SEIU Healthcare IL

Home Care Health Plan

Union Health Service

Medical Home Plan

Summary Plan Description 2024

[Information for Inside Front Cover of Booklet]

Important Information

Claims

When you use the services of the Union Health Service (UHS), all services will be provided to you at no charge (except for a $10 co-pay at the main location). When you use the hospitals affiliated with the Plan (referred by the Union Health Service), services will be provided to you according to the Plan of Benefits on page 1. However, you must follow the UHS referral procedures for all care outside of UHS as outlined in Section 4. You are not required to file a claim form for any medical care provided by the UHS. Keep in mind that this Plan does not cover your dependent spouses and children.

If You Need Additional Information

For this benefit information	***Contact***	***By***
General Plan Information	The Fund Office	Calling 1-877-734-8543 or 1-773-385-9300, or writing to: SEIU Healthcare IL Home Care Health Plan 2229 S. Halted St., Ste. 122 Chicago, Illinois 60608
Healthcare Benefit Providers	Union Health Service (UHS)	Calling 1-312-423-4200, 24 hours per day, before seeking any care
Prescription Drug Retail Providers or Formulary List	Union Health Service (UHS)	Calling 1-312-423-4200
24-Hour Nurse Hotline, or General Health Information	Wellness Support Nurse Assistance Line	Calling 1-866-647-6113
Discount Vision Care Program	Union Health Service (UHS)	Calling 1-800-877-7195
Discount Dental Program	Aegis Premier	Calling 1-888-881-2307
Navigators (ACA)	The SEIU Benefits Center	Calling 1-855-744-6878

This booklet contains a summary in English of your Plan rights and benefits under the SEIU Healthcare IL Home Care Health Plan. If you have difficulty understanding any part of this booklet, contact our office at 773-385-9300 for assistance or at 2229 S. Halsted St., Ste. 122, Chicago, IL 60608. Office hours are from 8:30 a.m. to 5:00 p.m., Monday through Friday.

NOTICIA IMPORTANTE

Este folleto contiene un sumario en Ingles de sus derechos y beneficios bajo el Plan. Si tiene dificultad en entender cualquier parte de este folleto póngase en contacto con el SEIU Healthcare IL Home Care Health Plan, 2229 S. Halsted St., Ste. 122, Chicago, IL 60608. Las horas de oficina son de 8:30 a.m. a 5:00 p.m., de Lunes a Viernes. Para obtenir asistencia también puede llamar a las oficinas al 773-385-9300.

WAŻNE

Ta broszura zawiera streszczenie w języku angielskim Państwa praw i korzyści wynikających z tego Planu. W przypadku trudności ze zrozumieniem jakiejkolwiek części tej broszury prosimy o kontakt z SEIU Healthcare IL Home Care Health Plan, 2229 S. Halsted St., Ste. 122, Chicago, IL 60608. Biuro czynne codziennie od poniedzialku do piątku od 8:30 pm do 5:00. Pomoc można uzyskać telefonicznie pod numerem 773-385-9300.

SEIU HEALTHCARE IL HOME CARE HEALTH PLAN

2229 S. Halsted St., St. 122
Chicago, Illinois 60608
Telephone: 773-385-9300

TO ALL PLAN PARTICIPANTS

The Trustees of your Health Fund are pleased to furnish you with this Summary Plan Description booklet explaining your Plan of Benefits as of January 1, 2024. This booklet replaces and supersedes any prior benefit booklets or explanatory material. You should read this booklet carefully so that you will know what benefits you are entitled to receive from the Plan.

This Plan has been drafted to comply with the provisions of the Patient Protection and Affordable Care Act of 2010 (PPACA or ACA), in keeping with the guidance that has been provided to date about those provisions. The Plan will be amended as needed when addition guidance is issued.

Be sure to keep this booklet with your other important papers so that you can refer to it when necessary. Share the information in this booklet with your family members and let them know where you keep it filed.

Please contact the Fund Administrator if you have any questions regarding your benefits.

Sincerely,

BOARD OF TRUSTEES

Important Notice

This booklet is intended to give you an accurate summary of the benefits and provisions of the Plan of Benefits adopted by the Trustees. This booklet is effective January 1, 2024. This booklet also serves as the official Plan Document, which contains a detailed description of the rules, limitations, exclusions, terms, benefits, and provisions of your Benefit Plan.

Only the full Board of Trustees is authorized to interpret the Plan of Benefits described in this booklet. No agent, representative, officer, or other person from the Union or from any Employer has any authority to speak for the Trustees. If you have questions concerning your eligibility or if you want other information, the only person authorized to answer such questions for the Board of Trustees is the Fund Administrator. The Fund Administrator refers matters that are not clear or that require interpretation to the Board of Trustees. Benefits under the Plan will be paid only when the Board of Trustees or persons delegated by the Board decide, in their sole discretion, that you are entitled to such benefits. Neither the Fund Administrator nor any other person has the authority to act contrary to the written terms of this governing Plan Document.

SEIU HEALTHCARE IL HOME CARE HEALTH PLAN

2229 S. Halsted St., St. 122
Chicago, Illinois 60608
Telephone: 773-385-9300

BOARD OF TRUSTEES

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TABLE OF CONTENTS

Section

PLAN OF BENEFITS .... **SECTION 1**

ELIGIBILITY .... **SECTION 2**
Initial Eligibility and Enrollment for September 1, 2009 .... Section 2.1
Enrollment .... Section 2.2
Continuing Eligibility .... Section 2.3
Termination of Your Eligibility .... Section 2.4
Rescission of Coverage .... Section 2.5
Reinstatement of Eligibility .... Section 2.6
Special Enrollment .... Section 2.7
Coverage during Leave under the Family Medical Leave Act (FMLA) .... Section 2.8
Coverage during Military Leave under USERRA .... Section 2.9
COBRA Continuation Coverage .... Section 2.10
Health Insurance Marketplace .... Section 2.11

GENERAL RULES GOVERNING PAYMENT OF HEALTHCARE BENEFITS .... **SECTION 3**

USING THE UNION HEALTH SERVICE -- YOUR MEDICAL HOME .... **SECTION 4**
Health Maintenance Organization (HMO) .... Section 4.1
Union Health Service (UHS) .... Section 4.2
Appointment at UHS .... Section 4.3
Services Excluded by UHS .... Section 4.4
Hospitals and Other Providers Referred by Union Health Service .... Section 4.5

MEDICAL EXPENSE BENEFITS .... **SECTION 5**
Hospital Expense Benefits .... Section 5.1
Hospital Emergency Room .... Section 5.2
Observation Room Benefit .... Section 5.3
Out-Patient Benefits .... Section 5.4
Surgical Expense Benefits .... Section 5.5
Women's Health and Cancer Rights Ace of 1998 .... Section 5.6
In-Hospital Doctor’s Surgical Expense Benefits .... Section 5.7
Radiology Expense Benefits .... Section 5.8
Laboratory and Pathology Benefits .... Section 5.9
Hospice Care .... Section 5.10
Anesthesia Benefits .... Section 5.11
Mental Health Benefits .... Section 5.12
Chemical Dependency and Substance Abuse Treatment Benefits .... Section 5.13
Durable Medical Equipment and Supplies .... Section 5.14
Dialysis Benefit .... Section 5.15
Chemotherapy and Immunotherapy Services .... Section 5.16
Ambulance Benefits .... Section 5.17
Physician Consultations Referred by a UHS Physician .... Section 5.18
Services Provided at Union Health Service (UHS) .... Section 5.19
Services Excluded at Union Health Service (UHS) .... Section 5.20
Preventive Services .... Section 5.21
Coverage of Routine Costs of Clinical Trials .... Section 5.22

Genetic Testing........Section 5.23

BENEFIT PLAN EXCLUSIONS, CONDITIONS, AND LIMITATIONS........SECTION 6

PRESCRIPTION DRUG BENEFITS........SECTION 7

24-HOUR NURSE NETWORK AND HEALTH INFORMATION HOTLINE........SECTION 8

VISION CARE PROGRAM........SECTION 9

FILING A MEDICAL CLAIM FOR BENEFITS AND APPEALING THE DENIAL OF A CLAIM........SECTION 10
Filing a Medical Claim for Benefits........Section 10.1
When Medical Claims Must Be Filed........Section 10.2
Assignment of Your Benefits........Section 10.3
Allowable Charge........Section 10.4
Where To File Medical Claims........Section 10.5
Authorized Representatives........Section 10.6
Payment of Your Medical Claim........Section 10.7
Benefit Payment to an Incompetent Person........Section 10.8
Circumstances that May Result in Denial or Loss of Benefits........Section 10.9
Claim Rules for Initial Healthcare Claims........Section 10.10
Notice of Denial of Claims or Adverse Benefit Determination........Section 10.11
Your Right to Appeal the Denial of a Claims........Section 10.12
Review Process........Section 10.13
Timing of Notice of Decision on Appeal........Section 10.14
Notice of Decision on Appeal........Section 10.15
Outline of Timeframes for the Claims and Appeals Process........Section 10.16
Exhaustion of Plan Remedies........Section 10.17
Elimination of Conflict of Interest........Section 10.18
Release of Information........Section 10.19
Examinations........Section 10.20
Process for External Review of Claims........Section 10.21
External Review of Standard Claims........Section 10.22
Preliminary Review........Section 10.23
Review by Independent Review Organization (IRO)........Section 10.24
Expedited External Review of Claims........Section 10.25
Preliminary Review........Section 10.26
Review by Independent Review Organization........Section 10.27
After External Review........Section 10.28
Free Choice of Doctor........Section 10.29

SUBROGATION AND REIMBURSEMENT........SECTION 11

COORDINATION OF BENEFITS........SECTION 12
General COB Information........Section 12.1
Order of Benefit Payments........Section 12.2
Coordination of Benefits with Medicare........Section 12.3

GENERAL INFORMATION ABOUT YOUR PLAN........SECTION 13

YOUR PRIVACY RIGHTS UNDER THE PLAN........SECTION 14

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION .... SECTION 15

YOUR RIGHTS UNDER ERISA .... SECTION 16

DEFINITIONS .... SECTION 17

PRIVACY NOTICE .... SECTION 18

APPOINTMENT OF PERSONAL REPRESENTATIVE .... SECTION 19

Section 1 – Plan of Benefits

Call Union Health Service (UHS) at 1-312-423-4200 before seeking medical treatment. All care must be directed by a Union Health Service (UHS) Physician. Any services you receive outside of the Union Health Service facility require a referral. Services not directed by a UHS Physician are not covered.

Medical Benefits	
Calendar Year Deductible	$0
Calendar Year Out-of-Pocket Maximum (Out-of-Pocket maximum includes payments made for copayments, deductibles and coinsurance of Covered Expenses except for non-surgical TMJ treatment.)	$3,000
Calendar Year Out-of-Pocket Maximum for In-Network Prescription Drug	$3,600
Urgent Care	Plan pays 100%
Hospital Emergency Room	$200 copayment (waived if admitted to hospital) **You or your family must contact UHS as soon as possible and no later than 48 hours after emergency treatment or an emergency admission to a hospital. Failure to notify UHS may result in you being responsible for some or all of your medical bills.**
Observation Room	Plan pays 100%
Surgical Expense Benefit	Plan pays 100%
In-Patient Hospitalization (Room and board based on semi-private room rates)	Plan pays 100%
Skilled Nursing Facility	Plan pays 100%, subject to 90-day Calendar Year maximum
Home Health Care	Plan pays 100%
Hospice Care	Plan pays 100%
Physician's Office Visit Copayment	$10 UHS Main Office $0 UHS Satellite Facilities
Preventive Services	Plan pays 100%
Dialysis	Plan pays 100%
Chemotherapy and Immunotherapy	Plan pays 100%
Physical Therapy	Plan pays 100%; limited to 20 visits per calendar year
Occupational Therapy	Plan pays 100%; limited to 20 visits per calendar year
Speech Therapy	Plan pays 100%; limited to 20 visits per calendar year
Chiropractic Care	Plan pays 50%; limited to 20 visits per calendar year
Non-Surgical TMJ Treatment	Plan pays 50%
Podiatry	$10 UHS Main Office $0 Satellite Facility

Medical Benefits	
Durable Medical Equipment	Plan pays 100% of the UHS contract monthly rental rate up to purchase price amount
MRIs, CT and PET scans	Plan pays 100% of the UHS contract
Mental and Nervous Disorders Inpatient Outpatient	 Plan pays 100% $10 copayment per office visit
Inpatient and Outpatient Chemical Dependency	Plan pays 100%
All Other Covered Services and Supplies (such as ambulance service)	Plan pays 100%
Prescription Drug Benefits	
Formulary (Limited) Generic Brand	 $1 copayment $8 copayment
Non-Formulary Generic or Brand	 100% Coinsurance (Plan pays 0%)
Specialty Drug	Not Covered
Vision Benefits	
Optometry Visits	$10 UHS Main Facility $0 Satellite Facility
Vision Services	Discounted services available, through the providers that contract with UHS, with a prescription from UHS
Pre-Existing Conditions	
Pre-Existing Condition Limitations	None

Section 2 – Eligibility

2.1 – Initial Eligibility and Enrollment beginning September 1, 2009

Beginning Sept. 1, 2009, if you are a Home Care Worker, you will first become eligible to enroll for benefits on the first day of the month following the month in which you meet both of the following requirements.

1. You are working as a Home Care provider on the date you become eligible for benefits, and

2. You worked and/or earned an average of 18 Qualifying Hours per week for three consecutive months during which time contributions were made to the Plan on your behalf. Qualifying Hours includes your Department on Aging (DOA) hours and Department of Rehabilitative Services (DORS) hours, FMLA hours, and Workers' Compensation hours and effective June 1, 2019, Qualifying Hours also includes your paid sick hours, paid training hours, and paid vacation hours reported by a Home Care Agency.

To participate in the Plan, you may work for a Home Care agency.

Contributions must be made to the Plan on your behalf for each qualifying hour you work for and/or receive pay from a Home Care agency. Qualifying Hours for which you receive health care contributions include your Department on Aging (DOA) hours.

Home Care Workers become initially eligible to enroll for benefits by meeting the Qualifying Hours requirements described below. You must work and/or earn the required Qualifying Hours during the quarter noted to be eligible for coverage in the corresponding month noted in the chart below.

When You Become Eligible for Coverage	
If you work and/or earn an average of 18 Qualifying Hours per week for which hourly contributions are made to the Plan during this quarter	**Your coverage will begin on the first day of this month**
July, August, and September	January
August, September, and October	February
September, October, and November	March
October, November, and December	April
November, December, and January	May
December, January, and February	June
January, February, and March	July
February, March, and April	August
March, April, and May	September
April, May, and June	October
May, June, and July	November
June, July, and August	December

2.2 – Enrollment

You may enroll in the Plan at any time after you meet the eligibility requirements as long as you are still working in Home Care on the date of your enrollment. Enrollment instructions will be mailed to you when you meet the initial eligibility requirements. Even if you meet the eligibility requirements described above, you will NOT be eligible for benefits until you enroll. As long as you enroll after the first day of the month, your Plan coverage will begin the first day of the following month. If you call or submit your application

after the first day of the month for which you are eligible to enroll, then your Plan coverage will begin on the first day of the month after your enrollment is processed.

For Example:

If you have satisfied the eligibility requirements to enroll beginning March 1, you will be eligible for benefits on March 1 as long as you call to enroll before March 1. If you call to enroll on March 10, you will not be covered by the Plan until the first day of April.

2.3 – Continuing Eligibility for Enrolled Participants

Beginning Jan. 1, 2014, you will continue to be eligible for benefits during the next month if you work in Home Care at least an average of 15 Qualifying Hours per week during each corresponding quarter, as illustrated in the chart above.

For Example:

If you were covered by the Plan during the month of March 2017, and during the quarter that runs from October 1, 2016 through December 31, 2016, you worked an average of 15 Qualifying Hours per week, your coverage would continue during April 2017, provided you continue to work in Home Care during that month.

2.4 – Termination of Your Eligibility

Your eligibility for Plan benefits will terminate at midnight on the first to occur of the following dates, unless you make COBRA Continuation Coverage self-payments, if applicable:

1. The last day of the second month after you stop working in Home Care, (e.g. if you stop working in January, your coverage will end on March 31), or
2. The last day of the second month for which you have not earned eligibility due to insufficient hours, (e.g. if you do not have enough Qualifying Hours in January, February, and March, your coverage will end at the end of February), or
3. If you are making COBRA Continuation Coverage self-payments, the first to occur of any event stated in the *Termination of COBRA Continuation Coverage* in Section 2.11, or
4. When you enter the armed forces of any country (see Section 2.10 regarding continuing coverage under USERRA during your military service in the U.S. armed services), or
5. The date the Trustees terminate this Plan, or
6. The date of your death.

If your eligibility terminates, you must meet the initial eligibility requirements to reinstate benefit coverage (see Section 2.1).

