursed.

### 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 types of drugs for more than a 90-day period.

**Migraine Medications** – Coverage is limited to a specific quantity.

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

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

**Personalized Medicine** – A voluntary program for members using drugs 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.

## PRESCRIPTION DRUG PROGRAMS

### SPECIALTY CARE

Members must use the Specialty Care Pharmacy Program for injectables and other drugs that require special handling. Call the Benefit Fund at (877) 557-1199 or visit our website at [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org) for a list of drugs included in this program. Specialty care drugs are available only through mail delivery service.

### STEP THERAPY

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

### COORDINATING PRESCRIPTION DRUG BENEFITS

If your spouse is covered for prescription medication under another healthcare plan, that plan is **primary**. The Benefit Fund is the **secondary** plan for your spouse and may provide coverage for any co-payments that your spouse may incur up to the Benefit Fund's Schedule of Allowances.

Although your spouse's name will appear on your 1199SEIU Health Benefits ID card, your spouse must use his or her primary prescription insurer first.

### WHAT IS NOT COVERED

- Cold and cough prescription products;
- Compound drugs (except reformulations for injection or administration);
- Cost differentials for drugs that are not approved through the Benefit Fund's Prescription Drug Program;
- Experimental drugs;
- Medications for cosmetic purposes;
- Migraine medication in excess of FDA guidelines for strength, quantity and duration;
- Non-prescription items such as bandages or heating pads, even if your physician recommends them;
- Non-sedating antihistamines;
- Oral erectile dysfunction agents (except for penile functional rehabilitative therapy for up to

six months immediately following prostatic surgery);

- Over-the-counter drugs (except diabetic supplies);
- Over-the-counter vitamins;
- Prescriptions for drugs not approved by the FDA for the treatment of your condition;
- Proton pump inhibitors in excess of a 90-day supply for FDA-approved indications by diagnosis; 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**

- A. Your Disability Benefits
- B. When You Are on Workers' Compensation Leave

## DISABILITY BENEFITS RESOURCE GUIDE

### WHERE TO CALL

**Rochester Benefit Fund Office**  
**(585) 244-0830**

Call the Rochester Benefit Fund Office to:

- Notify the Rochester Benefit Fund Office when you return to work;
- Receive advice on benefits available from other sources if your disability lasts longer than 26 weeks; or
- Receive help with filing Workers' Compensation claims with your Employer's insurer.

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

### REMINDERS

**For accidents/injuries or illnesses that are not work-related:**

- Disability Benefits are provided through your Employer, not through the Benefit Fund.
- Notify your manager or immediate supervisor promptly.
- File a Disability claim with your Employer **within 30 days** of the onset of your non-work-related illness or accident/injury.
- Be evaluated or have your doctor submit medical updates when requested by your Employer; otherwise your benefits could be reduced or denied.
- Call the Rochester Benefit Fund Office when you return to work.

**If you are injured on the job:**

- Report an accident/injury or work-related incident to your Employer immediately.
- Call the Rochester Benefit Fund Office if you need help in filing a claim for Workers' Compensation from your Employer's insurer.
- Call the Rochester Benefit Fund Office if your Workers' Compensation claim is disputed or denied.

### WORK-RELATED INJURY OR ILLNESS

If your illness or injury is work-related, you are covered by your Employer's Workers' Compensation insurance. However, you must still contact the Benefit Fund to protect your benefits. See Section I.H for more information.



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## SECTION III. A

# YOUR DISABILITY BENEFITS

- Your disability benefits are provided through your Employer, not through the Benefit Fund.
- If you file a Disability claim with your Employer, you must file the claim **within 30 days** of the onset of your non-work-related illness or accident/injury.

### PROTECT YOUR DISABILITY AND HEALTH BENEFITS

While you are receiving Disability Benefits, you and your family are still eligible for the same Benefit Fund coverage you had before your disability. This coverage continues for a maximum of 26 weeks within a 52-week period.

It is important that your Employer receive your disability form **within 30 days** of your illness or accident/injury. Otherwise, you may jeopardize your Health Benefits.

**Here's why:** The Benefit Fund determines your eligibility for benefits based on wage reports it receives from your Employer. If you haven't received any wages, then your coverage may be suspended because the Benefit Fund does not know that you are out on Disability leave.

### CALL THE BENEFIT FUND

#### When You Return to Work

You must let the Benefit Fund know when you go back to work after being on Disability leave.

This way, the Benefit Fund can update its records and determine your eligibility for benefits. You must also notify the Fund if you do not return to work following a Disability or Workers' Compensation leave.

#### If Your Disability Continues

If your disability continues beyond the maximum 26-week period, your coverage through the Benefit Fund will stop immediately. (See COBRA continuation coverage, Section I.K.)

Please call the benefits office at your Employer or the Rochester Benefit Fund Office for further instructions.

However, you may be eligible for other benefits provided by governmental agencies. Call the Benefit Fund at (585) 244-0830 for more information and advice on how to file a claim for this aid.

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## SECTION III. B

# 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 through your Employer. This includes coverage for healthcare costs, loss of wages and lump-sum payments for permanent injuries. In some cases, payments may be higher and for longer periods of time than are provided through your Employer's disability plan.

You must file a Workers' Compensation claim with your Employer. Otherwise, you will jeopardize your rights to Workers' Compensation and your benefits from the Benefit Fund for yourself and your family.

### WHAT WORKERS' COMPENSATION COVERS

You are covered for Workers' Compensation when you have an accident/injury or illness as a result of your job, which:

- Prevents you from working;
- Causes a permanent defect, whether or not you lose time from work; and
- Requires you to seek medical attention or treatment.

Workers' Compensation Benefits include:

- Payment for lost wages (if you are unable to work for more than seven days);
- Lump-sum payments or other awards for permanent injuries;
- Medical expenses;
- Coverage for drugs and appliances; and
- Carfare to and from the doctor's office or hospital.

**NOTE:** Lost wages may be paid from the first day of your illness or accident/injury if you are unable to work for 14 or more days.

Remember to get receipts for all services and send them to your Employer's Workers' Compensation insurer.

A Workers' Compensation claim must be filed **within two years** of the date of the accident/injury or illness to protect your rights to Workers' Compensation Benefits.

### WHAT THE BENEFIT FUND COVERS

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

However, the Benefit Fund will continue to cover you and your family for benefits that are **not associated with the work-related accident/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 Benefit Fund will end. However, you may be eligible to receive certain benefits under COBRA continuation coverage (see Section I.K).

### PROTECT YOUR BENEFITS

1. Report your accident or work-related incident to your Employer immediately.
2. Get a **Workers' Compensation Incident Form** from your Employer and file a Workers' Compensation claim.
3. Notify the Benefit Fund **within 30 days** of the date of the accident/injury or onset of the illness to continue receiving benefits for care not associated with your job accident/injury or illness.