2.5 – Rescission of Coverage

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. The Plan may rescind your coverage for fraud or intentional misrepresentation of a material fact after the Plan provides you with 30 days advance written notice of that rescission of coverage. However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

1. When the Plan terminates your coverage retroactive to the date you lose eligibility for coverage, if there is a delay in administrative recordkeeping between the date you lose eligibility and the date the Plan is notified of your loss of eligibility;
2. When the Plan retroactively terminates your coverage because you fail to make timely self-payments for your coverage; or
3. When any unintentional mistakes or errors result in you or your Dependents being covered by the Plan when you should not have been covered; in this case, the Plan will cancel your coverage prospectively – for the future – once the mistake is identified.

2.6 – Reinstatement of Eligibility

If your coverage ends, you must meet the initial eligibility requirements to have your coverage reinstated.

2.7 – Special Enrollment

You may be eligible for a special enrollment if you decline coverage under this Plan because you have other health coverage and then you later lose the other health coverage. For special enrollments due to loss of other coverage, you must otherwise be eligible for Plan coverage, and have been covered under another group health plan or other health insurance when coverage under this Plan was declined, and enrollment must have been declined due to such other coverage.

If the other health coverage was COBRA continuation coverage, a special enrollment is only available after the COBRA continuation coverage has been exhausted. If the other coverage is not COBRA continuation coverage, a special enrollment is available if you are no longer eligible for coverage or employer contributions for the other coverage.

To enroll, you will need to complete, sign, and submit an enrollment form to the Fund Office within 30 days of the loss of other coverage. Coverage will become effective once the Fund Office approves the enrollment form Coverage will become effective on the date you lose the other health coverage.

Special enrollments are not available for loss of coverage due to failure to pay premiums, fraud, or misrepresentation. To be eligible for a special enrollment, you must notify the Fund Office within 30 days of the loss of other coverage.

2.8 – Coverage during Leave under the Family Medical Leave Act (FMLA)

Under the Family and Medical Leave Act of 1993 (FMLA), eligibility for benefits must be extended to you for up to 12 weeks if:

1. You are an active Participant; and
2. You have been granted leave by your Employer under the FMLA.

Unpaid FMLA leave is generally granted only for the following reasons:

1. Birth, adoption, or placement of a child with you for adoption;
2. Care of a seriously ill spouse, parent or child; Your serious Illness; or
3. You have an urgent need ("qualifying exigency") for leave because your spouse, son, daughter or parent is on active duty in the armed services in support of a military operation.

In addition, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member in the U.S. armed services. The service member must be:

1. Your spouse, son, daughter, parent, or next of kin;
2. Undergoing medical treatment, recuperation, or therapy for a serious illness or injury incurred in the line of duty while in military service; and
3. An outpatient or on the temporary disability retired list of the armed forces.

If you have been granted FMLA leave by your Employer, your Employer must notify the Health and Welfare Fund Office to prevent you from losing eligibility. You may wish to notify the Fund Office yourself, but you are not required to do so. Your Employer must verify your eligibility for benefits while on leave before the Health and Welfare Fund will provide benefits.

If you return to work within 12 weeks, you will not lose health care coverage. If you do not return to work within 12 weeks, you will then qualify to continue your coverage under COBRA Continuation Coverage. You may self-pay for COBRA Continuation Coverage for up to 18 months.

The FMLA requires your Employer to inform you of your rights and obligations under this law. You should ask your Employer if you have any questions about FMLA leave. In general, to be eligible for FMLA leave, you must:

1. Have worked for one Contributing Employer for at least 12 months; and
2. Have worked for one Contributing Employer for at least 1,250 hours over the previous 12 months; and
3. Work at a location where your Employer employs at least 50 employees within a 75-mile radius.

Your eligibility for leave under the Family and Medical Leave Act is determined by your Employer. If you and your Employer disagree over your eligibility or coverage under FMLA, your benefits will be suspended until the disagreement is resolved. The Fund will not intervene in any Employer-employee disputes.

2.9 – Coverage during Military Leave under USERRA

If you enter active service in any of the uniformed services of the United States, your benefits are protected under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Your health care coverage will continue under the Plan if you serve for up to 31 days. If you serve for more than 31 days, you may continue your coverage at your own expense for 24 consecutive months after your Plan coverage ends. You must make payments for continuing coverage under USERRA within the same timeframes provided for continuing coverage under COBRA. USERRA continuation coverage will run concurrently with COBRA continuation coverage.

You must elect continuation coverage under USERRA within 60 days after the date your eligibility for health care benefits under the Plan terminates due to your active service in the U.S. military. If you do not elect USERRA continuation coverage within the 60-day timeframe, you will no longer be eligible for USERRA continuation coverage.

Generally, if you return to work after you complete your service, your Plan participation will be reinstated without any waiting period, if you otherwise meet the requirements of USERRA.

Your USERRA coverage may be terminated if:

1. You do not pay the required premium for continuation of coverage;
2. You exhaust the 24-month coverage period;
3. The Plan ceases to provide group health coverage;
4. You lose your rights under USERRA (for instance, for a dishonorable discharge); or

5. You fail to return to work or apply for reemployment within the time required under USERRA.

2.10 – COBRA Continuation Coverage

Under the federal law, you have the right to make self-payments for continued health care coverage if you lose coverage under the Plan for certain reasons called “qualifying events.” This continued coverage is called COBRA Continuation Coverage. If you are eligible to elect COBRA Continuation Coverage, you are referred to as a qualified beneficiary.

Proof of Insurability Not Necessary

You do not have to show that you are insurable in order to be entitled to COBRA Continuation Coverage.

Benefits under COBRA Continuation Coverage

You may elect COBRA Continuation Coverage and make COBRA Continuation Coverage Self-Payments for the Plan’s healthcare benefits (medical and vision benefits) for which you were eligible on the day before the qualifying event that caused your loss of coverage. If you were eligible for benefits, but did not enroll in a Plan, you will not be eligible for COBRA.

18-Month COBRA Continuation Coverage

You are entitled to elect COBRA Continuation Coverage and to make self-payments for the coverage for up to 18 months after coverage terminates because of one of the following qualifying events:

1. A reduction in your hours, or
2. Your loss of employment (which includes retirement).

29-Month COBRA Continuation Coverage for Disabled Individuals

A special extension is available for disabled individuals under COBRA. If you are eligible for Social Security disability benefits on the date of, or within 60 days of the date of your loss of employment or reduction in hours, the maximum period of COBRA Continuation Coverage will be 29 months instead of 18 months.

To be eligible for this 11-month extension, you must provide the Fund Office with proof of the Social Security disability award within 60 days of the date you are found to be eligible for Social Security disability benefits and before the expiration of the 18-month continuation period. The Plan may charge you a higher self-payment rate for the extra 11 months of coverage. Contact the Fund Office for information about the self-payment rates for COBRA coverage.

If the Social Security Administration later determines that you are no longer disabled, you must notify the Fund Office in writing within 30 days of the date such notice is received from the Social Security Administration.

Your Notification Responsibilities

You must give timely written notice to the Fund Office of the following events:

1. You are receiving COBRA Continuation Coverage with a maximum of 18 months and are later determined by the Social Security Administration to be disabled. If the determination is made at any

time during the first 60 days of COBRA coverage, you may be eligible for an 11-month extension of the 18-month maximum coverage period, for a total of 29 months of COBRA Continuation Coverage. or

2. The Social Security Administration determines that you are no longer disabled.

You should send your written notice to the Fund Administrator at the Fund Office. The address is on page iv at the beginning of this booklet.

If you are providing notice of a Social Security Administration determination of disability, you must send notice during the first 18 months of COBRA Continuation Coverage and no later than **60 days after** the date of the disability determination by the Social Security Administration.

If you are providing notice of a Social Security Administration determination that you are **no longer** disabled, you must send notice no later than **30 days after** the date of the determination by the Social Security Administration that you are no longer disabled.

The required notice may be sent by you or any representative acting on your behalf. If you do not notify the Fund Office of a qualifying event within the timeframe noted, you will lose your right to elect or extend COBRA Continuation Coverage.

You must provide written notice of any of the situations listed above. You may send a letter to the Fund containing the following information: your name, the event for which you are providing notice, the date of the event and the date on which you will lose coverage.

You should keep a copy for your records of any notices you send to the Fund Office or Fund Administrator.

It is your Employer's responsibility to notify the Fund Office of any other qualifying events that could cause loss of coverage, such as your termination or death. However, to make sure that you are sent notification of your election rights as soon as possible, you should also notify the Fund Office any time any type of qualifying event occurs.

The Notification Responsibilities of the Fund Office

When the Fund Office is notified of a qualifying event, the Fund Office will send an Election (Self-Payment) Notice and Self-Payment Election Form to you due to the qualifying event. The Election Notice tells you about your right to elect COBRA Continuation Coverage, the due dates for returning the election form and the amount of the self-payment, etc.

If COBRA Continuation Coverage is unavailable to you for any reason, the Fund Office will notify you of that fact.

In order to protect your rights, you should keep the Fund Office informed of any change in your address. If you have any questions regarding your rights to COBRA Continuation Coverage, you may contact the Fund Office at the address and phone number given at the beginning of this booklet. You may also contact the nearest Regional or District Office of the Employee Benefits Security Administration (EBSA).

Electing COBRA Continuation Coverage

You must complete the Self-Payment Election Form and send it back to the Fund Office in order to elect COBRA Continuation Coverage. The following rules apply to the election of COBRA Continuation Coverage:

1. If you wish to elect COBRA Continuation Coverage, you have 60 days after the Election Notice is sent or 60 days after coverage would terminate, whichever is later, to send back the completed Election Form. An election of COBRA Continuation Coverage is considered to be made on the postmark date the Election Form is mailed back to the Fund Office.
2. If the Election Form is not mailed back to the Fund Office within the allowable period, you will be considered to have waived your right to COBRA Continuation Coverage.
3. You may not elect COBRA Continuation Coverage if you are covered under another group health care plan (as an employee or Dependent), unless you have a medical condition that would be covered under this Plan's COBRA Continuation Coverage and would not be covered under the other plan.

Self-Payments for COBRA Continuation Coverage

The following rules apply to your self-payments for COBRA Continuation Coverage:

1. COBRA Continuation Coverage self-payments must be made monthly.
2. The amounts of the monthly self-payments are determined by the Trustees based on Federal regulations. The amounts are subject to change, but not more often than once a year, unless substantial changes are made in the benefits.
3. If you are electing COBRA Continuation Coverage must make the initial self-payment for coverage within 45 days of the date you send back the signed COBRA Election Form to the Fund Office.
4. The due date for each following monthly payment is the first day of the month for which payment is made. A payment will be considered on time if it is received within 30 days of the due date.
5. If you do not make a self-payment within the time allowed, COBRA Continuation Coverage will terminate. You may not make up the payment or reinstate coverage by making up missed payments.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will be terminated before the end of the applicable 18-, or 29-month coverage period when the first of the following events occurs:

1. A correct and on-time payment is not made to the Fund,
2. The SEIU Healthcare IL Home Care Health Plan no longer provides group health coverage to any employees,
3. You become entitled to Medicare coverage,
4. You are receiving extended coverage due to disability and the Social Security Administration determines that you are no longer disabled, or
5. You become covered under another group health plan (as an employee or Dependent) that does not limit or exclude benefits that would otherwise be provided by this Plan.

2.11 – Health Insurance Marketplace

There may be other coverage options for you and your family. Under the ACA, you may be eligible to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pockets costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. However, enrollment in COBRA may affect your ability to enroll in the Marketplace outside of the annual Open Enrollment Period. 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.

Section 3 – General Rules Governing Payment of Healthcare Benefits

This section provides you with a detailed explanation of the healthcare benefits that the Plan provides for you. The following rules apply to all of the healthcare benefits for which payments are made under this Plan:

1. The Plan will pay for the reasonable and customary amount of covered charges you incur for care, treatment, operations, services, hospitalizations, certain examinations, tests and procedures up to the amount shown in the Plan of Benefits. It is important that you become familiar with your Plan of Benefits.

2. There are conditions, limitations and exclusions relating to certain types of charges. Be sure to read all of the provisions of the sections entitled *Benefit Plan Exclusions, Conditions, and Limitations*.

3. Payments are made for treatment of injuries and illnesses only if they are non-occupational, which means that they are not work-related. Any reference in this booklet to injuries and illnesses means only non-occupational injuries and illnesses.

4. Any service or supply that you receive must be Medically Necessary and must be received upon the recommendation of, or with the approval of, a licensed provider.

5. The Plan will only pay for charges that you incur while you are covered under this Plan.

6. The term "Covered Medical Expenses" means certain types of charges that are acceptable to be considered for payment by the Plan. This does not mean that all Covered Medical Expenses you incur will be paid. Payment will be made according to the provisions of each benefit, the benefit amounts and limitations shown on the Plan of Benefits, and the items listed in the section *Benefit Plan Exclusions, Conditions, and Limitations* in Section 6.

7. Expenses incurred by eligible female employees for maternity or for a pregnancy or pregnancy-related conditions are treated in the same manner as expenses incurred for an illness, subject to the exclusions and limitations of the Plan. Further, no pregnancy or maternity benefits are payable for surrogate pregnancies.

   The Plan will comply with the Federal law that states that group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours)

8. When the term "year" is used in reference to your medical benefits, it means a Calendar Year, as defined in Section 17.

Section 4 – Using the Union Health Service – Your Medical Home

4.1 – Health Maintenance Organization (HMO)

The Trustees have entered into an agreement with a Health Maintenance Organization (HMO), the Union Health Service (UHS) and hospitals and providers referred by the Union Health Service.

4.2 – Union Health Service (UHS)

The UHS provides services to you free of charge, after a copayment, or at the amount listed in your Plan of Benefits. All of the UHS medical services are provided only on the premises of UHS. Prescription drug benefits are provided through the UHS. Discounted vision services are available through agreements UHS has with third-party providers.

Before you receive any medical care on a non-emergency basis, you must call or visit the UHS office. Any care you receive without the approval will be considered Out-of-Network, and will not be paid by the Plan. Any non-emergency services that you receive from a provider that is not located at the Union Health Service, must be referred by UHS, or those services will not be covered by the Plan.

In an emergency, you or your family member must contact UHS as soon as possible and no later than 48 hours after emergency treatment or an emergency admission to a hospital. Failure to notify UHS may result in you being responsible for some or all of your medical bills.

Free parking is provided at UHS, which is located at:

Union Health Service
Main Medical Center
1634 West Polk Street
Chicago, Illinois 60612

4.3 – Appointments at the UHS

If you need medical care, call UHS at 312-423-4200 to make an appointment. You can call for an appointment at the UHS Main Medical Center, which provides appointment times between the following hours:

Monday, Wednesday, or Friday	9:00 a.m. – 5:30 p.m.
Tuesday or Thursday	9:00 a.m. – 8:00 p.m.
Saturday	9:00 a.m. – 1:00 p.m.

When you become eligible for benefits under this Plan, you will be issued a UHS identification (ID) card on your first visit to UHS. Be sure to take your ID card with you to all appointments.

If you cannot keep an appointment, you must cancel the appointment at least one full working day before the appointment date.

Some services may be provided at UHS Satellite facilities. When you call 312-423-4200, the UHS service representative will let you know if your appointment can be made at one of the following UHS Primary Care Neighborhood Centers, which have more limited hours and services:

4701 N. Cumberland (NWC), Suite 21 – 26, Norridge, Illinois 60706

2800 W. 87th St. (California), Chicago, Illinois 60652

610 S. Maple Ave. (OPC), Ste. 2300, Oak Park, Illinois 60304

6700 w. 167TH St., Ste. 4 & 5, Tinley Park, Illinois 60477

6800 Centennial Dr., Ste. D, Tinley Park, Illinois 60477

3700 W. 203rd St., Ste. 110, Olympia Fields, Illinois 60461

In addition, depending on your location, you may be referred to some south suburban UHS facilities if they offer the services you need. You may receive such a referral when you call 312-423-4200 for an appointment.

4.4 – Services Excluded by UHS

In addition to the exclusions listed in the *Benefit Plan Exclusions, Conditions, and Limitations* section, UHS does not provide emergency services, first aid treatment, or other services for injuries that occur on the job.

4.5 – Hospitals and Other Providers Referred by the Union Health Service

The hospitals referred by the Union Health Service provide services to employees at the amount listed in your Plan of Benefits. See the Plan of Benefits for more details.

Section 5 – Medical Expense Benefits

5.1 – Hospital Expense Benefits

The Plan will pay hospital benefits when you receive the hospital services described below to treat your non-occupational injury or illness. Benefits are paid at the contracted amount for charges made by the hospital or UHS referred provider.

Remember that benefits are provided for services received at the hospitals and other providers referred by the Union Health Service only if you follow the UHS referral procedures. You must contact the Union Health Service at 312-423-4200 before all non-emergency services or hospital admissions. If you are admitted to a hospital referred by the Union Health Service on an emergency basis, the UHS referral procedures are waived, but you or your family member or representative must contact UHS as soon as possible, and no later than 48 hours after an admission.