**Here's why:** The Benefit Fund determines your eligibility for benefits based on wage reports it receives from your Employer. If you haven't received any wages, then your coverage may be suspended because the Benefit Fund does not know that you are on Workers' Compensation.

4. Continue to send copies of all correspondence you have received, including any electronic communications you receive from Workers' Compensation, to the Rochester Benefit Fund Office. This electronic communication may be a **First Report of Injury (FROI) Form**, which indicates that your benefits have begun, or a **Supplementary Report of Injury (SROI) Form**, which indicates that your benefits have been stopped or modified. This will help the Benefit Fund keep up to date on the status of your Workers' Compensation claim.
5. If your Workers' Compensation claim is denied or disputed, notify the Rochester Benefit Fund Office immediately at (585) 244-0830.

### NEED HELP AND ADVICE ON YOUR WORKERS' COMPENSATION CLAIM?

#### Call the Benefit Fund

Within 18 days after your claim is filed, your Employer's insurance company must, by law, either:

- Send you a check; or
- Notify you that your claim is being questioned or contested.

#### Call the Rochester Benefit Fund Office at (585) 244-0830 if:

- You do not hear from the insurance company within 21 days;

- You are called for an examination or hearing;
- Your claim is rejected or disputed;
- You need help filing your claim; or
- You need a referral to a qualified attorney.



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

- A. Life Insurance Eligibility
- B. Life Insurance Benefit
- C. Accidental Death and Dismemberment

## LIFE INSURANCE BENEFIT RESOURCE GUIDE

### WHERE TO CALL

**Rochester Benefit Fund Office**  
**(585) 244-0830**

Call the Rochester Benefit Fund Office to:

- Request an **Enrollment Form** or an **Enrollment Change Form**; or
- Request a claim form for life insurance.

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

### REMINDERS

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

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# SECTION IV. A

## LIFE INSURANCE ELIGIBILITY

### WHO IS COVERED

Once you're enrolled in the Benefit Fund and eligible for benefits, you are covered for:

- Life insurance; and
- Accidental death and dismemberment.

Your spouse and children are not covered for these benefits.

### CHOOSING YOUR BENEFICIARY

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

When you fill out your **Enrollment Form**, list at least one person as your beneficiary.

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

- Call the Rochester Benefit Fund Office at (585) 244-0830 and ask for an **Enrollment Change Form**, or visit our website at **[www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org)**;
- Fill out the form; and
- 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 of your divorce to the Fund. If you do not designate or change your beneficiary thereafter, your Life Insurance Benefit will be paid as if there is no beneficiary (see "If There Is No Beneficiary" below).

### HOW YOUR BENEFICIARY APPLIES FOR BENEFITS

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

1. Notify the Rochester Benefit Fund Office; and
2. Submit a certified original copy of your death certificate and a completed claim form to the Benefit Fund.

### IF THERE IS NO BENEFICIARY

If you do not list a beneficiary, your beneficiary dies before your death or the Benefit Fund cannot locate your beneficiary after reasonable efforts, your Life Insurance Benefit is paid to the administrator or executor of your estate. If no estate exists, your Life Insurance 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.

### **IF THERE IS A DISPUTE**

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

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

### **IF YOU BECOME PERMANENTLY DISABLED**

**Before age 60**, you will continue to be covered for life insurance if all of the following conditions are met:

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

**When you reach age 65**, your life insurance amount is immediately reduced by 20%. Then every year thereafter, the original amount is further reduced by 20% until you reach the minimum life insurance amount of \$1,250.

**After age 60**, you'll be eligible for life insurance for a **maximum of 12 months** from the date your disability began if all of the following conditions are met:

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

### **ASSIGNMENTS**

Proceeds of a Life Insurance Benefit may be assigned, by you or your beneficiary, to pay the costs of your funeral. If your beneficiary chooses to assign his or her benefit after your death, that assignment shall be considered final and cannot be changed.



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# SECTION IV. B

## LIFE INSURANCE BENEFIT

### BENEFIT BRIEF

#### Life Insurance

- First year maximum \$1,250
- After first year, based on your Wage Class and annual rate of pay
- Death from any cause

Wage Class I: Member Only

Wage Class II: Member Only

Wage Class III: Member Only

See “Continuing Your Life Insurance” in Section I.K.

Life insurance is paid for your death for any cause without restriction.

Your life insurance is **\$1,250 during the first year** you are covered by the Benefit Fund.

After the first year, if you are in **Wage Class I**, your life insurance is your annual rate of pay to a maximum of \$15,000.

If you're in **Wage Class II**, your maximum life insurance amount is \$2,500.

If you're in **Wage Class III**, your maximum life insurance amount is \$1,250.

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# SECTION IV. C

## ACCIDENTAL DEATH AND DISMEMBERMENT

### BENEFIT BRIEF

#### Accidental Death and Dismemberment

- Accidental death or injury
- Equal to, or one-half of, your life insurance, depending on the loss suffered

Wage Class I: Member Only

Wage Class II: Member Only

Wage Class III: Member Only

Accidental Death and Dismemberment (AD&D) Benefits are paid only if your death or injury:

- 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 **in addition** to your life insurance. Proof of the cause of death is required.

Your **Accidental Dismemberment Benefit** is:

- **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 Accidental Death and Dismemberment 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 Section IV.C.

## **FILING YOUR CLAIM**

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

Your eligibility for this benefit is the same as your eligibility for life insurance (see Section IV.A).

## **WHAT IS NOT COVERED**

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

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





## **SECTION V – OTHER BENEFITS**

- A. Anne Shore Sleep-Away Camp Program
- B. Joseph Tauber Scholarship Program
- C. Social Services/Member Assistance Program

## OTHER BENEFITS RESOURCE GUIDE

### WHERE TO CALL

#### **Anne Shore Sleep-Away Camp Program and Joseph Tauber Scholarship Program (877) 557-1199**

- These programs are administered by the 1199SEIU Child Care Corporation

Call Camp and Scholarship:

- To request an application for the Camp Program or Scholarship Program; or
- For more information on either the Camp or Scholarship programs.

#### **Member Assistance Program (877) 557-1199**

Call the Member Assistance Program to:

- Make an appointment to confidentially discuss a personal or family problem.