Hospital In-Patient Benefits

The Plan will cover the following charges:

1. Hospital daily room and board charges for a semi-private room as shown in your Plan of Benefits. The Plan will not pay any additional charge for a private room.

2. Miscellaneous hospital charges are payable as shown in your Plan of Benefits for the contracted amount for charges on any day for which a room and board benefit is payable. Charges must be Medically Necessary hospital services, treatments and supplies that include anesthetics and their administration and radiology and pathology studies. You must pay any amount not paid by the Plan, but you will pay at the discounted Network rate when you use a Network provider.

5.2 – Hospital Emergency Room

When you visit the Emergency Room of a Hospital, you must pay the copayment listed in the Plan of Benefits. This copayment will be waived if you are admitted to the hospital. Related charges not billed by the hospital (reading of lab, x-ray, etc.) are subject to any deductible, coinsurance, or copayment that may apply to those types of service.

The Plan will pay emergency treatment per incident (subject to the copayment listed in your Plan of Benefits) if you incur expenses for the initial diagnosis and treatment of a medical emergency. Benefits are payable for medically necessary services and supplies provided in a hospital emergency/out-patient department or in an emergency treatment center.

To be considered a medical emergency, the following requirements must be met:

1. A medical condition which, if immediate medical attention is not provided, can reasonably be expected to be life-threatening, or can reasonably be expected to lead to serious adverse medical consequences. These conditions must be severe, sudden in onset and involve one or more of the major organ systems of the body, such as the cardiovascular, nervous, gastrointestinal or urinary system. A condition will not be considered an emergency if the first treatment by a doctor is provided more than 24 hours after the onset of the symptoms.
2. If symptoms exist which reasonably may have been interpreted as an emergency under the above definition, that condition will be considered an emergency even if the final diagnosis is of another

condition. For example, severe chest pain that creates a reasonable suspicion of a heart attack and for which cardiac tests are done will be considered an emergency even if the final diagnosis indicates that it was not actually a heart attack.

3. In addition to medical conditions that are emergencies as defined above, there are some conditions that result from accidents which reasonably appear under the circumstances to be so serious and threatening to a body part so as to require emergency room treatment; such conditions will be considered emergencies.
4. In addition, being taken for treatment to a hospital or trauma center by police, fire department or ambulance, when such transportation is made under circumstances over which the eligible individual has no control, will be considered an emergency.

If you receive treatment in a hospital emergency room for a condition that DOES NOT meet the Plan's definition of an *emergency*, the benefits you would have otherwise received for that treatment will be **REDUCED BY 50%**. This is to encourage you to go to the Union Health Service, a clinic, Urgent Care Center, or your doctor's office for non-emergency treatment. Be sure to familiarize yourself with the definition of *emergency*.

5.3 – Observation Room Benefit

The Plan will pay Observation Room Benefits as follows:

1. The first 48 hours of Observation room and nursing charges will be limited to the facility's lowest daily room and board rate.
2. Observation room and nursing charges after the first 48 hours are not covered.

5.4 – Out-Patient Benefits

The Plan will cover the following Medically Necessary out-patient services from providers and hospitals referred by the Union Health Service to treat your non-occupational injury or illness as shown in your Plan of Benefits:

1. Treatment of injury, which includes services provided in a hospital out-patient or emergency department or in an emergency treatment center for treatment of an injury,
2. Out-patient surgery that can safely be performed in a doctor's office, the out-patient department of a hospital or an out-patient surgical center. Charges incurred for out-patient surgery include anesthetics and their administration and radiology and pathology studies. You must follow the UHS referral procedures for out-patient surgery (see Section 4).
3. Out-patient pre-admission testing, which includes x-ray and laboratory tests you have performed before approved in-hospital surgery in a facility referred by UHS. These x-ray and laboratory tests must be performed in the out-patient department of a facility referred by UHS before your admission to the hospital.

NOTE: If you go to a hospital and receive out-patient treatment and then are admitted as an in-patient, the out-patient treatment you receive will be considered as part of the in-patient care. Your entire hospital treatment will be considered as an in-patient confinement.

5.5 – Surgical Expense Benefit

The Plan will pay for your surgical expenses in the amount that is the contracted amount for such surgery, in accordance with your Plan of Benefits, as long as the surgery is performed at a Hospital referred by the Union Health Service.

The Plan will pay for surgical procedures to treat illness or non-occupational related injury. Surgical payment may be based on CMS guidelines wherever applicable. Members or service providers should call Med-Care Management prior to scheduled treatment. The Fund reserves the right to adopt policies according to criteria established and approved by the Trustees.

1. Global Period – The Plan will not pay the surgeon charges for visits in or out of the hospital the day of surgery and for a follow-up period defined as "Global Period". The Global varies depending on the severity of the procedure performed. Any charges for examination of the patient by the surgeon or another provider practicing within the same group will not be paid during the Global Period.

   The following exception will be permitted:
   a. Examination of the patient on the day of surgery is required to make decision for surgery. e.g. Patient was examined by the surgeon as an emergency in the hospital and decision made to perform an appendectomy.
   b. Surgical Consultation leading to surgery on the same day. e.g. Patient is admitted to the hospital under a Family Practitioner or Internist and surgeon is called in for consultation and the surgeon feels the need to operate on the same day.
2. Bilateral Procedures – For bilateral procedures (procedures performed on both the left and right such as foot, hand, knee, eye), the total benefit will be 50% of the amount payable for the first procedure.
3. Multiple procedures – When more than one surgical procedure is performed in the same operative field or through the same incision, the total benefit will be equal to the amount payable for the primary procedure. If the surgical procedures are in different operative fields requiring separate incisions, the total benefit will be 100 percent of the amount payable for the primary procedure plus 50 percent of the amount payable for the second and subsequent procedures (the amount payable for the third and subsequent procedures will be reduced to 25 percent of the amount payable for these procedures where such procedures do not add any significant time or complexity to the patient's care).
4. Multiple procedures coded and billed individually which are commonly carried out as an integral component of a procedure will not be considered for payment.
5. Payment to Assistant Surgeon – When medically necessary, benefits deemed will be provided for assistant surgeon charges. The assistant surgeon must be a medical doctor or a surgical physician Assistant approved by the hospital, and charges must be billed separate from the primary surgeon. No benefits are payable for assistant services provided by hospital personnel.
6. Rebundling unbundled code – When a comprehensive code is billed with a component code, payment will be made only for the comprehensive code and not for the component code. Use of modifiers will not be permitted for the component codes. The Plan will not pay for any component codes when billed with a comprehensive code.
7. Separate Procedure – When a procedure code designated as "Separate procedure" is billed along with other procedures in the same anatomic area, only separate procedure will be paid and all procedures billed in the anatomic area will be denied.

5.6 – Women's Health and Cancer Rights Act of 1998

Subject to the Plan's other provisions; this Plan complies with the Women's Health and Cancer Rights Act of 1998. That law provides that if you are receiving benefits in connection with a mastectomy and you elect breast reconstruction in connection with the mastectomy, coverage is provided, in a manner determined in consultation with your attending physician, for:

1. Reconstruction of the breast on which the mastectomy was performed,

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

5.7 – In-Hospital Doctor's Surgical Expense Benefits

When you are admitted to a hospital referred by the Union Health Service as an in-patient because of an illness or injury or for surgery, the Plan will pay benefits as provided in your Plan of Benefits. When you are admitted to a hospital referred by the Union Health Service as an in-patient for treatment that does not involve surgery, benefits are payable for only one visit per day by your doctor and are payable only on any day for which hospital room and board benefits are payable.

5.8 – Radiology Expense Benefits

When you receive any of the following services from a hospital referred by the Union Health Service or from the Union Health Service, the Plan will pay the charges as shown in your Plan of Benefits:

1. Hospital diagnostic x-ray services on any day for which benefits are payable for room and board, provided the service is necessary to and concurrent with surgical services or medical care,
2. Diagnostic x-ray service provided at the Union Health Service or a hospital out-patient or emergency room (of a hospital referred by the Union Health Service) during the initial visit to get emergency care of an injury,
3. Diagnostic x-ray service, whether at the Union Health Service or at a hospital out-patient/emergency room (of a hospital referred by the Union Health Service), when required for the initial correction of fractures or complete dislocations,
4. Radiation therapy, including x-ray, radon or radioisotope therapy for treatment of cancer,
5. Radioisotope therapy for the specific conditions of hyperthyroidism, chronic angina pectoris and chronic cardiac decompensation,
6. Chemotherapy rendered in a hospital out-patient department or other chemotherapy facility (of a hospital referred by the Union Health Service), or
7. Radiology service rendered in a doctor's office, an Emergency Treatment Center, or a hospital out-patient or emergency room.

5.9 – Laboratory and Pathology Benefits

This benefit is payable if you receive laboratory and pathology services while you are confined in a hospital referred by the Union Health Service or when the services are provided in a hospital out-patient department or other facility referred by the Union Health Service in connection with out-patient surgery for which Plan benefits are payable. The doctor who makes a charge for the supervision or interpretation of such tests or exams must specialize in the field of radiology or pathology.

If the doctor's charges are not included in the hospital bill but are billed separately, the Plan will pay the amount of the doctor's charge as shown in the Plan of Benefits. This benefit is payable, however, only if a hospital room and board benefit (at a hospital referred by the Union Health Service) or a Surgical Benefit is also payable.

Services provided at an independent laboratory or a physician's office for laboratory and pathology is payable under this benefit.

5.10 – Hospice Care

Hospice Care benefits are payable under the Plan. The Plan will follow the CMS guidelines for Hospice Care:

1. The physician and hospice medical director certify the patient is terminally ill and probably has less than six months to live;
2. The member receives care from an approved hospice program.

The following are services, under the Hospice Care, that would be considered. These services include, but are not limited to:

1. Doctor services,
2. Nursing care,
3. Medical equipment (such as wheelchairs or walkers),
4. Medical supplies (such as bandages and catheters),
5. Drugs for symptom control and pain relief,
6. Short-term care in the hospital, including respite care,
7. Home health aide,
8. Physical and occupational therapy,
9. Speech therapy,
10. Social worker services,
11. Dietary counseling,
12. Counseling to help the patient and family with grief and loss.

5.11 – Anesthesia Benefits

Anesthesia benefits are payable when you receive anesthesia services from an anesthesiologist in conjunction with surgery in a facility referred by the Union Health Service.

Anesthesia services include services rendered for preoperative and postoperative visits, the administration of the anesthetic and the administration of fluids and/or blood in conjunction with the surgery.

5.12 – Mental Health Benefits

The Plan provides benefits for treatment of mental health disorders for Eligible Employees, as provided in the Plan of Benefits.

5.13 – Chemical Dependency and Substance Abuse Treatment Benefits

The Plan provides benefits for the treatment of chemical dependency and substance abuse for Eligible Employees, as provided in the Plan of Benefits.

5.14 – Durable Medical Equipment and Supplies

The Plan provides benefits for Durable Medical Equipment (DME) under the HMO plan and requires a referral from Union Health Service. This plan will only pay for the rental of DME. The Plan will pay the monthly rental amount of the UHS contracted rate for DME up to the purchase price. DME rental is paid at 100% of the UHS contracted rate up to the purchase price amount. For DME where no rental rates are available, the Plan will apply a monthly amount at a maximum of 10% of the purchase price per month, not to exceed that purchase price.

The plan will pay for the medical supplies and replacement parts for durable medical equipment. Centers for Medicare and Medicaid Services (CMS) replacement guidelines will be used when replacement of a part is required. In the event that a part or supply is needed prior to the allowed time, written necessity will be required from the medical provider for review and approval.

5.15 – Dialysis Benefit

The Plan covers inpatient and outpatient dialysis, except when a patient would otherwise be eligible for dialysis under Medicare. You must contact UHS before receiving any dialysis services.

It is required that individuals with end stage kidney/renal disease promptly apply for Medicare coverage, regardless of age. The Plan will pay its normal Plan benefits or the balance due after Medicare payments, whichever is less, and will consider payments from Medicare for end stage kidney/renal disease whether or not you are enrolled in Medicare. See also the Coordination of Benefits with Medicare section in Section 12.3 that discusses what this Plan pays when you are also Medicare eligible.

5.16 – Chemotherapy and Immunotherapy Services

The allowed amount for chemotherapy & immunotherapy drugs will not exceed:

- 125% of the Medicare allowance when administered by a medical provider
- 150% of the Medicare allowance when administered by a Hospital

If Medicare covers a chemotherapy or immunotherapy drug for which there is not a specific allowance, the allowed amount will not exceed 110% of the Average Wholesale Prices (AWP) as determined by Medi-Span or other major sources for either inpatient or outpatient providers.

Other associated services including diagnostic testing, laboratory tests, equipment and supplies are a covered expense under the Plan only to the extent they are Medically Necessary, and only insofar as their cost does not exceed the maximum benefits.

This limit shall be applied to claims made by any healthcare provider, regardless of the healthcare provider's participation in a Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or otherwise has a contract directly or indirectly with the Fund.

All eligible employees requiring chemotherapy & immunotherapy are subject to pre-certification/referral, cost containment review, claim audit and/or review, negotiation and/or other related administrative services which the Plan Administrator may elect to apply in the exercise of the Plan Administrator's discretion.

5.17 – Ambulance Benefits

This Plan will only cover ambulance services to the nearest appropriate medical facility that's able to give you the care you need, or to the nearest in-network facility if further. If you are transported to a facility farther away, this Plan's payment will be based on the charge to the closest appropriate facility.

5.18 – Physician Consultations Referred by a UHS Physician

The Plan provides benefits for physician referrals made by a UHS Physician. The physician to whom you are referred may be a non-UHS Physician. However, you must receive the referral from a UHS Physician in order to receive benefits for the physician consultation.

Physician benefits cover medical examinations, treatment, diagnostic examinations received from the physician, routine annual physical examinations and routine x-rays and laboratory tests. However, the drawing of blood by the physician is excluded. Physician's visits on the same day of a surgery are not covered if a surgery benefit is paid for the same day; unless the examination is of a new patient on the day of a surgery which is required to make a decision for surgery.

5.19 – Services Provided at Union Health Service (UHS)

The Plan provides certain services for you through the Union Health Service (UHS), as follows. See the Plan of Benefits for a listing of the amount the Plan pays for these services.

1. Primary care and specialty physician services,
2. Diagnostic laboratory, x-ray, bone density study, ultra-sound, and electro-cardiogram,
3. Preventive services, such as periodic physicals, nutrition counseling, and cancer screening,
4. Mental health outpatient visits, with applicable copayment,
5. Optometry and ophthalmology (excluding lenses and frames),
6. Podiatry, and
7. Prompt-care services at UHS facilities that have extended hours for service without an appointment.

5.20 – Services Excluded by Union Health Service (UHS)

In addition to the exclusions listed in the *Benefit Plan Conditions and Limitations* section, UHS does not directly provide the following services (some of these services may be covered by the HMO Plan, however, with a referral from UHS):

1. Facility charges (hospital, surgi-center, skilled nursing, and specialty care facilities),
2. Medical transportation,
3. Dialysis,
4. CAT Scans and MRIs,
5. Specialty clinical testing (such as cardiac lab, sleep studies, or neurological studies),
6. Physical and/or occupational therapy,
7. Medical equipment,
8. Home health care, and
9. Emergency treatment, first aid treatment, or other services for injuries that occur on the job.

5.21 – Preventive Services

This Plan provides coverage for certain Preventive Services as required by the ACA. Coverage is provided with no cost-sharing (for example, no deductibles, coinsurance, or copayments), only if provided on an in-network basis for the following services:

1. Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations,
2. Services described in the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and
3. Health Resources and Services Administration (HRSA) Guidelines.

In-network preventive services that are identified by the Plan as part of the ACA guidelines will be covered with no cost-sharing by the participant. This means that the service will be covered at 100% of the Plan's allowable charge, with no coinsurance, copayment, or deductible.

If preventive services are received from a non-network provider, they will be covered by the Plan, but will be subject to non-network cost sharing, as outlined in the Plan of Benefits.

In some cases, federal guidelines are unclear about which preventive benefits must be covered under the ACA. In that case, the Trustees will determine whether a particular benefit is covered under this Preventive Services benefit.

Preventive Services Benefit Overview

Physical Examination covered after Deductible with the standard coinsurance: The Plan will cover the expense related to a routine physical examination (including routine OB/GYN exams) by a Physician after you meet the annual deductible with the standard coinsurance. This benefit is limited to one examination per year for each participant.

Preventive Services Covered with No Cost-Sharing: The following benefits are available under the Fund's Preventive Services Benefit with no cost-sharing. In certain circumstances, as determined by the Fund, the preventive benefit is only payable with an appropriate diagnosis.

Preventive Services for Adults

1. Abdominal Aortic Aneurysm one-time screening for men ages 65-75 who have ever smoked.
2. Alcohol Misuse screening and counseling: Screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
3. Aspirin use for men and women of certain ages is covered.
4. Blood Pressure screening for all adults.
5. Cholesterol screening (Lipid Disorders Screening) for men aged 35 and older; men aged 20-35 if they are at increased risk for coronary heart disease; and women aged 20 and older if they are at increased risk for coronary heart disease.
6. Colorectal Cancer screening for adults beginning at age 50.
7. Depression screening for adults.
8. Type 2 Diabetes screening for adults with high blood pressure.
9. Diet counseling for adults at higher risk for chronic disease.
10. HIV screening for all adults at higher risk.
11. Routine adult immunizations are covered for participants who meet the age and gender requirements and who meet the CDC medical criteria for recommendation. Immunization vaccines for adults--doses, recommended ages, and recommended populations must be satisfied:
    a. Diphtheria/tetanus/pertussis (DTP)
    b. Measles/mumps/rubella (MMR)
    c. Poliomyelitis
    d. Influenza (Flu Shot)
    e. Human papillomavirus (HPV)
    f. Pneumococcal (polysaccharide)
    g. Hepatitis A
    h. Hepatitis B
    i. Meningococcal
    j. Herpes Zoster
    k. Varicella
12. Obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. Screening includes measurement of BMI by the clinician with the purpose of assessing and addressing body weight in the clinical setting.
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk.

14. Tobacco Use screening for all adults and cessation interventions for tobacco users.
15. Syphilis screening for all adults at higher risk.

Preventive Services for Women, Including Pregnant Women

1. Anemia screening on a routine basis for pregnant women.
2. Bacteriuria urinary tract or other infection screening for pregnant women.
3. BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 or BRCA 2 genes will receive referral for counseling.
4. Breast cancer mammography screening every 1 to 2 years for women aged 40 and older.
5. Breast Cancer Chemoprevention counseling for women at higher risk. The Plan will pay for counseling by Physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention.
6. Breast feeding comprehensive support and counseling from trained providers, as well as access to breast feeding supplies for pregnant and nursing women.
7. Cervical Cancer screening for sexually active women.
8. Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, Chlamydia infection screening is covered as part of the prenatal visit.
9. Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers".
10. Domestic and interpersonal violence screening and counseling for all women.
11. Folic Acid supplements for women who may become pregnant.
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
13. Gonorrhea screening for all women at higher risk.
14. Hepatitis B screening for pregnant women at their first prenatal visit.
15. HIV Screening and Counseling for sexually active women.
16. Human Papillomavirus (HPV) DNA tests every 3 years for women with normal cytology results who are 30 years old or older.
17. Osteoporosis screening for women over age 60 depending on risk factor.
18. Rh Incompatibility screening for all pregnant women or other women at increased risk.
19. Sexually Transmitted Infections Counseling for sexually active women.
20. Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users.
21. Syphilis screening for all pregnant women or other women at increased risk.
22. Well-woman visits to obtain recommended preventive services.

Office Visit Coverage

Preventive Services are paid for based on the Plan's payment schedules for the individual services. However, there may be limited situations in which an office visit is payable under the Preventive Services benefit. The following conditions apply to payment for in-network office visits under the Preventive Services benefit. Non-network office visits are not covered under the Preventive Services benefit under any condition.

1. If a preventive item or service is billed separately from an office visit, then the Plan will impose cost sharing with respect to the office visit.
2. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is the delivery of such preventive item or service, then the Plan will pay 100 percent for the office visit.
3. If the preventive item or service is not billed separately from the office visit, and the primary purpose of the office visit is not the delivery of such preventive item or service, then the Plan will impose cost sharing with respect to the office visit.

For example, if a person has a cholesterol screening test during an office visit and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Plan will charge a copayment for the office visit but not for the lab work. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Plan will charge a copayment for the office visit because the blood pressure check was not the primary purpose of the office visit.

5.22 – Coverage of Routine Costs of Clinical Trials

Note that under this medical plan, experimental, investigational or unproven does not include routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses. For individuals who will participate in a clinical trial, precertification/referral is required in order to determine if the participant is enrolled in an "approved clinical trial" and notify the Plan's claims administrator(s) that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial. The routine costs that are covered by this Plan are discussed below:

a. "Routine costs" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
b. An "approved clinical trial" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally-funded; (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
c. A participant is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring physician is a participating health care provider in the plan who has determined that the individual's participation in the

approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.

d. The plan may require that an eligible individual use an in-network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.
e. The plan may rely on its Utilization Management Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for his/her condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process. See the *Filing a Medical Claim for Benefits and Appealing the Denial of a Claim* in Section 10 for information on the appeal process of the Plan. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial. See the Utilization Management in Section 4 chapter for information on referral requirements.

5.23 – Genetic Testing

Precertification is required for all genetic testing. Medically necessary genetic testing is payable under this Plan if for:

a. State-mandated newborn screening tests for genetic disorders;
b. Fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alpha fetoprotein (AFP) analysis in covered pregnant women and only if the procedure is Medically Necessary as determined by the Plan Administrator or its designee;
c. Tests to determine sensitivity to FDA approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity;
d. Genetic testing recommended by the American College of Obstetrics and Gynecology for pregnant women such as genetic carrier testing for cystic fibrosis;
e. Genetic testing (e.g. BRCA) and genetic counseling required as a Preventive Service in accordance with regulations under the Affordable Care Act;
f. Pre-parental genetic testing (also called carrier testing) intended to determine if an individual (such as a prospective parent) is at risk of passing on a particular genetic mutation (at risk for producing affected children).
g. The detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in covered participants if all of the following conditions **are met**:

    1. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and
    2. The covered individual displays clinical features/symptoms, or is at direct risk (family history or 1st or 2nd degree relative) of developing the genetically linked heritable disease/condition in question (presymptomatic); and
    3. The results of the test will directly impact clinical decision-making; outcome or treatment being delivered to the covered individual.

Genetic Counseling is payable when ordered by a Physician, performed by a qualified Genetic Counselor (or other qualified health care provider) and provided with regard to a genetic test that is payable by this Plan. Certain genetic counseling is payable as a Preventive Service in accordance with the Affordable Care Act.

Genetic Testing and Counseling Exclusions

1. Genetic Testing:

The following expenses for genetic tests are not covered, including obtaining a specimen and laboratory analysis to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics. (Certain genetic tests are covered as listed as payable in the Genetic Testing row in the Schedule of Medical Benefits.) Genetic services that are not covered include:

a. Expenses for Pre-Implantation Genetic Diagnosis (pGD) where one or more cells are removed from an embryo and genetically analyzed to determine if it is normal in connection with in vitro fertilization;
b. No coverage of genetic testing of plan participants if the testing is performed primarily for the medical management of family members who are not covered under this Plan. Genetic testing costs may be covered for a non-covered family member only if such testing would directly impact the medically necessary treatment of a plan participant;
c. Home genetic testing kits/services are not covered.
d. Genetic testing determined by the Plan Administrator or its designee to be not medically necessary or is determined to be experimental or investigational.

2. Genetic Counseling:

Expenses for genetic counseling are not covered, unless these three conditions are met: a) is ordered by a Physician, and b) performed by a qualified genetic counselor (or other qualified health care provider) and c) performed with regard to a genetic test that is payable by this Plan.

Section 6 – Benefit Plan Exclusions, Conditions, and Limitations

Covered Expenses do not include and no Plan payment will be made for:

1. Charges incurred for any services or supplies that are not recommended and approved by your physician,

2. Charges incurred by anyone other than you, the eligible employee,

3. Charges incurred for services, supplies, treatments, or procedures that are not rendered for the treatment or correction of, or in connection with, a specific non-occupational bodily injury or illness, unless such charges are stated as covered in any applicable provision of this Plan,

4. Charges incurred for treatment of infertility,

5. Any charges of marital examination, or any other medical examination or test for check-up purposes were not necessary for treatment of an illness or injury, unless specified in your Plan of Benefits,

6. Charges incurred for services, treatments, or surgical procedures rendered in connection with an overweight condition or obesity unless you meet **all** of the following conditions and criteria:

    a. Your Primary Care Physician has recommended the treatment;
    b. Your Primary Care Physician states you are at least 100 pounds over your medically desirable weight;
    c. You have a body mass index of 45 or more;
    d. The obesity is a threat to your life due to life threatening co-morbidities, such as diabetes, heart disease, hypertension, etc.;
    e. You have a documented history of unsuccessful attempts to reduce weight by more conservative measures;
    f. You have successfully completed a psychiatric evaluation and have no psychiatric conditions which may reduce the chances the surgery will have long-term success;
    g. You actively participate in a Disease Management program with Hines & Associates for six months prior to surgery which includes nutritional counseling and a weight reduction program; and
    h. You have not had any form of bariatric surgery in the past. Revision bariatric surgeries are not covered under the Plan.

    In addition to the criteria above, the Plan will only cover surgery related expenses if the surgery is performed at a Center of Excellence approved by the Plan. If you qualify for bariatric surgery, the Plan will provide a list of Centers of Excellence for bariatric surgery upon request.

    Following a bariatric surgery covered under this Plan, the Fund will cover panniculectomy surgery to remove excess skin following significant weight loss, having reached a BMI of 30 or less and maintained a stable weight for at least one year. The Fund will also cover panniculectomy surgery that is deemed medically necessary by our medical review organization.

7. Charges incurred for services, treatments, or surgical procedures rendered in connection with gene or genetic therapy.

8. Charges incurred for any treatment or surgical procedure or service that is of an elective nature, such as for any non-emergency plastic or cosmetic surgery on the body, including but not limited to, the eyelids, nose, face, breasts and abdominal tissue.

   Exception: This limitation does not apply to:

   a. Cosmetic surgery that is performed for the correction of defects incurred through traumatic injuries sustained as a result of bodily injury,
   b. An abortion, if legal when performed,
   c. Corrective surgical procedures on organs of the body that perform or function improperly, or
   d. Breast reconstruction surgery performed in connection with a mastectomy, in a manner determined in consultation with your attending physician for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

9. Charges incurred for the reversal or attempted reversal of any voluntary vasectomy or other sterilization procedure,

10. Charges incurred for services or supplies received from a doctor or hospital that does not meet this Plan's definition of “doctor” or “hospital,” or “mid-level providers”,

11. Charges incurred for correction of eye refractions or for eyeglasses, contact lenses, hearing aids, or the fitting of any such appliance,

12. Charges incurred for any type of custodial care. Custodial care means that type of care, wherever furnished and by whatever name called, including room and board or any other type of care, that is designed primarily to assist an individual in meeting the activities of daily living. This exclusion applies to all such care regardless of what the care is called,

13. Charges incurred while you are confined in an institution that is primarily a place of rest, a place for the aged or a nursing home, or for charges incurred for any care in health resorts, hotels, convalescent homes, custodial homes, sanitariums or institutions, or any treatment in any extended care, minimal care, self-care ambulatory or part-time care unit of a Hospital, or services at home or in a sheltered care unit, or any care in a separate department, unit or facility of a Hospital that is intended to duplicate the care of a facility excluded above,

14. Charges incurred for education, training or room and board while you are confined in an institution that is primarily a school or institution of learning or training,

15. Charges incurred for any operation or treatment in connection with sex transformations or any type of sexual dysfunction, including any complications arising from such conditions,

16. Charges incurred for any treatment, care, procedures, services or supplies that, in the opinion of the Trustees, are not Medically Necessary, experimental or investigative,

17. Charges that are in excess of the contracted rate for the service, treatment, or supply rendered,

18. Charges incurred for services performed by a medical assistant,

19. Charges incurred for self-administered medications, except as provided through the Optum program,

20. Charges incurred for specialty drugs,

21. Charges incurred for services provided by a doctor or dentist for extraction or filling of teeth, performance of alveolectomies, gingivectomies, apicoectomies, or prophylaxis, or for artificial restorations,

22. Charges incurred for any dental treatment, dental x-rays, dental surgery or any care and treatment of the teeth and gums,

23. Charges incurred in connection with bodily injury, illness or disease sustained while doing any act or thing pertaining to any occupation or employment for remuneration or profit or for which benefits are or may be payable, in whole or in part, in accordance with the provisions of any Workers' Compensation Law, Employer's Liability Law, Occupational Diseases Law or similar law. All charges related to such bodily injury, illness or disease which are denied due to failure to properly report and timely file a claim under Workers' Compensation Law, Employer's Liability Law, Occupational Diseases Law or similar law are excluded from coverage under this Plan,

24. Charges incurred while you are confined in any Hospital that is operated by the United States Government or any agency of the United States Government. However, if such charges are made by a Veterans Administration (VA) Hospital that claims reimbursement for the "reasonable cost" of care furnished to you by the VA for a non-service related disability, such charges are Covered Expenses to the extent that they would have been considered Covered Expenses under the Plan had the VA not been involved,

25. Charges incurred as a result of any bodily injury or illness caused by any act of war (whether war is declared or undeclared), any act of international armed conflict, any conflict involving the armed forces of an international body, any riot or any insurrection,

26. Charges made by a doctor or other provider of medical services or supplies for completing claim forms or other forms required by the Plan for the processing of claims,

27. Charges that would not have been made if this Plan did not exist, or charges for any hospital confinement or any other medical care or service for which you would not be legally required to pay,

28. Charges incurred for services or supplies that are furnished, paid for or otherwise provided due to your past or present service in the armed forces of a government (unless any applicable law requires otherwise),

29. Charges incurred for prosthetic devices, dental or cochlear implants,

30. Charges you incur for any care or treatment for which benefits are normally provided under this Plan once you have already received the maximum benefit available to you during any specified period of time as stated in your Plan of Benefits,

31. Charges for any organ or tissue transplants including all transplant related charges for pre-transplant and post-transplant tests and treatments,

32. Charges incurred for pregnancy or maternity expenses when the mother is carrying the child as a surrogate mother,

33. Charges incurred for medical services other than at the Union Health Service or at a provider or hospital referred by the Union Health Service as described in the Plan of Benefits,

34. Charges for, with respect to treatment of a mental or nervous disorder, any treatment or consultation with a marriage therapist and/or counselor,

35. Charges for consultations or sessions with family member (s) even if the consultations or sessions are required as part of the psychological or psychiatric treatment,

36. Charges incurred for any item that is not Medically Necessary, including but not limited to surgical trays, maintenance treatment or therapy, cosmetics, magazines, radio, television, telephone, personal laundry, guest trays, beds, or cots for guests or family members or any other personal comfort item,

37. Charges for, with respect to inpatient hospitalization, any diagnostic or therapeutic procedures not related to the condition for which hospital confinement is required,

38. Any charges for a facility stay and physician charges for any covered member that leaves the hospital against medical advice,

39. Any charges for any procedure for which you have not followed the UHS referral procedure,

40. Services of assistant surgeons, unless the provider is a UHS contracted provider,

41. Any hospital admission primarily for the purpose of conducting tests, studies, examinations, evaluations or observations or for convenience or environmental control,

42. Any charges for drugs, dressings or other supplies taken home or away from the hospital or other facility,

43. Any charges that exceed the maximum visits allowed for physical therapy, occupational therapy, and speech therapy,

44. Charges for, with respect to the Hospital Expense Benefit, medical equipment, including any special braces, appliances, ambulatory apparatus or specialized equipment,

45. Any room & board and/or nursing charges incurred with Observation exceeding 48 hours,

46. Charges for CRNA service with medical direction by a physician,

47. Any house calls by a doctor,

48. Surgeon’s visit on the day of surgery,

49. Multiple visits by the same physician on the same day,

50. With respect to radiology expense, any charges incurred for screening, case findings or research studies,

51. Preventive Services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Services covered for diagnostic reasons are coved under the applicable Plan benefit, not the Preventive Services benefits. A services is covered for diagnostic reasons if the participant had symptoms requiring further diagnosis or abnormalities found on previous

preventive or diagnostic studies that required additional examinations, screenings, test, treatment, or other services,

52. Services covered under the Preventive Services Benefit are not also payable under other portions of the Plan,

53. The Plan will use reasonable medical management techniques to control costs of the Preventive Services benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Services, which must be satisfied in order to obtain payment under the Preventive Services benefit,

54. Immunizations are not covered, even if recommended by the CDC, if the recommendation is based on the fact that some other risk factor is present (e.g. on the basis of occupational, lifestyle, or other indications). Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus, are not covered,

55. Examinations, screening, test, items, or services are not covered when they are investigational or experimental, as determined by the Plan,

56. Examinations, screenings, test, items, or services are not covered when they are provided for the following purposes:

    a. When required for education, sports, camp, travel insurance, marriage, adoption, or other non-medical purposes,
    b. When related to judicial or administrative proceedings,
    c. When required to maintain employment or a license of any kind.

57. Drugs, medicines, vitamins, and/or supplements, whether available through a prescription or over-the-counter, except to the extent covered under the Preventive Services benefits. For example, the following drugs, medicines, vitamins, and supplements are only covered as provided under the Preventive Services Benefit:

    a. Aspirin,
    b. Tobacco cessation product, drugs, or medicine, except as required under the ACA.