### REMINDERS

- The **Application Request Form** for the Joseph Tauber Scholarship Program is available in the fall. If your children are receiving a scholarship from the Benefit Fund, they must re-apply each year for the year to come. The Application Request Form must be returned to the 1199SEIU Child Care Corporation by the last day of January.
- Please mail the Application Request Form to:  
  
1199SEIU Child Care Corporation  
Joseph Tauber  
Scholarship Program  
330 West 42nd Street, 18th Floor  
New York, NY 10036-6977
- To be considered for the Anne Shore Sleep-Away Camp Program, members must complete an **Application Request Form** and submit it to the 1199SEIU Child Care Corporation by the last day of January. Application Request Forms are available upon request or online at **www.1199SEIUBenefits.org/childcare**. Call the Anne Shore Sleep-Away Camp Program at (877) 557-1199 for more information or to request an Application Request Form.

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

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# SECTION V. A

## ANNE SHORE SLEEP-AWAY CAMP PROGRAM

### BENEFIT BRIEF

#### Camp

- For children 9 to 15 years old
- Summer sleep-away camp program provided at no cost to you, except registration fee
- FICA and FUTA taxes paid by the Benefit Fund (you may be responsible for income taxes)

Wage Class I: Children Only

Wage Class II: Not Covered

Wage Class III: Not Covered

Your children may be selected to participate in the Benefit Fund's Anne Shore Sleep-Away Camp Program if all of the following conditions are met:

- You file an official application form within the time period required by the Benefit Fund;
- You have been eligible for Wage Class I Benefits for at least one year;
- They are 9 to 15 years old; and
- They are eligible for benefits as described in Section I.A.

The camp program is provided at no cost to you, except for a small registration fee. The value of the Camp Benefit is considered as wages by the IRS for which you may owe income tax. You will receive a W-2 tax form from the Benefit Fund at the end of each year. However, the other taxes that are normally taken out of your paycheck, like FICA and FUTA, will be paid by the Benefit Fund. Camps are located in Vermont, New Jersey, Connecticut and upstate New York, including camps for children with special needs.

An effort is made to give each member a chance to send his or her children to camp. Only one child per family may attend each year, except for twins, who can attend together. If space is available, repeat campers and additional children per family will be considered.

### CRITERIA APPROVED BY TRUSTEES

The number of children who can participate in the camp program is based upon actuarial formulas recommended by the Benefit Fund Actuary and adopted by the Camp and Scholarship Committee of the Board of Trustees.

Criteria for selection are approved and announced by the Board of Trustees.

## **APPLICATION REQUEST FORMS**

Application Request Forms for the Anne Shore Sleep-Away Camp Program are available in the fall. They must be returned to the 1199SEIU Child Care Corporation by the last day of January.

Call the Anne Shore Sleep-Away Camp Program at (877) 557-1199 if you would like a form or need more information.



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# SECTION V. B

## JOSEPH TAUBER SCHOLARSHIP PROGRAM

### BENEFIT BRIEF

#### Scholarship

- Scholarships provided to attend accredited schools after high school
- Provided to eligible children of members

Wage Class I: Children Only

Wage Class II: Not Covered

Wage Class III: Not Covered

Your children may be considered for the Benefit Fund’s Joseph Tauber Scholarship Program if all of the following conditions are met:

- You file an official application form within the time period required by the Benefit Fund;
- You have been eligible for Wage Class I Benefits for at least one year;
- They are eligible for benefits as described in Section I.A;
- They are high school graduates or post-secondary school students;
- They are enrolled full time in an accredited undergraduate program for a minimum of 12 credits each semester;

- They are attending or planning to attend an accredited institution of higher learning no more than three years after graduating from high school; and
- They are applying for *both* state and federal grants.

Any accredited school is acceptable, including:

- 2-year colleges;
- 4-year colleges or universities;
- Business schools;
- Nursing schools;
- Trade schools; and
- Art and design schools.

Scholarships are not available for post-graduate studies. However, consideration is given for students pursuing medical careers where five years of undergraduate work may be required.

The Joseph Tauber Scholarship Benefit is considered as wages by the IRS for which you may owe income tax. You will receive a W-2 tax form from the Benefit Fund at the end of each year. However, the other taxes that are normally taken out of your paycheck, like FICA and FUTA, will be paid by the Benefit Fund.

## **APPLICATIONS**

Applications for the Joseph Tauber Scholarship Program are available in the fall. They must be returned to the 1199SEIU Child Care Corporation in May.

## **YOUR CHILDREN MUST RE-APPLY EVERY YEAR**

If your children are receiving Joseph Tauber Scholarship Benefits, they must re-apply every year for the next year. Leaves of absence from school of more than one year will jeopardize a student's eligibility for this benefit.

## **INCENTIVE PROGRAM**

To encourage academic excellence, an Incentive Program was established for students who perform well in their studies.

Your child's grade point average (GPA) each term is used to determine whether he or she will be considered for the additional monetary incentive award.

## **CRITERIA APPROVED BY TRUSTEES**

The number of scholarship grants and the amount of these grants is based upon actuarial formulas recommended by the Benefit Fund Actuary and adopted by the Camp and Scholarship Committee of the Board of Trustees. Criteria are approved and announced by the Board of Trustees.

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# SECTION V. C

## SOCIAL SERVICES/MEMBER ASSISTANCE PROGRAM

### BENEFIT BRIEF

#### Member Assistance Program

- Help and referral for personal and family problems for you, your spouse or your children

Wage Class I: Family

Wage Class II: Family

Wage Class III: Family

Call the Member Assistance Program at (877) 557-1199.

**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.

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 Benefit Fund's social workers or other staff. They can work with you to try to get you the help you need to cope with a broad range of problems, including:

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





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

The Benefit Fund does not provide Retiree Health Benefits.





## **SECTION VII – GETTING YOUR BENEFITS**

- A. Filing a Claim Form for Medical and Health Benefits
- 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

#### **MVP Health Care**

**(585) 325-3113 or (800) 767-1678**

Call if you have any questions about your claims for Medical and Health Benefits.

#### **Rochester Benefit Fund Office**

**(585) 244-0830**

Call the Rochester Benefit Fund Office if:

- You need a claim form for Dental or Prescription Benefits;
- You have questions about completing your claim form;
- You have questions about what is not covered by the Benefit Fund;
- You have questions about the processing of your claim; or
- You need information on appealing your claim.

#### **Excellus BlueCross BlueShield**

**(800) 724-1675**

Call if you have any questions about your Dental Benefits.

#### **1199SEIU Benefit Fund**

#### **Fraud and Abuse Hotline**

**(877) 557-1199**

- If you know or suspect that fraud or abuse of healthcare benefits is taking place, call the Benefit Fund's hotline or 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).**



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# SECTION VII. A

## FILING A CLAIM FORM

### FOR MEDICAL AND HEALTH BENEFITS

When you receive services from a provider, hospital or facility that does not participate with MVP, you may need to file a claim. If you need to file a claim, here is the process:

**1. Request a Claim Form from MVP**

You may request claims forms by contacting your Plan Administrator or MVP at (585) 325-3113 or (800) 767-1678. You may also request or download claim forms by visiting MVP's website at **[www.MVPHealthCare.com](http://www.MVPHealthCare.com)**.