58. Handling or transporting of specimen,

59. Charges incurred for procedures or drugs that are deemed unclassified, unlisted, or unspecified,

60. Special Services, Procedures, and Reports, e.g. after hours cares or services that is in addition to the basic services rendered, mammogram assessment category codes (series 3340F through 3350F), or any CPT Category II Codes from series 0001F through Category III Codes 0318T,

61. Alternative Therapy, also known as Alternative Medicine, include but not limited to, homeopathy, naturopathy, acupuncture, holistic therapies, and herbal medicine,

62. Any charges related to treatment, care, services, supplies or procedures provided due to injuries sustained in the course of the commission of a crime (whether or not a crime is charged, a plea agreement is reached or the charges are dropped), except that expenses or charges to treat a person for self-inflicted injuries will be covered,

63. Any charges related to a "Never Event" included in the CMS list of NQF Serious Reportable Adverse Events,

64. Any expenses incurred by dependent spouses and dependent children,

65. Any sales tax charges,

66. Any services or supplies excluded in the section entitled *Benefit Plan Exclusions, Conditions, and Limitations*,

67. Any charges for treatment received outside of Illinois or states adjoining Illinois (Wisconsin, Iowa, Missouri, Kentucky, and Indiana). This exclusion does not apply to emergency treatment or urgent care treatment that arises while outside of Illinois or its adjoining states or when treatment for Covered Expenses is unavailable in Illinois or its adjoining states,

68. Any charges other than those listed as Covered Expense.

The preceding list is not an all-inclusive listing of the Plan's limitations and exclusions, services or supplies. It is only representative of the types of charges for which Plan benefits are limited or not payable and of the types of situations in which charges are incurred for which Plan benefits are limited or not payable. Basically, benefits are only payable under this Plan for the direct treatment of non-occupational injuries and illnesses.

Section 7 – Prescription Drug Benefits

Your prescription drug benefits for this Plan are provided by Union Health Service, Inc. (UHS) through Optum. Your benefits are outlined in the Plan of Benefits in Section 1.

Plan, UHS, through Optum, will send you the identification card, a list of participating pharmacies and drug benefits information brochure. You will use your ID card when you are purchasing prescription drugs at participating pharmacy.

A Formulary is a list of medications approved by the FDA (U.S. Food and Drug Administration) that are regularly in stock and on hand at most of the pharmacy. The amount you pay for generic and brand name Formulary medications is outlined in the Plan of Benefits.

Only the drugs on the Formulary list are covered at the co-payment amounts. You may check the list of covered drugs on UHS and/or Optum website.

If you need a medication that is not on the Formulary list and is not part of Specialty drug, it is still covered, but you must pay the percentage of the cost of the drug that is listed in the Plan of Benefits. However, you will still save money because you will receive the Optum discounted price for the medication. The Plan will pay for the balance of the cost of Non-Formulary drugs.

If your medication is not in a pill form, you can purchase one unit of the medication for one co-payment if it is a Formulary medication.

If you need information about participating pharmacies, you may call the Member Service Department of UHS or Optum or review the prescription drug benefits information brochure you received along with your ID card.

The prescription drug benefits information brochure is incorporated into this Summary Plan Description and Plan Document, and is made a part of this Plan. If you need an additional copy of the prescription drug benefits information brochure, please contact the Fund Office (773)385-9300. The Fund Office will furnish you with a copy, free of charge.

Section 8 – 24-Hour Nurse Network and Health Information Hotline

The Plan provides you with access to a 24-hour nurse assistance line and health information hotline when you have a health concern.

You can the 24-hour nurse assistance and health information hotline at 866-647-6113.

Section 9 – Vision Care Program

The Plan provides discounted vision care services through the providers that contract with UHS. You should contact UHS for information about discounted services offered by specific vision programs.

The UHS contracts with vision providers, which contain the information about the discounted vision care services, are incorporated into this Summary Plan Description and Plan Document and are made a part of this Plan. If you need information about vision benefits, please contact UHS (312)423-4200.

Section 10 – Filing a Medical Claim for Benefits and Appealing the Denial of a Claim

10.1 – Filing a Medical Claim for Benefits

If you use the services of a medical provider referred by Union Health Service (UHS), the provider must file a claim with the Fund on your behalf. Keep in mind that the Plan will not pay benefits for providers that are not referred by the UHS.

Covered Expenses are the eligible charges that the Plan will consider for payment. Not all Covered Expenses will be paid because they are subject to applicable limitations and rules of the Plan.

10.2 – When Medical Claims Must Be Filed

Generally, if you use the services of a network provider, the provider will file a claim for payment and must do so within certain timeframes. If you use the services of an out-of-network provider or are otherwise required to be involved in the claim filing process, as soon as the Fund Office receives notice of a possible claim, it will, if necessary, furnish you with the forms you need to file a proof of claim. Proof of hospitalization or medical expenses must be filed within 90 days after the date on which the charges were incurred. If the claim has not been submitted to the network or the Fund within 90 days, the claim may be denied. However, the Fund may, at its discretion, grant an additional 90-day grace period for a total of six months. After that time period the claim will be denied for late filing. Your proof of claim must include a completed claim form, itemized bills, and any other required forms. If you have been asked to provide additional information to the Fund, that information must be submitted not later than six months after such request, or one year after the date of loss, whichever is earlier. After that time period, the claim will be denied for late filing.

10.3 – Assignment of Your Benefits

You cannot assign your rights as a Plan Participant to a provider or other third party or in any way alienate your claim for benefits. Any attempt to assign those rights or in any way alienate a claim for benefits will be void and will not be recognized by the Fund for that purpose. The Fund will treat any document you are asked by a provider to sign to assign your rights as a Plan Participant or to alienate a claim for benefits to a provider, to be only an authorization for direct payment by the Fund to the provider. For example, the Fund will NOT allow you to assign your provider any rights as a Participant in the Plan, including, but not limited to, the right to appeal a claim denial or the right to receive documentation concerning claims. In the event that the Fund does receive a document claiming to be an assignment of benefits, the Fund will send payments for the claims to the provider, but will send all claim documentation, such as an Explanation of Benefits, and appeal procedures directly to you as the Claimant. In no event shall receipt by a provider of payment or documentation concerning claims be accepted by the Plan as a waiver of the prohibition on assignments of benefits. You may file an appeal of a claim submitted by a provider that was denied in whole or in part and may authorize a representative to file such an appeal on your behalf and you or your representative may use information provided by a provider to support your appeal.

10.4 – Allowable Charge

1. With respect to a network provider, the Allowable Charge is the negotiated fee/rate set forth in the agreement of the network with the participating network health provider, facility, or organization. The Plan may utilize the services of professional firms with resources to assist in payment determinations to review the itemized billing statements for the appropriateness of charges. In the

event of any dispute over reductions recommended by the professional firm(s), the Participant shall have the right to file an appeal of any partial or full claim denial, and the Trustees shall, in their sole discretion, determine whether the bill was properly reduced. When you file an appeal or authorize a representative to file an appeal on your behalf seeking higher payments on a claim, you should be aware that your interests may be in conflict with the interests of a network provider seeking higher claim payments since a successful appeal could increase your copayment amount for that particular claim. A network provider is not permitted to balance bill you for amounts not paid as a result of network discounts.

2. With respect to an out-of-network provider, the Allowable Charge will not exceed 150% of the current Medicare allowable fee for hospital and ambulance claims and 125% for all other claims; services which are not routinely covered by Medicare or are services for which Medicare has not published an allowable amount and which are covered under the Plan will be covered up to the amount the Plan has paid network providers, as determined by the Board of Trustees utilizing information concerning network claim payments or information from the network provider. When you file an appeal or authorize a representative to file an appeal on your behalf seeking higher payments on a claim, you should be aware that your interests may be in conflict with the interests of an out-of-network provider that is seeking higher claim payments than those paid by the Plan since a successful appeal could increase your copayment amount for that particular claim. An out-of-network provider is not prevented from balance billing you for amounts in excess of what the Plan pays.

10.5 – Where To File Medical Claims

The Fund will consider your claim to have been filed as soon as it is received at the Fund Office. When you need to file a claim, you should file it at the following address:

Healthlink
P.O. Box 419104
St. Louis, MO 63141-9104

The UHS/Healthlink network providers must file claims for you. You will not need to file a proof of claim for those services.

10.6 – Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself. You may obtain a form from the Fund Office to designate an authorized representative. The Fund may request additional information to verify that this person is authorized to act on your behalf.

10.7 – Payment of Your Medical Claim

If your claim is approved, the Plan will pay for the amount of Covered Expenses that you have incurred up to the maximum shown in your Plan of Benefits.

10.8 – Benefit Payment to an Incompetent Person

Benefit payments under the Fund may become payable to a person who is adjudicated incompetent or to a person who, by reason of mental or physical disability, in the opinion of the Trustees, is unable to administer such payments properly. In that event, the Trustees may make payments for the benefit of the incompetent

person to the legal guardian of the person or to the individual who has assumed the care and principal support of the incompetent person if there is no legal guardian for such person.

If any question or dispute arises concerning the proper person or persons to whom any payment will be made under the Fund, the Trustees may withhold payment until a binding adjudication of the question or dispute is made. The resolution must be satisfactory to the Trustees in their sole discretion. Alternatively, the Trustees may pay the benefits if they have been adequately indemnified to their satisfaction against any resulting loss.

10.9 – Circumstances that May Result in Denial or Loss of Benefits

The Trustees or their representatives are authorized to deny payment of a claim. Some of the reasons for a denial of your claim may include one or more of the following:

1. You did not contact UHS before seeking non-emergency treatment.
2. You were not eligible for benefits on the date the expenses were incurred.
3. The medical provider did not file the claim within the Plan time limits.
4. The amount of benefits denied was your responsibility to pay, such as a deductible, coinsurance, or copayment.
5. The expenses that were denied are not covered under the Plan or the expenses for which you filed the claim were not actually incurred.
6. You have already received the maximum benefit allowed for that type of expense during a stated period of time, for example, services such as Home Health or Skilled Nursing.
7. A third party was responsible for paying the expenses and you did not submit the required subrogation documents that would permit the Plan to process the claim and recover payment from the third party or the third party's insurance company (See the *Subrogation* in Section 11).
8. Another plan was primarily responsible for paying benefits for the expenses (See the *Coordination of Benefits* in Section 12).
9. The Trustees amended the Plan eligibility rules or decreased Plan benefits.
10. Information relating to the claim for benefits was knowingly misrepresented or falsified.
11. No payment was made or a reduced payment was made because some or all of the treatment or services rendered were not considered to be Medically Necessary.
12. The Plan of Benefits was terminated.
13. Benefit payments were reduced or temporarily suspended in order for the Fund to recover an overpayment of benefits previously paid to you in error.
14. The Plan rescinded your coverage, whether or not the rescission has an adverse effect on any particular benefit at the time of rescission.

The preceding list is not an all-inclusive listing of the circumstances that may result in denial or loss of benefits. It is only representative of the types of circumstances, in addition to failure to meet the continuing eligibility requirements that might cause denial of a claim for benefits. If you have any questions about a claim denial, contact the Fund Office.

10.10 – Claim Rules for Initial Healthcare Claims

Different procedures apply to determine health care claims (which include medical and prescription drug benefits), depending on the type of claim:

1. Pre-service (applicable to Hospitalization, and outpatient surgical claims);
2. Urgent care (applicable to Hospitalization, and outpatient surgical claims);
3. Concurrent care (applicable to Hospitalization, and outpatient surgical claims); or

4. Post-service (applicable to all other health care claims).

Pre-Service Claims

A pre-service claim is a claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) before you obtain medical care. The Plan requires you to obtain Pre-certification/referral of Hospitalization and outpatient surgery.

Example You request Pre-certification/referral of your out-patient surgery after your Physician recommends the surgery for the treatment of your Illness.

The Plan will not deny benefits for pre-service claims if it is not possible for you to obtain Pre-certification/referral, or the Pre-certification/referral process would jeopardize your life or health.

Timing of notice of decision on pre-service claims. You will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the Plan's control. You will be notified of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In this case, you will have 45 days from receipt of the notification to supply the additional information. If you do not provide the information within that time, your claim will be decided on the basis of the information that the Plan has and your claim may be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision on a pre-service claim and notify you of the determination.

Urgent Care Claims

An urgent care claim is any claim for medical care or treatment with respect to which the application of the periods for making pre-service claim determinations:

1. Would seriously jeopardize your life or health or your ability to regain maximum function if normal pre-service standards were applied; or
2. Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

Example You request Pre-certification/referral of a diagnostic test for appendicitis.

Whether your claim is an urgent care claim is determined by the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. In addition, any claim that a Physician with knowledge of your medical condition determines is an urgent care claim within the meaning described above, will be treated as an urgent care claim.

Timing of notice of decision on urgent care claims. If you are requesting a decision on an urgent care claim, the time deadlines are different from pre-service claims. The Plan will respond with a determination by telephone as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim by the Plan. The determination will also be confirmed in writing.

If an urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, you will be notified as soon as possible, but no later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You must provide the specified information within 48 hours, and then the decision on your claim will be made not later than 48 hours after the information is received. If the information is not provided within that time, your claim will be decided on the basis of the information that the Plan has and your claim may be denied.

Concurrent Claims

A concurrent claim is a claim that is reconsidered after it is initially approved and the reconsideration results in reduced benefits, extension of benefits, or a termination of benefits.

Timing of notice of decision on concurrent claims. There is no formal deadline to notify you of the termination or reduction of a previously approved benefit (other than by Plan amendment or termination). However, you will be notified of the decision as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated.

Example Your inpatient Hospital stay is originally Pre-certified for five days and your stay is reviewed at three days to determine if the full five days is appropriate.

If you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

Post-Service Claims

Post-service claims are any claims for health care benefits that are not pre-service claims. When you file a post-service claim, you have already received the services in your claim.

Example You have diagnostic tests performed and then make your claim for benefits afterwards.

Timing notice of decision on post-service claims. Ordinarily, the Fund Office will notify you of the decision on your claim within 30 days from the Plan’s receipt of the claim. This period may be extended one time by the Plan for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is needed because the Fund needs additional information from you, the extension notice will specify the information needed. In that case, you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Fund then has 15 days to make a decision on your claim and notify you of the determination.

10.11 – Notice of Denial of Claim or Adverse Benefit Determination

For purposes of the Plan's claims and appeals procedures, a denial of claim or an adverse benefit determination ("adverse determination") includes a rescission of coverage (which does not include failure to timely pay required premiums or contributions), a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

1. A determination of an individual's eligibility to participate in the Plan;
2. A determination that a benefit is not a covered benefit;
3. The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
4. A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

The Trustees must provide you with a notice of their initial determination about your claim within certain timeframes after they receive your claim. The notice must provide you with the following information:

1. Identification of the claim involved,
2. The specific reason or reasons for the denial of benefits or other adverse benefit determination, including the denial code and its corresponding meaning as well as any Plan standards used in denying the claim,
3. A statement that, upon request and free of charge, the diagnosis code and/or treatment code and their corresponding meanings will be provided; however, a request for this information will not be treated a s request for an internal appeal or external review,
4. A specific reference to the pertinent provisions of the Fund upon which the decision is based,
5. A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim,
6. A description of any additional material or information that is needed to process your claim and an explanation of why the information is needed,
7. An explanation of the Fund's internal review procedures and the Fund's external review process, along with time limits and information regarding how to initiate an appeal,
8. A statement that you may bring a lawsuit under ERISA following the review of your claim appeal,
9. If an internal rule, guideline, protocol or similar criteria was relied on in the process of making a decision on your claim, a copy of that internal rule, guideline, protocol or similar criteria or a statement that a copy is available to you at no cost upon request,
10. If your healthcare claim was denied on the basis of Medical Necessity, Experimental treatment or similar exclusion, a copy of the scientific or clinical judgment that was relied on in the process of making a decision on your claim or a statement that it is available to you at no cost upon request,
11. A disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with the internal claims and appeals and external review processes.

10.12 – Your Right to Appeal the Denial of a Claim

You have the right to a full and fair review if your claim for benefits is denied by the Fund or you receive any adverse benefit determination. You must make your request to the Fund Office for an appeal of a healthcare claim within 180 days after you receive notice of denial.

Your application for appeal must be in writing and it must include the specific reasons you feel denial was improper. You may submit any document you feel appropriate, as well as submitting your written statement.