**2. Submit a Properly Completed Claim Form to MVP**

Mail your properly completed claim form, with any bills and receipts, by first-class mail, postage prepaid, to MVP at:

MVP Select Care, Inc.  
220 Alexander Street  
Rochester, NY 14607

For Behavioral Health claims, mail to:

Value Options  
PO Box 1408  
Latham, NY 12110

All bills must include:

- The name of the Plan;
- The member's name;
- The patient's/member's name;
- MVP ID number;
- The provider's name, address and telephone number;
- The diagnosis;
- The types of services rendered, with diagnosis and procedure codes;
- The date(s) of service; and
- The provider's charges.

The Plan will only provide benefits for claims submitted within the following time frames: (1) if the claim is submitted by a Participating Provider, then within 180 days from the date services were provided or as otherwise stated in the fee agreement between the Participating Provider and MVP, except when Coordination of Benefits applies and this Plan is the secondary payer; or (2) if the claim is submitted directly by you, your non-physician designee or a non-Participating Provider, then within one year from the date services were provided, except when Coordination of Benefits applies and this Plan is the secondary plan. If your claim is subject to Coordination

of Benefits, as described in your SPD, and this Plan is your secondary plan, you must submit your claim to MVP within two years of the date of the final statement from your primary plan.

## FOR PRESCRIPTION BENEFITS

### 1. **Get a Claim Form Before You Go to See Your Provider**

Claim forms are available at the Benefit Fund office or by calling the Rochester Benefit Fund Office at (585) 244-0830. You can also obtain a claim form from the “Forms and Other Resources” section of the Benefit Fund’s website, [www.1199SEIUBenefits.org](http://www.1199SEIUBenefits.org).

### 2. **Print Your Information**

Your claim can be processed faster if your form is filled out completely. Clearly print all the information requested:

- The member’s name, address and Social Security number; and
- The patient’s name and birth date.

### 3. **Have Your Pharmacist Complete His or Her Section**

- He or she needs to sign and date the claim form.
- Prescription claims must be filed with the Benefit Fund no longer than 90 days after the services were provided.
- Dental claims must be filed with Excellus BlueCross BlueShield no longer than

90 days after the services were provided.

- Disability claims must be filed with your Employer within 30 days of the start of your disability.
- Life insurance and AD&D claims must be filed with the Benefit Fund no longer than one year after the date of death or loss.
- All other claims will be denied if they are filed more than one year after the services were provided. Claim forms that are late due to extenuating circumstances may be processed, in the sole discretion of the Plan Administrator. In no event, however, will the Benefit Fund pay claims filed more than one year after the service or treatment is provided.

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.

The Plan Administrator for Prescription Benefits is the Board of Trustees and any individuals duly designated by the Trustees to carry out administrative functions.

The Plan Administrator for Dental Benefits is Excellus BlueCross BlueShield.

The Plan Administrator for all other Health Plan Benefits is MVP Health Care.

The Administrative Review will be handled by the appropriate Plan Administrator. Any appeals will be handled by the Appeals Committee of the Board of Trustees.

**NOTE:** The assignment feature of the Benefit 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 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.

### **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 Benefit Fund benefits, you must get Prior Approval from the Plan Administrator. You may file any 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:

### **Concurrent Notice**

Concurrent Notice means the notice you or your provider must give to MVP while you are receiving certain Covered Services. MVP does not review, approve or deny benefits at this time. Your call is necessary for MVP to assign a length of stay or other Concurrent Review schedule.

Concurrent Notice is required for the following in-network and out-of-network services:

- Emergency inpatient admissions
- Inpatient maternity care (call after delivery)

To give Concurrent Notice, you or your provider must contact MVP's Utilization Management Department at (800) 767-1678 within 48 hours (or as soon as reasonably possible) after you begin receiving these services. You or your provider must provide MVP with your name, MVP ID number, provider's name and address, services you are receiving, date(s) of service and your diagnosis. **It is your responsibility to make sure that Concurrent Notice is given.**

MVP will respond to the Concurrent Notice by providing a written notice confirming the call.

### **Concurrent Review**

Concurrent Review means MVP's review of a request to extend a course of treatment to determine whether such services continue to be Medically Necessary Covered Services. MVP will contact your provider; however, you must ensure that your provider gives MVP the clinical information needed to conduct this review before the end of each period for which your benefits were approved.

### **Urgent Matters**

If all necessary information is received at the time of the Concurrent Review, MVP will notify you and your provider, in writing, of the determination within 24 hours after the review.

If all necessary information is not received at the time of the Concurrent Review, MVP will deny benefits.

### **Non-urgent Matters (Pre-service)**

If all necessary information is received at the time of the Concurrent Review and services have not yet been provided to you, MVP will notify you and your provider of the determination, in writing, within 15 days after the review.

If all necessary information is not received at the time of the Concurrent Review and services have not yet been provided to you, MVP will notify you and your provider, in writing, of any necessary information that is needed to complete the review. You and your provider will have 45 days from the receipt of MVP's notice to provide MVP with the missing information. In such

cases, MVP will notify you and your provider, in writing, of the determination within 15 days after: (a) MVP's receipt of the missing information; or (b) the end of your time to provide the missing information, whichever is sooner. Except in cases of missing information, MVP's time to complete this review shall not exceed a total of 15 days.

### **Non-urgent Matters (Post-service)**

If all necessary information is received at the time of the Concurrent Review and services have already been provided to you, MVP will notify you and your provider, in writing, of the determination within 30 days after the review.

If all necessary information is not received at the time of the Concurrent Review and services have already been provided to you, MVP will notify you and your provider, in writing, of any necessary information that is needed to complete the review. You and your provider will have 45 days from the receipt of MVP's notice to provide MVP with the missing information. In such cases, MVP will notify you and your provider, in writing, of the determination within 30 days after: (a) MVP's receipt of the missing information; or (b) the end of your time to provide the missing information, whichever is sooner.

### **Retrospective Review**

Retrospective Review means MVP's review, after services have been provided to you, to determine whether such services were Medically Necessary Covered Services and to what extent benefits are payable.

MVP will conduct Retrospective Review on all claims.

**To obtain a Retrospective Review for in-network services:** When you obtain services in-network, the provider will submit your claim and bill MVP directly.

**To obtain a Retrospective Review for out-of-network services:** When you obtain services out-of-network, in most cases, the provider will bill you directly. In such cases, you must pay the provider and request reimbursement from MVP or submit the provider's bill and request that MVP pay the provider. In either case, you must submit your claim to MVP as described in this section. In some cases, the provider will bill MVP directly. In such cases, the provider must submit a claim to MVP as described in this section.

If all necessary information is received at the time of the claims submission, MVP will notify you of any adverse determination, in writing, within 30 days after MVP's receipt of the claim.

If all necessary information is not received at the time of the claims submission, MVP will provide you and your provider, within 30 days after MVP's receipt of the claim, a 15-day notice of extension and a description of any missing information that is needed to decide the claim. You and your provider will then have 45 days from receipt of MVP's notice to provide MVP with the missing information. In such cases, MVP will notify you of any adverse determination, in writing, within 15 days after: (a) MVP's receipt of the missing information; or

(b) the end of your time to provide MVP with the missing information, whichever is sooner.

**RIGHT TO APPEAL**

If you disagree with the decisions made under this section, you may file an appeal as described in the Appeals section of this SPD (Section VII.B).

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# SECTION VII. B

## YOUR RIGHTS ARE PROTECTED —

### APPEALS PROCEDURE

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

#### **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.

**NOTE:** All claims by you, your spouse, your children, your beneficiaries or third parties against the Benefit 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 an assignee of you, your spouse or your children after five years from the date of service. All lawsuits for benefits must be filed in a federal court in New York.

#### **2ND STEP — APPEAL TO THE APPEALS COMMITTEE OF THE BOARD OF TRUSTEES**

##### **All 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 a request must be filed within 60 days after the receipt of the denial notice. Your request for a review must be in writing unless your claim involves urgent care, in which case the request may be made orally. If your appeal is denied by 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.

##### **Lien Determinations**

If the 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 appeals procedures.

## **WHAT YOU ARE ENTITLED TO**

In connection with your right to appeal, you:

- Are entitled to submit written comments, documents, records or any other matter relevant to your claim;
- 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 (specialized) 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 healthcare professional 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.
- 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 quick and efficient methods.



## HOW TO REQUEST AN ADMINISTRATIVE REVIEW

### Requests for Administrative Review of prescription claims should be sent to:

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

### Requests involving urgent care can be made by:

- Phone: (646) 473-7446
- Fax: (646) 473-7447

### Requests for Administrative Review of dental claims should be sent to:

Excellus BlueCross BlueShield  
Customer Advocacy Unit  
PO Box 4717  
Syracuse, NY 13221

### For all other medical claims:

- Contact MVP's Customer Care Center by phone at (585) 325-3113 or (800) 767-1678. TTY users call (585) 325-2629 or (800) 252-2452. Or you can write: MVP Health Care, Service Recovery Department, 220 Alexander Street, Rochester, NY 14607, or fax MVP at (585) 327-5724. Please refer to the reference number on all correspondence or when contacting MVP Health Care regarding this request.
- A dispute can be made orally or in writing. If orally, the Customer Care Center Representative will begin processing your dispute and will forward it to you for review, update and signature.

## HOW TO REQUEST AN APPEAL TO THE APPEALS COMMITTEE OF THE BOARD OF TRUSTEES

### Requests for appeals should be sent to:

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

### Requests involving urgent care can be made by:

- Phone: (646) 473-7446
- Fax: (646) 473-7447

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

After each step of the process (i.e., the Administrative Review, and the appeal to the Appeals Committee of the Board of Trustees) you will be provided with a written decision. If your claim or Request for Benefits is totally or partially denied, you will be given the specific reason(s) for the decision and the process, 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 an Urgent Care Request, a Pre-service Care Request or a Post-service Care Claim, depending on the facts.

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

## COMPLAINT PROCESS FOR MVP HEALTH CARE SERVICES

You can file a complaint when your dissatisfaction does not involve changing a Health Plan determination. You can utilize the Administrative Review and appeals process if you disagree with a decision on a claim or with a benefit determination.

1. You may initiate a complaint (a dissatisfaction with the access, attitude or quality of care provided by our network of providers) by contacting MVP's Customer Care Center by phone locally at (585) 325-3113 or (800) 767-1678. TTY users call (585) 325-2629 or (800) 252-2452. Or you can initiate a complaint by writing: MVP Health Care, Service Recovery Department, 220 Alexander Street, Rochester, NY 14607, or by faxing MVP Health Care at (585) 327-5724.
2. You may allow your name to be used during the investigation or remain anonymous.
3. MVP Health Care's Quality Management organization receives, investigates, tracks and resolves member complaint issues.
4. Other complaints (dissatisfactions with benefits or service) are directed to those departments within MVP Health Care that are responsible for the product or service that is the basis for the complaint.
5. Complaints are acknowledged within five business days and resolved with the member within 30 business days.

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## **SECTION VII. C**

### **WHEN BENEFITS MAY BE SUSPENDED, WITHHELD OR DENIED**

**It is important that you provide the Benefit Fund or MVP Health Care with all the information, documents or other material needed to process your claim for benefits.**

The Benefit Fund may be unable to process your claim if you, your spouse or your children:

- Do not sign the “Assignment of Benefits” authorization statement on your claim form 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 Benefit Fund.
- That were the subject of a legal claim against a third party for which a lien form was not signed and received by the Benefit Fund, or was not repaid to the Benefit Fund, as required in Section I.G.

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;
- That your spouse or dependent children were not entitled to receive;
- For claims that you, your spouse or dependent children would otherwise be entitled to until full restitution (which may include interest and expenses incurred by the Fund) has been made for any fraudulent claims that were paid by the Fund; or

#### **BENEFIT FUND’S RIGHT TO CONFIRM CLAIMS**

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

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

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# SECTION VII. D

## WHAT IS NOT COVERED

### HOSPITAL, MEDICAL AND INTERMEDIATE CARE

- Any cosmetic operation or procedure, or any related hospital service, except:
  - » Medically Necessary reconstructive surgery, which is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part; or
  - » Which is needed to correct a congenital disease or anomaly (birth defect) of a covered dependent, that has resulted in a functional defect.
- Charges by private physicians when care is given in a governmental or municipal hospital
- Comfort and convenience items in the hospital that are not Medically Necessary
- Custodial care or sub-acute care in a hospital or any other institution. We use the same definition of “custodial care” as Medicare. Custodial means that services are mainly personal and do not require skilled nursing services.
- Hospital expenses for non-covered services
- Hospitalization covered under federal, state or other laws, except where otherwise required by law
- If you are discharged from a hospital and do not leave your bed on time, you will be responsible for all charges after you were supposed to leave
- Private rooms in a hospital
- Acupuncture
- Appliances or devices used to treat temporomandibular joint (TMJ) disorder
- Blood or blood plasma when a voluntary blood replacement program is available
- Care which is primarily for rest cures
- External prosthetic devices and collars
- Lactation services and equipment
- Long-term psychiatric day care and enrollment in special schools, except where such services are specifically provided in this Plan
- Physical examinations or immunizations that are required for employment, insurance, licensing, marriage or travel, which are not otherwise Medically Necessary