10.13 – Review Process

The review process works as follows:

1. You have the right to review documents relevant to your claim. A document, record or other information is relevant if:
   a. It was relied upon by the Fund in making the decision,
   b. It was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon),
   c. It demonstrates compliance with the Fund's administrative processes for ensuring consistent decision-making, or
   d. It constitutes a statement of Plan policy regarding the denied treatment or service.
2. Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Fund on your claim, without regard to whether their advice was relied upon in deciding your claim.
3. A different person will review your claim than the one who originally denied the claim. Your appeal will be decided by the appeals committee whose members are designated by the Board of Trustees. The appeals committee will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that you may submit.
4. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Investigational or Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.
5. The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim, along with the rationale for the decision based on that information. The information and rationale will be provided as soon as possible and sufficiently in advance of the date on which the matter is to be decided in order to give you a reasonable opportunity to respond.
6. Claims and appeals will be adjudicated by the Plan impartially.

10.14 – Timing of Notice of Decision on Appeal

The appeals committee will review all of the material you submit with your claim, the action taken by the Fund Office, the additional information you have provided and the reasons you believe the claim should be paid. The appeals committee will make a decision on your appeal, or will refer the decision to the full Board of Trustees, if necessary. Your appeal will be decided and you will be notified of the decision within the following timeframe: The Appeals Committee will notify you of their decision regarding your healthcare claim as follows:

1. **Urgent Care Claims:** You will be sent a notice of a decision on review within 72 hours from the date the Plan receives your appeal.
2. **Pre-Service Claims:** You will be sent a notice of decision on review within 30 days from the date the Plan receives your appeal.
3. **Post-Service Claims:** You will be sent a notice of decision on review within 60 days from the date the Plan receives your appeal.

There is only one level of appeal.

10.15 – Notice of Decision on Appeal

The Fund will provide you with a written decision on any review of your claim. The notice of a denial of a claim on review will provide:

1. The identification of the claim involved,
2. A statement that, upon request and free of charge, the diagnosis code and/or treatment code and their corresponding meanings will be provided; however, a request for this information will not be treated as a request for an internal appeal or external review,
3. The specific reasons for the determination, including the denial code and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim,
4. A reference to the specific Plan provisions on which the determination is based,
5. A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge,
6. A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review,
7. An explanation of the Plan's appeal procedures and the external review process, along with any time limits and information regarding how to initiate the next level of review,
8. If an internal rule, guideline or protocol was relied upon by the Fund, upon your request, you will receive either a copy of the rule or a statement that it is available upon request at no charge,
9. If the determination was based on medical necessity or because the treatment was Experimental or Investigational or other similar exclusion, upon your request, the Fund will provide you with an explanation of the scientific or clinical judgment for the determination applying the terms of the Fund to your claim or a statement that it is available upon request at no charge, and
10. Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

This concludes the appeal process under the Plan. The Plan does not offer a voluntary appeal process.

10.16 – Outline of Timeframes for the Claims and Appeals Process

Overview of Claims and Appeals Timeframes				
	Urgent	**Concurrent**	**Pre-Service**	**Post-Service**
Plan must make **Initial Claim Benefit Determination** as soon as possible, but no later than:	72 hours – 24 hours as of May 1, 2012	Before the benefit is reduced or treatment terminated	15 days	30 days
Extension permitted during initial benefit determination?	No[1]	No	Yes, one 15-day extension	Yes, one 15-day extension
Appeal must be submitted to the Plan by the claimant within:	180 days	180 days	180 days	180 days
Plan must make **Appeal Claim Benefit Determination** as soon as possible, but no later than:	72 hours	Before the benefit is reduced or treatment terminated	30 days	60 days
Extension permitted during appeal review?	No	No	No	No

1. No formal extension is provided for urgent care claims, but regulations allow that if a claimant files insufficient information, the claimant will be allowed up to 48 hours to provide the information.

10.17 – Exhaustion of Plan Remedies

You must exhaust all of the claims and appeals procedures of the Plan before you bring any action in court or administrative action for benefits. If the Plan fails to comply with its claim and appeal procedures, you will be deemed to have exhausted the procedures. After you have exhausted all of the procedures in this section and if you are dissatisfied with the written decision of the Board of Trustees on appeal, you may request an external review of your claim or institute legal action, including actions or proceedings before administrative agencies. All legal actions, including actions or proceedings before administrative agencies, must be brought within three years from the date the claim was submitted for payment under the terms of the plan.

10.18 – Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claims adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such has decisions related to hiring, compensation, promotion, termination) or retention will not be made on the basis of whether that person is likely to support a denial of benefits.

10.19 – Release of Information

Subject to the privacy requirements noted in Section 14, when you file a claim for benefits, you are required to authorize any doctor, Hospital, Employer, government agency or any other person, corporation or organization to release to the Trustees information that may be required to determine your claim.

10.20 – Examinations

The Trustees have the right to have a Doctor examine you in connection with your claim for benefits and to ask for an autopsy in the case of a death. They also have the right to examine any and all Hospital or medical records relating to a claim.

10.21 – Process for External Review of Claims

This External Review process is intended to comply with the ACA external review requirements.

If your appeal of a claim is denied based upon medical necessity, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

NOTE that if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan, external review is not available.

10.22 – External Review of Standard Claims

Your request for external review of a standard (not urgent) claim must be made, in writing, within four (4) months of the date that you receive notice of the denial of your claim appeal or adverse benefit determination on appeal of your claim. For convenience, these determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

Because the Plan's internal review and appeals process generally must be exhausted before external review is available, in the normal course, external review of standard claims will only be available for an Adverse Determination.

10.23 – Preliminary Review

1. Within five (5) business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:

   (a) You were covered under the Plan at the time the health care item or service was provided;
   (b) The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;
   (c) You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances); and
   (d) You have provided all of the information and forms required to process an external review.

2. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your application meets the threshold requirements for external review. If applicable, this notification will inform you:

   (a) If your request is complete and eligible for external review; or
   (b) If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
   (c) If your request is not complete, the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

10.24 – Review by Independent Review Organization (IRO)

If the request is complete and eligible, the Plan will assign the request to an IRO. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.

Once the claim is assigned to an IRO, the following procedure will apply:

1. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).
2. Within five (5) business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its Adverse Determination.
3. If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination; it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
4. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's

requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

5. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.
6. The assigned IRO's decision notice will contain:

    (a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
    (b) The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
    (c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
    (d) A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    (e) A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;
    (f) A statement that judicial review may be available to you; and
    (g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the ACA to assist with external review processes.

10.25 – Expedited External Review of Claims

You may request an expedited external review if:

1. You receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
2. You receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or,
3. You receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

10.26 – Preliminary Review

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above.

10.27 – Review by Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, described above. In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

10.28 – After External Review

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

10.29 – Free Choice of Doctor

The Plan will not interfere with your doctor-patient relationship and you may maintain your relationship with the doctor of your choice. When you use the services of a provider who participates in the HMO/UHS Network, your share of the cost for those services will be discounted. If you use the services of an out-of-network provider, your expenses are not covered.

Section 11 – Subrogation and Reimbursement

You are required to notify the Plan within ten days of any accident or injury for which someone else may be liable. Further, in order to protect the Plan's rights, you or your attorney must notify the Plan within ten days of the start of any action or lawsuit arising out of the accident, and within ten days of the conclusion of any settlement, judgment or payment relating to the accident in any action or lawsuit related to your illness or injury.

If you receive any benefit payments from the Plan for an injury or illness and you recover, *any* amount from *any* third party or parties in connection with such injury or illness, you must reimburse the Plan from that recovery the total amount of all benefit payments the Plan made or will make on your behalf in connection with such injury or illness.

In addition, if you receive any benefit payments from the Plan for any injury or illness, the Plan is subrogated to all rights of recovery available to you arising out of any claim, demand, cause of action or right of recovery that has accrued, may accrue or that is asserted in connection with such injury or illness, to the extent of any and all related benefit payments made or to be made by the Plan on your behalf. This means that the Plan has an independent right to bring an action in connection with such injury or illness in your name. The Plan also has a right to intervene in any such action brought by you, including any action against an insurance carrier under any uninsured or under-insured motor vehicle policy.

The Plan's rights of reimbursement and subrogation apply regardless of the terms of the claim, demand, right of recovery, cause of action, judgment, award, settlement, compromise, insurance or order, regardless of whether the third party is found responsible or liable for the injury or illness, and regardless of whether you actually obtain the full amount of such judgment, award, settlement, compromise, insurance or order. The Plan's rights of reimbursement and subrogation provide the Plan with first priority to any and all recovery in connection with the injury and illness, whether such recovery is full or partial and no matter how such recovery is characterized, why or by whom it is paid, or the type of expense for which it is specified. Such recovery includes amounts payable under your own uninsured motorist insurance, under-insured motorist insurance, or any medical pay or no-fault benefit payable. The "make-whole" doctrine does not apply to the Plan's right of reimbursement and subrogation. The Plan's rights of reimbursement and subrogation are for the *full* amount of *all* related benefits payments; this amount is not offset by legal costs, attorneys' fees or other expenses incurred by you in obtaining recovery. The Plan shall have a lien on any amount received by you or your representative (including an attorney) that is due to the Plan under this Section, and any such amount shall be deemed to be held in trust by you for the benefit of the Plan until paid to the Plan.

Consistent with the Plan's rights set forth in this section, if you submit claims for or receives any benefit payments from the Plan for an injury or illness that may give rise to any claim against any third-party, you will be required to execute a "Subrogation, Assignment of Rights, and Reimbursement Agreement" affirming the Plan's rights of reimbursement and subrogation with respect to such benefit payments and claims. This agreement must also be executed by your attorney, if applicable.

Benefits will not be paid unless you sign a Subrogation Agreement. If you do not sign a Subrogation Agreement the claim will be denied and you will need to follow the Claims and Appeals Procedures outlined in Section 10.16.

Further, the Plan excludes coverage for any charges for any medical or other treatment, service or supply to the extent that the cost of the professional care or hospitalization may be recoverable by or on behalf of you in any action at law, any judgment, compromise or settlement of any claims against any party, or any

other payment you or your attorney may receive as a result of the accident or injury, no matter how these amounts are characterized or who pays these amounts, as provided in this section.

Under this provision, you are obligated to take all necessary action and cooperate fully with the Plan in its exercise of its rights of reimbursement and subrogation, including notifying the Plan of the status of any claim or legal action asserted against any party or insurance carrier and of your receipt of any recovery. You cannot assign any rights you may have to recover against another party. You also must do nothing to impair or prejudice the Plan's rights. For example, if you choose not to pursue the liability of a third party, you may not waive any rights covering any conditions under which any recovery could be received. If you are asked to do so, you must contact the Fund Office immediately. Where you choose not to pursue the liability of a third party, the acceptance of benefits from the Plan authorizes the Plan to litigate or settle your claims against the third party. If the Plan takes legal action to recover what it has paid, the acceptance of benefits obligates you (and your attorney if you have one) to cooperate with the Plan in seeking its recovery, and in providing relevant information with respect to the accident.

You must also notify the Plan before accepting any payment prior to the initiation of a lawsuit. If you do not, and you accept payment that is less than the full amount of the benefits that the Plan has advanced you, you will still be required to repay the Plan, in full, for any benefits it has paid. The Plan may withhold benefits if you waive any of the Plan's rights to recovery or fails to cooperate with the Plan in any respect regarding the Plan's subrogation rights.

If you refuse to reimburse the Plan from any recovery or refuse to cooperate with the Plan regarding its subrogation or reimbursement rights, the Plan has the right to recover the full amount of all benefits paid by methods that include, but are not necessarily limited to, offsetting the amounts paid against your future benefit payments under the Plan. "Non-cooperation" includes the failure of any party to execute a Subrogation, Assignment of Rights, and Reimbursement Agreement and the failure of any party to respond to the Plan's inquiries concerning the status of any claim or any other inquiry relating to the Plan's rights of reimbursement and subrogation.

This reimbursement and subrogation program is a service to you. It provides for the early payment of benefits and also saves the Plan money (which saves you money too) by making sure that the responsible party pays for your injuries.

Section 12 – Coordination of Benefits

This coordination of benefits provision is referred to as "COB." If you are covered by this Plan as well as by another plan that provides group health benefits, benefits will be coordinated between the two plans.

12.1 – General COB Information

1. Benefits are coordinated on all of your healthcare claims. COB applies only to health care benefits.
2. The Fund Office may release or receive necessary information about your claim to or from other sources, subject to the privacy rules. You must furnish the Fund Office with any information needed to process your claim.
3. Benefits are paid under COB only for allowable expenses, which are expenses that are eligible to be considered for reimbursement.
4. You must file a claim for any benefits you are entitled to from any other health insurance plans. Your Plan payments will be calculated as though you have received benefits you are entitled to from the other health plans. For example, if you are eligible for Medicare, the Plan will coordinate with both Parts A and B even if you are not enrolled for both parts.
5. Benefits are coordinated with other group plans, including group Blue Cross Blue Shield and blanket insurance plans, but not with state Medicaid programs. Benefits are also coordinated with Medicare, as noted in item 4 above. If you are covered under another plan, you can contact the Fund Office to find out whether that plan fits the definition of a group plan.

12.2 – Order of Benefit Payments

When you are covered under different group health plans and you have a claim, you should file the claim with each plan.

The plan that must pay its normal benefits on the claim first is the primary plan. The plan that makes payments based on the amount that is not paid by the primary plan is the secondary plan. This way, you not only receive the normal payments from the primary plan, but you may get additional payments from the secondary plan that can provide a reimbursement up to, but not to exceed, 100% of allowable expenses.

The order of benefit payments is determined as follows:

1. If you are covered under another group plan that does not have COB, the other plan is primary and this Plan is secondary.
2. When the other plan does have COB, the plan covering the person for whom the claim is filed as an employee is primary, and the plan covering the person for whom the claim is filed other than as an employee is secondary.
3. If a claimant whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the following provisions apply:

    a. The plan that covers the claimant as an employee, retiree, member or subscriber pays first and the plan providing continuation coverage to that same claimant pays second,
    b. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If these rules for the order of benefit payments still do not clearly show which plan should pay first, the plan that has covered the person for the longest period of time will pay first. The plan that has covered the person for the next longest period of time will pay second, and so on.

12.3 – Coordination of Benefits with Medicare

For Medicare Eligible Employees under Age 65

If you are under age 65 and are eligible for Medicare under the Medicare disability rules, or if you are an End Stage Renal Disease beneficiary, this Plan may be required by law to pay primary benefits for certain periods of time. Contact the Fund Office to see if this rule applies.

For Employees Continuing to Work after Age 65

If you continue to work for a contributing Employer who has 20 or more employees after you become age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the continuing eligibility rules. This Plan will be your primary provider of health care benefits. Medicare will pay secondary benefits only for expenses it covers that are not paid by the Plan.

You can decline coverage under this Plan. If you do, Medicare will be your only health care coverage. If you prefer Medicare as your health care coverage when you are age 65, contact the Fund Office. Unless you make such a choice, this Plan will continue to pay primary benefits for you as long as you stay eligible for the benefits of this Plan.

Enrollment in Medicare

You are responsible for enrolling in Medicare Part A and Part B. At present, there is no cost to you for Part A, which provides Hospital benefits. Part B covers such items as Doctors' services and nurses' services. The government makes a monthly charge for Part B.

You are also responsible for enrolling in Medicare Part D Prescription Drug Coverage. The Plan has determined that its prescription drug coverage does not pay as much as standard Medicare Part D coverage, and is not creditable coverage. Therefore, if you do not have any other prescription drug coverage that pays as much as Medicare Part D, you should enroll in Medicare Part D Prescription Drug Coverage as soon as you are eligible for it. This will prevent you from having to pay a penalty in the form of higher Medicare premiums for Part D coverage if you decide to enroll later.

Late Enrollment in Medicare Part B

If you do not continue to work after age 65 and do not enroll in Part B within certain time limits, there is a penalty. You must pay a higher amount for Part B when you do enroll. However, if you continue to work after age 65 and stay covered under the Plan, there is no late enrollment penalty if you enroll within certain time limits after you stop working.

If you want information about Medicare enrollment, contact your local Social Security office at least 30 days before your 65th birthday, if possible.

Late Enrollment in Medicare Part D

There is a penalty if you do not enroll in Part D within certain time limits upon becoming eligible. You must pay a higher amount for Part D when you do enroll.

Section 13 – General Information about Your Plan

Name of Plan/Fund

The name of your Plan is the SEIU Healthcare IL Home Care Health Plan. The name of the Trust Fund through which your Plan is provided is the Trust of the SEIU Healthcare Illinois Home Care & Child Care Fund.

Plan Sponsor and Plan Administrator

Your Plan is sponsored and administered by a joint labor-management Board of Trustees. The Board is divided equally between Trustees selected by the Union and by Trustees appointed by Employers who contribute to the Fund. The names and addresses of the members of the Board of' Trustees and of the Fund Office are shown on page iv. Participants and beneficiaries may receive from the Administrator, upon written request, information as to whether a particular employer or employee organization is a plan sponsor of the Plan and, if so, the sponsor's address. A complete list of the employers and employee organizations sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries.

The Trustees are assisted in the administration of the Plan by an Administrator (Third-Party Administrator) who is responsible for routine administrative duties and processing claims and benefit payments. The name and address of the Fund Administrator is on page iv.