- Reversals of voluntary sterilization, in vitro fertilization, artificial insemination, embryo storage and cryosterilization
- Speech therapy which is primarily educational
- Venipuncture
- Care or service in a nursing home, skilled nursing facility, rest home or convalescent home. Long-term care in a nursing home is usually considered custodial and is not covered.
- Private-duty nursing, unless MVP Health Care or the Benefit Fund finds such care is Medically Necessary and has approved it in advance
- Charges for infertility treatment, including, but not limited to, in vitro fertilization, artificial insemination, embryo storage, cryosterilization and reversal of voluntary sterilization
- Charges for in-hospital services that can be performed on an ambulatory or outpatient basis
- Charges for invalid and/or obsolete CPT or HCPCS codes
- Charges for over-the-counter, personal, comfort or convenience items, such as bandages or heating pads (even if your physician recommends them)
- Charges for procedures, treatments, services, supplies or drugs for cosmetic purposes, except to remedy a condition that results from an illness or accidental injury

## **OTHER LIMITATIONS**

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

- 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
- Charges for claims containing misrepresentations or false, incomplete or misleading information
- Charges for claims submitted more than 12 months after the date of service
- Charges for services covered under any mandatory automobile or no-fault policy
- Charges for services in excess of or not in compliance with the Benefit Fund's guidelines, policies or procedures
- Charges for services or materials that do not meet the Benefit Fund's standards of professionally recognized quality
- Charges for services provided and supplies or appliances used before you, your spouse or your children became eligible for Benefit Fund coverage

- Charges for services that are custodial in nature
- Charges for services that are not covered by the Benefit Fund, even if the service is Medically Necessary
- Charges for services that are not FDA-approved for a particular condition
- Charges for services that are not Medically Necessary
- Charges for services, 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 in excess of the Benefit Fund's Schedule of Allowances
- Charges made by your provider for broken appointments
- Charges not generally recognized or accepted as appropriate by health professionals for treatment of your condition
- 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 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 that are not itemized
- Charges that are unreasonable, excessive or that are beyond a provider's normal billing rate or beyond his or her scope or specialty
- Charges that would not have been made if no coverage existed or charges that neither you nor any of your dependents are required to pay. For example, the Benefit Fund will not pay for services provided by members of your or your dependent's immediate family.
- Experimental or unproven procedures, services, treatments, supplies, devices, medications, etc. (see definition of "Experimental" and exceptions for clinical trials in Section IX)
- Payment for services which normally would be provided without charge
- Services provided outside the service area, the need for which could reasonably have been foreseen prior to leaving the service area, unless the services were expressly approved in advance by the 1199SEIU National Benefit Fund
- Services which are not pre-approved in accordance with the terms of the Plan

- 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.



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## 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, accident/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 Benefit Fund or the Trustees until all remedies under the Benefit 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 an assignee of you, your spouse or your children 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.

Payments made by the Benefit Fund which are not consistent with the Plan — as stated in this SPD or as it may be amended — must be returned to the Benefit 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.

Notwithstanding the foregoing, the Benefit Fund shall have the power and authority to authorize the distribution of benefits in accordance with the terms of a court order that it determines is a Qualified Medical Child Support Order (QMCSO), as required by applicable federal law.

The Fund does not cover claims containing misrepresentations or false, incomplete or misleading information. If a false or fraudulent claim is filed, the Fund may seek full restitution plus interest and reimbursement of any expenses incurred by the Fund. In addition, the Fund may suspend the benefits to which the participant and his or her dependent(s) 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

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# SECTION VIII. A

## YOUR ERISA RIGHTS

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

### GETTING INFORMATION

You have the right to:

- Examine, without charge, at the Benefit Fund office, all required Benefit Fund documents, including Schedules of Allowances, 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 Benefit 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 Benefit 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 or beneficiary, are entitled to request the documents described above.

### CONTINUE GROUP HEALTH COVERAGE

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

### 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 Rochester Office of the 1199SEIU Family of Funds’

Eligibility Department may share eligibility and enrollment information with the Benefit Fund, your Employer or the Union for enrollment and outreach purposes. The Benefit Fund may share enrollment information with the Rochester Office of the 1199SEIU Family of Funds' Eligibility Department for enrollment purposes. A complete description of how the 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 (877) 557-1199.

## **FIDUCIARY RESPONSIBILITY**

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

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

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 Benefit 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 Benefit Fund review and reconsider your claim, using the appeals 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.
- 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, 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 of a decision 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.
- 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.
- 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).

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

### **ASSIGNING YOUR RIGHTS**

You may not transfer or assign your Plan rights or benefits to anyone, with one exception: You may assign to non- Participating Providers your right to a Plan benefit and to sue to get a Plan benefit. If you assign to a non- Participating Provider your right to a Plan benefit, the provider will have no greater rights than you have, and may not in turn assign the right to anyone else. If the provider exercises the right to the benefit,

you will no longer have the right to receive that benefit. A non-Participating Provider can only file a lawsuit disputing an adverse benefit determination:

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

**NOTE:** No other rights conferred under the terms of this Plan or ERISA may be transferred or assigned. You cannot assign your right to appeal an adverse benefit determination but you can authorize a representative to appeal on your behalf. See Section VII.B.

### **QUESTIONS?**

If you have any questions about:

- Your Benefit Fund, contact the Benefit Fund office at (877) 557-1199; 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  
NW, 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.

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# **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 non-forfeitable right to receive benefits under the Benefit Fund.



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## **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).

Without limiting the generality of the statements in Section VIII.C, the Plan Administrator shall have the ultimate discretionary authority to:

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

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

All determinations made by the Plan Administrator (or any duly authorized designee of the Plan Administrator) 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.

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# SECTION VIII. D

## INFORMATION ON YOUR PLAN

### NAME OF THE PLAN

The 1199SEIU National Benefit Fund for Health and Human Service Employees

### TYPE OF PLAN

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

### ADDRESSES

#### Headquarters:

330 West 42nd Street  
New York, NY 10036

#### Office:

Rochester Benefit Fund Office  
259 Monroe Avenue, Suite 220  
Rochester, NY 14607

### SOURCE OF INCOME

Payments are made to the Benefit Fund by your Employer and other Contributing Employers, according to the Collective Bargaining Agreements with 1199SEIU United Healthcare Workers East.

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

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

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

### ACCUMULATION OF ASSETS

The Benefit 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 Trustees to whom the Trustees have delegated this fiduciary duty.

### PLAN YEAR

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

## **PLAN ADMINISTRATOR**

The Plan Administrator consists of the Board of Trustees and its duly authorized designees and subordinates, including, but not limited to, the Executive Director, the Appeals Committee of the Board of Trustees and other senior employees.

The Trustees may be contacted at:

c/o Executive Director  
1199SEIU National Benefit Fund for  
Health and Human Service Employees  
330 West 42nd Street  
New York, NY 10036

For Rochester members, MVP Health Care is a third-party administrator of the 1199SEIU National Benefit Fund.

## **FOR SERVICE OF LEGAL PROCESS**

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

The Trustees may be contacted at:

c/o Executive Director  
1199SEIU National Benefit Fund for  
Health and Human Service Employees  
330 West 42nd Street  
New York, NY 10036

The Benefit Fund's Counsel may be contacted at:

1199SEIU National Benefit Fund for  
Health and Human Service Employees  
General Counsel's Office  
330 West 42nd Street, 31st Floor  
New York, NY 10036

## **IDENTIFICATION NUMBER**

Employer Identification Number:  
13-1628401

## **DISCRIMINATION IS AGAINST THE LAW**

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

If you believe the Funds have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Compliance Coordinator, 330 West 42nd Street, New York, NY 10036; (646) 473-6600 (phone); (646) 473-8959 (fax); [PrivacyOfficer@1199Funds.org](mailto:PrivacyOfficer@1199Funds.org) (email). You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Compliance Coordinator can help you.

You can also file a civil rights complaint with the U.S. Department of Health

and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201; (800) 368-1019 or (800) 537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## TRUSTEES

The 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 Trustees of the Benefit Fund are:

UNION TRUSTEES	
Jacqueline Alleyne Executive Vice President 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036	Lisa Brown Executive Vice President 1199SEIU United Healthcare Workers East 611 North Eutaw Street Baltimore, MD 21201
Norma Amsterdam Executive Vice President 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036	Maria Castaneda Secretary-Treasurer 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036
Yvonne Armstrong Senior Executive Vice President 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036	George Gresham President 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036
Michael Ashby Vice President 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036	Steve Kramer Executive Vice President 1199SEIU United Healthcare Workers East 310 West 43rd Street New York, NY 10036

<p>Dalton Mayfield  Vice President  1199SEIU  United Healthcare Workers East  310 West 43rd Street  New York, NY 10036</p>	<p>Veronica Turner  Senior Executive Vice President  1199SEIU  United Healthcare Workers East  330 West 42nd Street  New York, NY 10036</p>
<p>Joyce Neil  Executive Vice President  1199SEIU  United Healthcare Workers East  310 West 43rd Street  New York, NY 10036</p>	<p>Laurie Vallone  Executive Vice President  1199SEIU  United Healthcare Workers East  310 West 43rd Street  New York, NY 10036</p>
<p>Bruce Popper  Vice President  1199SEIU  United Healthcare Workers East  259 Monroe Avenue  Rochester, NY 14607</p>	<p>Estela Vazquez  Executive Vice President  1199SEIU  United Healthcare Workers East  310 West 43rd Street  New York, NY 10036</p>
<p>Helen Schaub  Vice President  1199SEIU  United Healthcare Workers East  330 West 42nd Street  New York, NY 10036</p>	<p>Gladys Wrenick  Vice President  1199SEIU  United Healthcare Workers East  310 West 43rd Street  New York, NY 10036</p>

## EMPLOYER TRUSTEES

<p>Susan Bornstein  Vice President of Human Resources  Menorah Center for Rehabilitation and Nursing Care  1516 Oriental Boulevard  Brooklyn, NY 11235</p>	<p>Rebecca Gordon  Vice President of Labor and Employee Relations  Northwell Health System  1111 Marcus Avenue, Suite LL20  Lake Success, NY 11042</p>
<p>David Brodsky  Vice President of Employee and Labor Relations  Montefiore Medical Center  111 East 210th Street  Bronx, NY 10467</p>	<p>Howard Green  c/o Trustee Relations  1199SEIU National Benefit Fund  330 West 42nd Street  New York, NY 10036</p>
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## **SECTION IX – DEFINITIONS**

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# 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 Guardian Life Insurance Company of America under an agreement with the Trustees providing for payments to a beneficiary designated by the employee under the circumstances described in Section IV.C and in the Certificate of Coverage (policy).

## **Administrative Review**

The procedure to appeal a claim that MVP Health Care, Excellus BlueCross BlueShield or the Benefit Fund has rejected or denied in part. An Administrative Review can be requested by you, your dependents (your spouse and/or your children) or a provider of services that has received an "Assignment of Benefits" authorization and your written authorization to appeal on your behalf.

## **Affordable Care Act**

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

## **Allowed Amount**

The payment amount set forth in the provider's contract with MVP Health Care or an MVP Health Care network for the service provided.

## **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.

## **Annual Rate of Pay**

Fifty-two times the base weekly wage rate under the Collective Bargaining Agreement with your Employer, which was in effect on January 1 of the last year you actually worked.

## **Assignment of Benefits**

1. MVP Health Care, Excellus BlueCross BlueShield and/or the Benefit Fund will pay its allowance to your doctor, dentist, laboratory, etc., directly when you request it to do so by signing the "Assignment of Benefits" authorization on your claim form.
2. See Lien Acknowledgment.

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

### **Average Weekly Earnings**

The weekly average of your wages reported to the Benefit Fund by your Employer. Sixteen weeks are averaged to determine your Wage Class. Eight weeks are averaged to determine your Disability Benefit amount.

### **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 forms that must be completed to request any of the benefits provided by the Plan.

### **COBRA Continuation Coverage or COBRA Coverage**

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

### **Concurrent Notice**

The notice you or your provider must give to MVP Health Care while you are receiving certain Covered Services.

### **Concurrent Review**

MVP Health Care's 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 with one of its affiliates, and who provides for regular monthly payments in an amount determined by the Trustees to this Benefit Fund on behalf of the employees covered by the agreement for all benefits in this Summary Plan Description.
2. 1199SEIU United Healthcare Workers East, its affiliates, the Benefit Fund or any other Employer accepted as a contributor by the

Trustees and its affiliated and related Benefit Funds that are obligated to make regular monthly payments in an amount determined 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.)

### **Co-payment**

A dollar amount paid by you directly to the healthcare provider at the time services are received. Some of the benefits to which you are entitled are subject to co-payments. These co-payments are described on a separate list which will be supplied to you.

Co-payments may be changed by the 1199SEIU National Benefit Fund from time to time.