Document Governing the Plan

This booklet serves as the Plan's Summary Plan Description and the official Plan Document governing the Plan.

Service of Legal Process

Service of legal process may be made on the Fund Administrator or on any member of the Board of Trustees (the Plan Sponsor) at the addresses shown on page iv or at the Fund Office.

Source of Financing, Plan Participation and Contributing Employers

The Fund receives Contributions from the State of Illinois. The Fund also receives self-payments from employees who wish to continue their benefits through COBRA continuation coverage.

You are entitled to participate in this Plan if you provide home care services as recognized by the State of Illinois and you meet the eligibility requirements of the Plan. You may receive from the Fund Administrator, upon written request, information as to whether a particular employer or employee organization contributes to the Plan and, if the employer or employee organization does contribute, the applicable addresses.

Examine, without charge, at the Fund Administrator's office all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report filed by the Plan, and copies of documents governing the operation of the Plan, including collective bargaining agreements and copies of the latest annual report and summary plan description. The Administrator may make a reasonable charge for the copies. You are also entitled to a copy of the summary annual report at no charge.

Type of Plan and Method of Providing Benefits

The Fund provides medical, hospital and surgical benefits to employees on a self-funded basis. When benefits are self-funded, it means they are paid directly from the Health and Welfare Fund to the employees or to a medical service provider.

Prescription drug benefits are self-funded benefits provided to Plan participants through agreements between the Trustees and UHS. You may reach UHS by using the contact information located at the front of this booklet.

Accumulation of Assets and Payment of Benefits

Contributions from the State of Illinois and employee contributions are received and held in trust by the Trustees pending the payment of benefits, insurance premiums and administrative expenses. Benefits can only be paid to the extent that assets are available in the Health Fund.

Plan Year/Fiscal Year

The Fund's financial records are maintained on a 12-month fiscal year basis beginning May 1 of each year and ending on April 30 of the following year. Your benefits and benefit limitations are calculated on a Calendar Year basis beginning January 1 of each year and ending December 31of that year.

Plan/Fund Identification Numbers

The Employer Identification Number (EIN) assigned to this Fund by the Internal Revenue Service is 26-2336180. The Plan Number (PN) assigned to the Plan of Benefits by the Trustees is 001.

Trustee Interpretation of Plan Provisions and Decisions Regarding Benefits

Under the Plan of Benefits and the terms of the Trust Agreement creating the Health Fund, the Trustees or persons acting for them, such as a claims appeal committee, have sole authority and broad discretion to make final determinations regarding any application for benefits and the interpretation of the terms of the Plan of Benefits, the Trust Agreement and any other regulations, procedures or administrative rules adopted by the Trustees. Decisions of the Trustees (or, where appropriate, decisions of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the intention of the parties to the Trust that such decision is to be granted judicial deference and be upheld unless it is determined to be arbitrary or capricious.

Amendment or Termination of the Plan

You do not have a vested right to health benefits under the Plan. All benefits under the Plan are subject to the Trustees' authority under the Trust Agreement to change them.

The Trustees have the authority to increase, decrease, change, amend or terminate benefits, eligibility rules, or other provisions of the Plan of Benefits as they may determine to be in the best interests of Plan participants and beneficiaries. The Trustees will make any amendment to the Plan or termination of the Plan in accordance with the terms of the Trust Agreement governing the Plan and in accordance with ERISA. The Trustees will notify you in writing of any changes to the Plan.

Effect of Termination of the Plan

This Plan of Benefits may be discontinued or terminated under certain circumstances. In such an event, benefits for Covered Expenses incurred before the termination date will be paid on behalf of eligible individuals as long as the Plan's assets are more than the Plan's liabilities. Full benefits may not be paid if the Plan's liabilities are more than its assets, and benefit payments will be limited to the funds available in the Trust Fund for such purposes. The Trustees will not be liable for the adequacy or inadequacy of such funds.

If there are any assets remaining after payment of all Plan liabilities, those assets will be used for purposes determined by the Trustees according to the Trust Agreement. However, any use of such assets will be made only for the benefit of the Plan participants who were covered under the Plan at the time of the Plan's termination.

Workers' Compensation Not Affected

This Plan is not in place of and does not affect any requirement for coverage under any Workers' Compensation Law, Employer's Liability Law, Occupational Diseases Law or similar law. Benefits that would otherwise be payable under the provisions of these laws will not be paid by the Plan merely because you fail or neglect to file a claim for benefits under the rules of these laws.

Governing Law and Legal Actions

This Plan is created and accepted in the State of Illinois. All questions pertaining to the validity and construction of the Trust Agreement or this Plan or any questions concerning the acts and transactions of the Trustees or any other manner that affects the Plan will be determined under federal law where applicable federal law exists. If there is no applicable federal law, then the laws of the State of Illinois will apply.

You may not bring any action at law or in equity or any administrative proceeding to recover a loss unless you have followed and exhausted the Plan's claim filing and appeals procedures. Unless permitted by a controlling statute, no such action may be brought more than three years from the date the claim was submitted for payment under the terms of the Plan. Any action brought by a participant relating to or arising under the Plan shall be brought and resolved only in the U.S. District Court for the Northern District of Illinois and any courts in which appeals from such court are heard, and such courts shall have personal jurisdiction over the participant named in the action.

Misrepresentation or Falsification of a Claim

If you or a medical provider or any other individual knowingly misrepresents or falsifies any information in connection with a claim, the Trustees may deny all or part of the benefits that might otherwise be due in connection with that claim. If benefits are paid on such a claim, the Plan has the right to recover all benefits paid. The Plan may reduce all future benefits until the Plan has made full recovery of the misrepresented amounts. The amount of the recovery may also include medical investigation charges, auditors' fees and attorneys' fees, as necessary.

Severability Clause

If any provision of or amendment to this Summary Plan Description and Plan Document should be determined or judged to be illegal or unlawful, such illegality will apply only to the provision of the Summary Plan Description and Plan Document involved, unless the illegality would make it impractical or impossible for the Summary Plan Description and Plan Document to function.

Exclusive Benefit Rule

The Plan is maintained for the exclusive benefit of the Plan’s participants.

Section 14 – Your Privacy Rights under the Plan

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that the Plan protect the confidentiality and security of your private health information. A complete description of your rights under HIPAA can be found in the Privacy Notice in Section 18. If you need an additional copy of the Privacy Notice, you may request it from the Fund Office.

In accordance with the privacy rules, this Plan and the Board of Trustees will not use or further disclose information that is protected by HIPAA ("protected health information"), except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan will require all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.

Under HIPAA, you have individual rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You will also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Please contact the Fund Administrator if you have questions about the privacy of your health information or if you wish to file a complaint under HIPAA.

Section 15 – Use and Disclosure of Protected Health Information

The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim),
2. Coordination of benefits,
3. Adjudication of health benefit claims (including appeals and other payment disputes),
4. Subrogation of health benefit claims,
5. Establishing employee contributions,
6. Risk adjusting amounts due based on enrollee health status and demographic characteristics,
7. Billing, collection activities and related health care data processing,
8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments,
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance),
10. Medical necessity reviews, or reviews of appropriateness of care or justification of charges,
11. Utilization review, including precertification, preauthorization, concurrent review and retrospective review,
12. Disclosure to consumer reporting agencies related to collection of premiums or reimbursement (the following protected health information may be disclosed for payment purposes: name and address, date of birth, Social Security Number, payment history, account number, and name and address of the provider and/or health Plan), and
13. Reimbursement to the Plan.

Health Care Operations include, but are not limited to, the following activities:

1. Quality Assessment,
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,
3. Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
4. Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance),
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies,
7. Business management and general administrative activities of the entity, including, but not limited to:

a. Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification,
b. Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers,
c. Resolution of internal grievances, and
d. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity.

8. Compliance with and preparation of all documents as required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500s, Summary Annual Reports, and other documents.

The Plan will use and disclose protected health information as required by law and as permitted by authorization of the participant or beneficiary. With an authorization, the Plan will disclose protected health information to related plans, workers' compensation insurers, etc. for purposes related to administration of these plans.

For purposes of this section, the joint Board of Trustees is the Plan Sponsor. The Plan will disclose protected health information to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan Document has been amended to incorporate the following provisions:

With respect to protected health information, the Plan Sponsor agrees to:

1. Not use or further disclose the information other than as permitted or required by the Plan Document or as required by law,
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information,
3. Not use or disclose the information for employment-related actions and decisions unless authorized by the individual,
4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor unless authorized by the individual,
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided, of which it becomes aware,
6. Make protected health information available to the individual in accordance with the access requirements of HIPAA,
7. Make protected health information available for amendment and incorporate any amendments to protected health information in accordance with HIPAA,
8. Make available the information required to provide an accounting of disclosures,
9. Make internal practices, books, and records relating to the use and disclosure of protected health information received from the group health Plan available to the Secretary of Health and Human Services for the purposes of determining compliance by the Plan with HIPAA, and
10. If feasible, return or destroy all protected health information received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate separation between the Plan and the Plan Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following employees or classes of employees may be given access to protected health information:

1. The Plan Administrator, and
2. Staff designated by the Plan Administrator.

The persons described in the above paragraph may only have access to and use and disclose protected health information for Plan administration functions that the Plan Sponsor performs for the Plan. If the persons described in the paragraph above do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

For purposes of complying with the HIPAA privacy rules, this Plan is a Hybrid Entity because it has both health plan and non-health plan functions. The Plan designates that its health care components that are covered by the privacy rules include only health benefits and not other plan functions or benefits.

The Plan Sponsor protects the security of electronic Protected Health Information (PHI) by:

1. Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensuring that an adequate separation between the Plan and Plan Sponsor is maintained, specific to electronic PHI, by supporting reasonable and appropriate security measures;
3. Ensuring that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect electronic PHI; and
4. Reporting to the Plan any security incident of which it becomes aware concerning electronic PHI.

The Health Information Technology for Economic and Clinical Health (HITECH) Act requires the Fund Office to provide notification to you following the discovery of a breach of your unsecured PHI. In addition, the Fund Office is also required to notify the Department of Health and Human Services (HHS) if there is a breach. Further, if the breach involved more than 500 individuals, the Act requires the Fund Office to provide notification to the media.

If your unsecured PHI is breached, the Fund Office will notify you without unreasonable delay and in no case no later than 60 calendar days after discovery of the breach. Notice will be provided by first-class mail where possible, so it is important to keep the Plan up to date with your current mailing address.

Under HIPAA, you have a statutory right to file a complaint with the Fund Office or the HHS Secretary if you believe that your privacy rights have been violated. The HITECH Act specifically provides that you also have a right to file a complaint should you feel that the Fund Office has improperly followed the breach notification process.

Section 16 – Your Rights under ERISA

As a participant in the SEIU Healthcare IL Home Care Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants are entitled to:

Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan. These include insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan. These include insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the Plan;
  - You become entitled to elect COBRA continuation coverage; or
  - Your COBRA continuation coverage ceases.

  You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA). For single copies of publications, contact the EBSA Brochure Request Line at 866-444-3272 or contact the EBSA field office nearest you.

You may also find answers to your Plan questions at the EBSA website at http://www.dol.gov/ebsa/.

Section 17 – Definitions

To avoid awkward wording in this book, the masculine personal pronouns (he, him, and his) include the feminine (she, her, and hers) wherever they are used and apply. When used in this booklet, the term "you" refers to an employee who is eligible for Plan benefits.

The following definitions are in alphabetical order. If you are looking for a term used in this booklet that is not contained in the following list, you should contact the Fund Office for a definition of the term.

ALLOWABLE CHARGE – maximum amount on which payment is base for covered health care services. This may be called "eligible expense", "payment allowance", "negotiated rate", or "allowed amount". If your provider charges more that the allowed amount, you may have to pay the difference.

For Non-PPO providers, the Allowable Charge is based on Medicare allowable rates for a service up to the amount shown in the Plan of Benefits. Services which are not routinely covered by Medicare and which are covered under the Plan will be covered up to the Reasonable and Customary Charge.

APPEAL – a request for your health insurer or plan to review a decision again.

BALANCE BILLING – when a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered expenses.

BENEFIT PLAN, PLAN, or **PLAN OF BENEFITS** – the Plan of Benefits of the SEIU Healthcare IL Home Care Health Plan as summarized in this booklet.

BOARD OF TRUSTEES – the Union and Employer Trustees, together with their successors, designated and appointed in accordance with the terms of the Trust Agreement. Trustees appointed by the Association are Employer Trustees. Trustees appointed by the Union are Union Trustees.

CALENDAR YEAR – the twelve-month period starting January 1 of any year and ending on December 31 of that year.

CHEMICAL DEPENDENCY or SUBSTANCE ABUSE TREATMENT BENEFITS – benefits that cover the treatment of chemical dependency and addictions to alcohol or drugs, or abuse of alcohol or drugs.

CHEMOTHERAPY – The use of chemical substances used to treat diseases, infections, or other medical treatment.

COINSURANCE – your share of the costs of a Covered Expense, calculated as a percent of the allowed amount.

C**ONTRIBUTIONS** – payments made to the Fund by Employers or other entities who have a written obligation to contribute to the Plan.

COPAYMENT – a fixed amount you pay for a Covered Expense, usually when you receive the service. The amount can vary by the type of covered health care service.

COVERED or **COVERED UNDER THE PLAN** – a person who is eligible to have contributions made to the Fund on his or her behalf and who is eligible to receive Plan benefits because of that person's

eligibility status. It may also refer to a person who is eligible to receive Plan benefits under COBRA or other applicable rules.

COVERED EXPENSES or **COVERED MEDICAL EXPENSES** – the Reasonable and Customary Charges incurred by an eligible individual upon the recommendation and approval of a doctor for Medically Necessary services and supplies that are required for treatment of the individual as a result of injury or illness and that are eligible to be considered for payment under this Plan.

DEDUCTIBLE – the amount you owe for health care services your plan covers before your plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.

DEPENDENT – your legal spouse and dependent children, including children who are the subject of a Qualified Medical Child Support Order (QMCSO). However, no dependents (neither your spouse nor your children) are eligible for any coverage under this Plan except as your beneficiaries where designated.

DOCTOR or **PHYSICIAN** – a legally qualified doctor, physician or surgeon, provided the individual is a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) who is licensed to practice medicine and surgery in all of its branches. To the extent that benefits are specifically provided by the Plan with respect to services provided by a practitioner whose license limits the scope of the Doctor's practice, such as a dentist (DDS) or a podiatrist (DPM), charges incurred for treatment furnished by such an individual will be payable only for services performed within the scope of such Doctor's license and only within the provisions and limitations of the Plan.

DURABLE MEDICAL EQUIPMENT (DME) – the equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, or a CPAP machine, etc.

ELIGIBLE EMPLOYEE – any person who meets the definition of an "Employee" and who has met the requirements established by the Trustees for being eligible for Plan benefits.

EMERGENCY MEDICAL CONDITION – an illness, injury, symptom or condition so serious that a person would seek care right away to avoid severe harm.

EMERGENCY MEDICAL TRANSPORTATION – ambulance services for an emergency medical condition.

EMERGENCY ROOM CARE – emergency services you get in an emergency room

EMERGENCY SERVICES – evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

EMERGENCY TREATMENT CENTER – a free-standing facility, regardless of what it is called, that is engaged primarily in providing minor emergency and episodic (occasional) medical care. A doctor, an RN and a registered x-ray technician must be in attendance at all times that the center is open. The center must maintain x-ray and laboratory equipment and a life support system. A facility located in or in conjunction with or in any way made a part of a regular hospital will not be considered an Emergency Treatment Center under this Plan.

EMPLOYEE or HOME CARE WORKER – any person for whom Contributions are required to be made to the Plan. An independent contractor may also be considered an Employee under the Plan, eligible for benefits in accordance with the Plan.

EMPLOYEE BENEFITS – the benefits provided by this Plan for you, the employee.

EMPLOYER or **CONTRIBUTING EMPLOYER** – an entity that employs Covered Employees and who has an obligation to contribute to the Fund.

EXCLUDED SERVICES – health care services that your plan doesn't pay for or cover.

EXPERIMENTAL or **INVESTIGATIVE** – services or treatments:

1. On which the consensus of expert medical opinion, based on reliable evidence (i.e. published reports and/or articles), indicates that further trials or studies are needed to determine the safety, efficiency and outcomes of such treatment or services compared to standard treatment,
2. That are not yet recognized as having proven beneficial outcomes,
3. That are still primarily confined to a research setting,
4. That are not appropriate based on:
   a. Medical circumstances, or
   b. The advanced stage of an individual's Illness, or
   c. The likelihood that the service or treatment will measurably improve the individual's illness or medical condition.

The Trustees or their designated representatives have the sole authority to determine whether a treatment, service or supply is Experimental or Investigative.

FUND, TRUST FUND – the entire Trust Estate of the Trust of the SEIU Healthcare IL Home Care & Child Care Fund as created by the Trust Agreement.