### **Cosmetic Surgery**

Cosmetic surgery includes any procedure whose primary purpose is to improve, alter or enhance appearance. Procedures to correct a cosmetic disfigurement resulting from disease are not covered unless the disfigurement causes a functional impairment, or unless the surgical correction of the cosmetic disfigurement resulting from 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 wounds, post-operative or chronic conditions, preparation of special diets and supervision of medication which 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 spouse or your 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**

When you are temporarily unable to work due to an accident/injury or illness.

**Doctor**

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

**Earnings**

Wages reported by a Contributing Employer as the basis for determining the Employer's payments to the Benefit Fund.

**Eligible**

You have met the criteria adopted by the Trustees of the Benefit Fund to determine your enrollment, plan of benefits and Wage Class.

**Emergency**

Services provided in connection with an "Emergency Condition," including screening and examination services provided to a member or his or her eligible dependent who requests medical treatment to determine if an Emergency Condition exists.

"Emergency Condition" means a medical or behavioral condition, the onset of which is sudden, that reveals itself by symptoms of sufficient severity, including severe pain, that a sensible layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical or surgical care 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 danger; (ii) serious impairment to such person's 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.

**Enrollment Form**

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

**ERISA**

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

## **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 or 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 a significant benefit over conventional treatment in terms of effectiveness, safety and reliability; or
- The improvement in net health outcome must be attainable under the usual conditions of medical practice.

## **Family**

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

## **FDA (Food and Drug Administration)**

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

## **Fiduciary**

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

## **Full Time**

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

## **Fund or Trust Fund**

The 1199SEIU National Benefit Fund for Health and Human Service Employees whose principal office is at 330 West 42nd Street in New York City through which benefits are provided.

## **Health Benefits ID Card**

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

## Hospital

- A. An acute general hospital licensed under state laws and which is not a federal hospital, a place for rest, a place for the aged, a skilled nursing facility or a nursing home.
- B. Mental health care may be provided in a hospital as defined in Section 1.03 of the Mental Hygiene Law.
- C. Contracting Hospital — a hospital which has an agreement with MVP Health Care to provide hospital services.

A hospital is an institution which:

- 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.

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

## Legal Separation

A marital status whereby spouses, while remaining legally married, have chosen to live separate lives physically and economically, as determined in the sole discretion of the Trustees, and as evidenced by (but not limited to) such circumstances as the following: living separate and apart from each other, maintaining separate legal residences and/or separate finances, having custody arrangements for children, or formally dividing joint legal property, assets and responsibilities.

## Legally Separated

See Legal Separation.

## Level of Benefit

The Wage Classification (Wage Class I, Wage Class II or Wage Class III) used to determine the specific package of benefits for which you, your covered spouse and your covered children are entitled.

## **Lien Acknowledgment**

A form that describes and acknowledges the Benefit Fund's right to recover up to the amount it has paid or will pay for expenses relating to any claims which you or your beneficiary 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 Guardian Life Insurance Company of America 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 (policy).

## **Maternity Care**

Includes prenatal and postnatal care, as well as care required by childbirth and miscarriages.

## **Medically Necessary**

Services or supplies which are determined by MVP Health Care, Excellus BlueCross BlueShield or 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 and necessary for 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.

An employee who formerly worked for a Contributing Employer and who is covered for certain benefits is a member only with respect to those benefits provided to his or her class of former members.

### **Mental Health Benefits**

Services for the illnesses typically treated by psychiatrists, psychologists or other licensed therapists using psychotherapy and/or psychotropic drugs.

### **Network**

See Participating Provider.

### **Newly Organized**

Those employees in a bargaining unit when 1199SEIU United Healthcare Workers East concludes a Union

contract, which for the first time, requires payment to the National Benefit Fund for employees in that bargaining unit. It does not include employees covered under expired contracts which are subsequently renewed or extended, or employees joining a bargaining unit after coverage under the Plan for employees in such a unit has been negotiated.

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

A duly licensed healthcare professional or other provider who does not have any fee agreement with MVP Health Care or Excellus BlueCross BlueShield.

### **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.

**Part Time**

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

**Participating Pharmacy**

A licensed, registered pharmacy that has signed an agreement with the Benefit Fund's Pharmacy Benefit Manager.

**Participating Provider**

A duly licensed health practitioner such as a dentist, dental specialist, physician, board-certified or board-eligible specialist, podiatrist, chiropractor, psychologist, psychiatric social worker, optician, optometrist or medical supplier, who has signed an agreement with MVP Health Care or Excellus BlueCross BlueShield.

**Permanently Disabled**

The inability to perform any gainful employment (work generally done for pay or profit) prior to age 65 as certified by the granting of a Social Security Award from the Social Security Administration.

**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 that are adopted and interpreted by the Trustees and the official documents, such as the Trust Agreement and this SPD (including its preface), in which those benefits and rules and regulations are described.

**Plan Administrator**

As used in this SPD, shall mean the Board of Trustees and any individuals, such as the Executive Director and MVP Health Care, 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.

**Primary Care Physician (PCP)**

An internist, pediatrician, family practice physician or obstetrician-gynecologist who is chosen by you from the MVP Health Care Physician List and who will provide or arrange for all the medical services provided by this Plan. Each person must choose a PCP. Women who choose an obstetrician-gynecologist as their

PCP may also choose an internist or family practice physician who will be responsible for general medical care outside of the practice of obstetrics-gynecology.

### **Prior Approval**

A requirement to submit a treatment plan or call MVP Health Care or Excellus BlueCross BlueShield prior to receiving services or supplies. This review process evaluates the Medical Necessity and appropriateness of a proposed service or care. This includes, but is not limited to, some dental claims, certain home care services or treatment, admissions and intermediate care for mental health or alcohol/substance abuse, admissions for physical rehabilitation, certain prescription drugs, all non-Emergency hospital admissions and surgical procedures. There may be certain penalties, as described in this SPD, if you fail to obtain Prior Approval.

### **Prior Authorization**

See Prior Approval.

### **Prior Notice**

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.

### **Retired Member or Retiree**

A person who is currently receiving a pension from the National Pension Fund for Hospital and Health Care Employees or its successors, including the 1199SEIU Health Care Employees Pension Fund.

### **Retrospective Review**

MVP Health Care's review, 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, vision or dental, 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.

### **Service Area**

The MVP Health Care service area consisting of Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming and Yates counties.

**Skilled Nursing Facility**

A facility that provides medical and nursing care and is recognized as such by Medicare.

**Spouse**

The person to whom a member is legally married and who is eligible for benefits from the Benefit Fund, as described in Section I.A.

**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.

**Totally Disabled**

See Permanently Disabled.

**Trust Agreement**

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

**Trustees**

The Benefit Fund Trustees acting in accordance with the Agreement and Declaration of Trust, which establishes the Benefit Fund, and any successor Trustees who are duly designated in the manner set forth in the Agreement and Declaration of Trust.

**Wage Class**

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

**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.









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