GLOBAL PERIOD – a period of time immediately prior to or after a surgical procedure in which all routine follow-up care is included in the original charge amount. Global periods vary depending on the procedure. Most global periods for minor surgical procedures are between 0-10 days (e.g. lacerations, wart removal, circumcision, etc.).

HEALTH INSURANCE – a contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

HOME HEALTH CARE – health care services a person receives at home.

HOSPICE SERVICES – services to provide comfort and support for persons in the last stages of a terminal illness and their families.

HOSPITAL – an institution that is engaged primarily in providing medical care and treatment for ill or injured individuals on an in-patient basis at the patient's expense and that fully meets the following requirements:

1. It is a hospital, a tuberculosis hospital, or a psychiatric hospital, as those terms are defined in Medicare, that is qualified to participate in Medicare and to receive payments under and in accordance with the provisions of Medicare, or

a. It provides in-patient basic diagnostic and therapeutic facilities for the medical and surgical diagnosis, treatment, and care of injured and ill individuals under the supervision of a staff of doctors licensed to practice medicine, and
b. It provides on the premises 24-hour-a-day nursing services by or under the supervision of RNs, and
c. It is operated continuously with organized facilities for operative surgery on the premises, and
d. It is not an institution that is primarily a clinic or other than incidentally, a place for rest, for the aged, or a nursing or convalescent home or similar establishment.

HOSPITAL OUTPATIENT CARE – care in a hospital that usually doesn't require an overnight stay.

HOSPITALIZATION – care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

IN-NETWORK COINSURANCE – the percent you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

MEDICALLY NECESSARY – only those services, treatments or supplies provided by a hospital, by a doctor, or Other Qualified Provider of medical services and supplies, that are required, in the judgment of the Trustees, based on the opinion of a qualified medical professional, to identify or treat your injury or illness and that:

1. Are consistent with the symptoms or diagnosis and treatment of your condition, illness, disease, ailment, or injury,
2. Meet acceptable standards of good medical practice,
3. Are not solely for your convenience or the convenience of the doctor or hospital, and
4. Are the most appropriate that can be safely provided under the circumstances.

MEDICARE - The Health Insurance for the Aged and Disabled under Title XVIII of the Social Security Act as such Act was amended by the Social Security Amendments of 1965 (Public Law 89-97) and as such program is currently constituted and as it may later be amended.

MENTAL HEALTH BENEFITS – benefits that cover the treatment of mental and nervous disorders, which include conditions of neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, regardless of any physiological or traumatic cause or origin of such condition.

MIDLEVEL PROVIDERS – health care providers who have received less training and have a more restricted scope of practice than physicians and other health professionals, but who do have a formal certificate and accreditation through the licensing bodies in their jurisdictions.

NETWORK – the facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care.

NON-NETWORK PROVIDER – a provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-network provider.

OPTHALMOLOGIST – a doctor who treats eye diseases such as glaucoma, high blood pressure and diabetes.

OTHER QUALIFIED PROVIDER – a physician, behavioral health practitioner, chiropractor, nurse, nurse practitioner, nurse midwife, physician assistant, occupational, physical, respiratory or speech therapist, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

OUT-OF-NETWORK CO-INSURANCE – the percent you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs more than in-network co-insurance.

OUT-OF-POCKET LIMIT – the most you pay during a calendar year before your health insurance or plan begins to pay 100% of the allowed amount.

OUT-PATIENT SURGICAL CENTER – for the purposes of this Plan, a facility that meets all of the following criteria:

1. It is a health care institution or facility, either freestanding or as part of a hospital, that is equipped and operated with permanent facilities for the primary purpose of performing surgical procedures on patients on an out-patient basis and to which a patient is admitted and from which a patient is discharged within a twenty-four-hour period,
2. It must be regularly licensed as an out-patient surgical facility by the governmental or other agency that has the responsibility for such licensing,
3. It must keep medical records on all patients,
4. It must be supervised by a full-time MD or DO and it must employ a licensed anesthesiologist and an RN,
5. It must have at least two operating rooms and a recovery room and be equipped to take care of emergencies,
6. It must have an agreement with a local hospital to take patients who develop problems, and
7. Any doctor performing surgery on the premises must also be allowed to perform surgery in a local hospital.

An office maintained by a doctor for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, is not considered an Out-Patient Surgical Center.

PLAN – a benefit your employer, union or other group sponsor provides to you to pay for your health care services.

PREMIUM – the amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

PRESCRIPTION DRUG COVERAGE – health insurance or plan that helps pay for prescription drugs and medications.

PRESCRIPTION DRUGS – drugs and medications that by law require a prescription.

PSYCHIATRIST – an M.D who specializes in the prevention, diagnosis and treatment of mental illness and can prescribe medication.

PSYCHOLOGIST – a professional specializing in diagnosing and treating diseases of the brain, emotional disturbance, and behavior problems. Psychologists can only use talk therapy as treatment; you must see a psychiatrist or other medical doctor to be treated with medication.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) – a state court order issued in a domestic relations proceeding that provides for the support of dependent children, including covered offered by the Plan for Dependents. The Plan will provide Dependent benefits in accordance with the terms of the QMSCO to the extent benefits are provided to Dependents under the Plan, as outlined in the Plan of Benefits. The Plan has established procedures for determining if the order it receives constitutes a QMCSO and for processing such orders. If you need a copy of the Plan's QMCSO procedures, you may contact the Fund Office and they will provide you with a copy, free of charge.

QUALIFYING HOURS – those hours which count towards your eligibility for benefits under the Plan and include only those hours for which your employer bills and is reimbursed by the Illinois Department on Aging (DOA) or Illinois Department of Human Services- Division of Rehabilitation Services (DRS), or other hours specifically determined by the Fund's Trustees to count toward eligibility.

RECONSTRUCTIVE SURGERY – surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents injuries or medical conditions.

REHABILITATION SERVICES – health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupation therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

SELF-PAYMENTS – payments you make to the Fund to maintain eligibility for benefits (e.g. COBRA).

SKILLED NURSING CARE – services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

SPECIALIST – a physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of the health care.

SUMMARY PLAN DESCRIPTION – this booklet. This booklet provides you with a summary of the Plan of Benefits. The booklet also serves as the official Plan Document.

TOTAL DISABILITY, TOTALLY DISABLED – your complete inability to perform any and every duty pertaining to your occupation or employment as a result of non-occupational bodily injury or illness.

TRUST AGREEMENT – the Restated Agreement and Declaration of Trust, including all amendments, and/or modifications, establishing the Trust of the SEIU Healthcare IL Home Care & Child Care Fund.

TRUSTEES, BOARD OF TRUSTEES – the Union and Employer Trustees, together with their successors, designated and appointed in accordance with the terms of the Trust Agreement.

UNION – the Service Employees International Union (SEIU) Healthcare IL and IN.

USUAL AND CUSTOMARY AND REASONABLE – amount which, at the Plan Administrator's sole discretion and if applicable, will not exceed the maximum allowable amount applicable to the treatment,

supplies, and/or services, which typically is 125% of the current Medicare allowable fee for the appropriate area.

Section 18 – A Brief Explanation of the Attached Privacy Notice

Federal regulations require your health plan to follow new procedures to protect your privacy – specifically, the privacy of your health information within the control of the Plan.

When you read the attached notice that the Plan is required to send to you under the new rules, please pay close attention to the following points:

You must complete a Privacy Request form found on the next page and send it to the Fund Office if you do not want the Fund Office to discuss your protected health information with your spouse.

- The rules allow the Plan to use and disclose your health information:
  - To pay claims; and
  - To administer the Plan.
- Unless you object, the rules allow the Plan to communicate orally about your claims with:
  - Your spouse if you are married

If you *do not* wish to have the Fund Office discuss your protected health information with your spouse, you must complete a Privacy Request form found on the next page and send it to the Fund Office. The form will take effect when the Fund Office receives it.

PRIVACY REQUEST

To: Ms. Elsa A. Galingan
Privacy Official
Local No. 4 SEIU Health and Welfare Fund
2229 S. Halsted, Suite 122
Chicago, Illinois 60608

The Fund Office does not have my permission to discuss my protected health information with:

☐ My Spouse

Name: ____________________________Social Security Number: __________________

Signature: ____Date: ____________________

PRIVACY REQUEST

To: Ms. Elsa A. Galingan
Privacy Official
Local No. 4 SEIU Health and Welfare Fund
2229 S. Halsted, Suite 122
Chicago, Illinois 60608

The Fund Office does not have my permission to discuss my protected health information with:

☐ My Spouse

Name: ____________________________Social Security Number: __________________

Signature: ____Date: ____________________

PRIVACY REQUEST

To: Ms. Elsa A. Galingan
Privacy Official
Local No. 4 SEIU Health and Welfare Fund
2229 S. Halsted, Suite 122
Chicago, Illinois 60608

The Fund Office does not have my permission to discuss my protected health information with:

☐ My Spouse

Name: ____________________________Social Security Number: __________________

Signature: ____Date: ___________________

Privacy Notice

Section 1: Purpose of This Notice and Effective Date

This Notice Describes:

1. How medical information about you may be used and disclosed; and
2. How you may obtain access to this information.

Please review this information carefully.

Effective date. The effective date of this updated notice is September 23, 2013.

This Notice is required by law. The Local No. 4 SEIU Health and Welfare Fund (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI),
2. Your rights to privacy with respect to your PHI,
3. The Plan's duties with respect to your PHI,
4. Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services, and
5. The person or office you should contact for further information about the Plan's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Plan in oral, written or electronic form.

PHI refers to your health information held by the Plan.

When the Plan May Disclose Your PHI

Under the law, the Plan may disclose your PHI without your consent or authorization or the opportunity to object in the following cases:

- ***At your request.*** If you request it, the Plan is required to give you access to certain PHI in order to allow you to inspect it and/or copy it.
- ***To the Plan's Trustees.*** The Plan will disclose PHI to the Plan Sponsor for purposes related to treatment, payment and health care operations. The Plan Sponsor is the Board of Trustees of Local No. 4 SEIU Health and Welfare Fund. The Plan Sponsor has amended its Plan Documents to protect your PHI as required by Federal law. For example, the Plan may disclose

information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.

- ***As required by an agency of the government.*** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.

- ***For treatment, payment or health care operations.*** The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object in order to carry out:

  - Treatment,
  - Payment, or
  - Health care operations.

The Plan does not need your consent or authorization to release your PHI when:

- You request it,
- A government agency requires it,
- Trustees are required to review it, or
- The Plan uses it for treatment, payment or health care operations.

Definitions of Treatment, Payment or Health Care Operations	
Treatment is health care.	Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. ***For example:*** The Plan discloses to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.
Payment is paying claims for health care and related activities.	Payment includes but is not limited to making coverage determinations and payment. These actions include billing, claims management, subrogation, Plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization. ***For example:*** The Plan tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.
HealthCare Operations keep the Plan operating soundly.	Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. ***For example:*** The Plan uses information about your medical claims to refer you to a disease management program, to project future benefit costs or to audit the accuracy of its claims processing functions.

When the Disclosure of Your PHI Requires Your Written Authorization

The Plan must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI For Which Consent, Authorization or Opportunity to Object Is Not Required

The Plan is allowed under federal law to use and disclose your PHI without your consent, authorization or request under the following circumstances:

1. ***When required by law.***

2. ***Public health purposes.*** To an authorized public health official if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

In general, the Plan does not need your consent to release your PHI if required by law or for public health and safety purposes.

3. ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

4. ***Oversight activities.*** To a public health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).

5. ***Legal proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.

6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).

7. ***Law enforcement emergency purposes.*** For certain law enforcement purposes, including:

   a. Identifying or locating a suspect, fugitive, material witness or missing person, and

   b. Disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.

8. ***Determining cause of death and organ donation.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. The Plan may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.

10. ***Research.*** For research, subject to certain conditions.

11. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. ***Workers' compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

Other Uses or Disclosures

The Plan may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Plan may disclose protected health information to the sponsor of the plan for reviewing your appeal of a benefit claims or for other reasons regarding the administration of this Plan. The "plan sponsor" of this Plan is the Board of Trustees of the Local No. 4 SEIU Health and Welfare Fund.

Section 3: Your Individual Privacy Rights

The Plan will accommodate an individual's reasonable request to receive communications of PHI **by alternative means or at alternative locations** where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI or to receive communications of PHI by alternative means or at alternative locations. Make such requests to:

Ms. Elsa A. Galingan
Privacy Official
Local No. 4 SEIU Health and Welfare Fund
2229 S. Halsted, Suite 122
Chicago, Illinois 60608

> ***Protected Health Information (PHI):*** includes all individually identifiable health information transmitted or maintained by the Plan, regardless of the form of the PHI.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

> ***Designated Record Set:*** includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

The Plan must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following official:

Ms. Elsa A. Galingan
Privacy Official
Local No. 4 SEIU Health and Welfare Fund
2229 S. Halsted, Suite 122
Chicago, Illinois 60608

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to Plan and the Secretary of the U.S. Department of Health and Human Services.

You Have the Right to Amend Your PHI

You have the right to make a written request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

> If you disagree with the record of your PHI, you may amend it.
>
> If the Plan denies your request to amend your PHI, you still have the right to have your written statement disagreeing with that denial included in your PHI.
>
> Forms are available for these purposes.

You should make your written request to amend PHI to the following official:

Ms. Elsa A. Galingan
Privacy Official
Local No. 4 SEIU Health and Welfare Fund
2229 S. Halsted, Suite 122
Chicago, Illinois 60608

You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI. The Plan does not have to provide you with an accounting of disclosures related to treatment, payment or health care operations or disclosures made to you or authorized by you in writing.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this notice, contact the following official:

Ms. Elsa A. Galingan
Privacy Official
Local No. 4 SEIU Health and Welfare Fund
2229 S. Halsted, Suite 122
Chicago, Illinois 60608

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

You may designate a personal representative by completing a form that is available from the Fund Office.

The Plan will recognize certain individuals as personal representatives without you having to complete an Appointment of Personal Representative form. For example, the Plan will automatically consider a spouse to be the personal representative of an individual covered by the Plan. A spouse may act on an individual's behalf, including requesting access to their PHI.

Section 4: The Plan's Duties

Maintaining Your Privacy

This notice is written to inform you of the Plan's obligation to maintain the privacy of your PHI.

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This updated notice is effective beginning on September 23, 2013 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply

the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

The Plan must limit its uses and disclosures of PHI or requests for PHI to the ***minimum necessary*** amount to accomplish its purposes.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Final HIPAA Rule

Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act generally referred to as the HIPAA Final Rule, are as follows:

- You have the right to be notified of a data breach relating to your unsecured health information.
- You have the right to ask for a copy of your electronic medical record in an electronic form provided the information already exists in that form.
- To the extent the Plan performs any underwriting, the Plan cannot disclose or use any genetic information for such purposes.
- The Plan may not use your PHI for marketing purposes or sell such information without your written authorization.

Section 6: Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the following official:

> You have the right to file a complaint if you feel your privacy rights have been violated.
>
> The Plan may not retaliate against you for filing a complaint.

Ms. Elsa A. Galingan
Privacy Official
Local No. 4 SEIU Health and Welfare Fund
2229 S. Halsted, Suite 122
Chicago, Illinois 60608

You may also file a complaint with:

Secretary of the U.S. Department of Health and Human Services

Hubert H. Humphrey Building
200 Independence Avenue S.W.
Washington, D.C. 20201

The Plan will not retaliate against you for filing a complaint.

Section 7: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following official at the Fund Office:

Ms. Elsa A. Galingan
Privacy Official
Local No. 4 SEIU Health and Welfare Fund
2229 S. Halsted, Suite 122
Chicago, Illinois 60608

Section 8: Conclusion

PHI use and disclosure by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

Section 19 – Local No. 4 SEIU Health and Welfare Fund
Appointment of Personal Representative

I, ____ [Name of Participant or Beneficiary]

Mailing address: ____

Phone: (________) ____

hereby designate: ________________________ [Name of Authorized Representative]

Mailing address: ____

Phone: (________) ____

Relationship to Participant or Beneficiary _____________________ to act on my behalf

I authorize my Personal Representative to act for me in receiving any information that is (or would be) provided to me as a participant/beneficiary of the plan, including but not limited to, any information that relates to my claim for coverage or benefits under the Plan and any individual rights that I have regarding my protected health information under HIPAA.

Or alternatively, --- I authorize my Personal Representative to act for me in receiving the following protected health information to conduct the following functions on my behalf:

____

____

I understand that this designation is subject to approval by the Plan. I also understand that, once approved, this designation will remain in effect unless I revoke it. I understand that I have the right to revoke this designation at any time by submitting a signed statement to that effect to the Plan Office.

I certify that I have reviewed the Plan's Policy for Recognition of Personal Representative.

____ ________________________________

Participant or Beneficiaries' Signature Date

____ ________________________________

Authorized Representative's Signature Date

NOTES