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

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

Effective on or about January 1, 2022, the 1199SEIU National Benefit Fund for Home Care Employees (the "Fund") SBC and SPD and/or Plan shall be amended to comply with certain provisions of the No Surprises Act of the 2021 Consolidated Appropriations Act as follows:

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

II. Any reference to a time limit for visiting the Emergency Department following a medical accident, injury, or onset of a serious illness shall be omitted.

III. The following notice shall be added to the SPD: **"You are protected from balance billing by a medical provider if you have an Emergency Condition and receive Emergency Services from a Non-Participating provider or facility. You are also protected from balance billing for certain services rendered by a Non-Participating Provider while receiving care at a Participating hospital or ambulatory surgical center, including emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed."**

IV. The following bolded underlined language shall be added to, and the strikethrough language shall be omitted from, the SPD:

PREFACE (p. 2)
The Fund believes it is a "Grandfathered Health Plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted in 2010. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, **the requirement to cover certain preventive services**, ~~for example, the requirement for an external review process for claims appeals~~.

OVERVIEW OF YOUR BENEFITS (p. 14)
EMERGENCY DEPARTMENT VISITS

• This benefit is for the hospital's charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered, depending on eligibility, as described in Section II.H of this SPD.
• Use of the Emergency Department must be for a **legitimate** medical Emergency **Condition** ~~within 72 hours of an accident, injury, or the onset of a sudden and serious illness~~.

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

SECTION II. B USING YOUR BENEFITS WISELY (p. 59-60)
In order to avoid out-of-pocket costs, you must comply with the following:
1199SEIU CAREREVIEW PROGRAM
If you **or a member of your family** need**s** to go to the hospital or require**s** ambulatory or outpatient surgery, you must contact the 1199SEIU CareReview Program to:
• To pre-certify your hospital stay within **two business days** of an Emergency **Services** admission;
EMERGENCY DEPARTMENTS ARE FOR EMERGENCIES
A hospital Emergency Department should be used only in the case of a legitimate medical Emergency **Condition**. **For Emergency Services to be covered by the Plan** ~~To be considered an Emergency~~, your Emergency Department visit must meet the definition of Emergency **Condition** (see Section IX) ~~and must occur within 72 hours of an accident, injury, or the onset of a sudden and serious illness~~.
The Plan Administrator reserves the sole discretion to determine whether a legitimate Emergency **Condition** existed, and benefits will only be provided in the event such a determination has been made.

SECTION II. C HOSPITAL CARE AND HOSPICE CARE
WHEN YOU NEED TO GO TO THE HOSPITAL (p. 63)
If you require services from a surgeon or an anesthesiologist, check to make sure they are a

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

SECTION II. D EMERGENCY DEPARTMENT VISITS (p. 67)
BENEFIT BRIEF
Emergency Department Visits
This benefit is for the hospital's charge for the use of its facility only. Coverage for services rendered by doctors, labs, radiologists or other services that are billed separately by these providers may be covered, as described in Section II.H.
• ~~Use of the Emergency Department must be within 72 hours of an accident, injury, or the onset of a sudden and serious illness~~

***
The Benefit Fund has negotiated Emergency Department rates with many hospitals in the **metropolitan** New York area. If you go to the Emergency Department of a Participating Hospital, you will have no out-of-pocket cost for the hospital's charge for the use of its facility.

EMERGENCY DEPARTMENTS ARE FOR EMERGENCIES
A hospital Emergency Department should be used only in the case of a legitimate medical Emergency **Condition**. **For Emergency Services to be covered by the Plan**, ~~To be considered an Emergency~~ your Emergency Department visit must meet the definition of Emergency **Condition** (see Section IX) ~~and must occur within 72 hours of an accident, injury, or the onset of a sudden and serious illness~~.
When you go to the Emergency Department, you must: 1. Show your 1199SEIU Health Benefits ID card. The Benefit Fund will pay the hospital directly. 2. Call the 1199SEIU CareReview Program at (800) 227-9360 within two business days if you are admitted. If you go to the Emergency Department in a hospital with which the Benefit Fund does not have an Emergency Department contract, you may incur out-of-pocket costs.
If you have any questions about a bill for Emergency Department treatment, call the Benefit Fund's Member Services Department at (646) 473-9200.

SECTION II. F SURGERY AND ANESTHESIA (p.71)
SURGERY
You are covered for surgery when performed: • By a licensed physician or surgeon; and • In an accredited hospital, ambulatory surgical center or office-based surgery suite. If you need to go to the hospital, **you must** call 1199SEIU CareReview at (800) 227-9360 before your hospital stay **for non-Emergency care**. See Section II.B for more information.

YOUR BENEFIT IS DETERMINED BY THE TYPE OF SURGERY YOU NEED
The Benefit Fund can only pay up to a certain amount for each type of surgical procedure. Your benefit is the Fund's allowance for your type of surgery, or the doctor's charge, whichever is less.
If you need two or more related operations at the same time, the total Fund allowance for all your procedures will be determined based upon the Fund's allowance and its claims processing rules for multiple or related operations.
If you use a Non-participating Doctor, you could face high out-of-pocket costs. Before you receive services from a Non-participating Provider, you should ask the provider to find out the total Benefit Fund allowance for the planned service by calling (646) 473-7160, and to notify you of what your out-of-pocket expenses will be.

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

SECTION VII. A GETTING YOUR HEALTHCARE BENEFITS
Urgent Care Requests (p.111)
Certain Pre-service Care or Concurrent Care Requests involve situations that have to be decided quickly because using the usual time frames for decision-making could: (i) seriously jeopardize the life or health of the patient; or (ii) in the opinion of the treating physician with knowledge of the medical condition, subject the patient to severe pain that cannot be adequately managed without the care or treatment being requested. These Requests for Benefits are treated as Urgent Care Requests and include those situations commonly treated as **Emergency Conditions** ~~Emergencies~~.

SECTION VII. B YOUR RIGHTS ARE PROTECTED – APPEAL**S** PROCEDURE (p. 170)
If your claim or your Request for Benefits is denied, the Plan provides for two levels of appeal, **and, in certain instances, an external review appeal,** as described in this section.

3RD STEP — INDEPENDENT EXTERNAL REVIEW

Independent External Review is available only to determine whether the plan's adverse determination was correct with respect to the following types of claims: (a) medical bills for Emergency Services received from Non-Participating Providers, (b)

medical bills for a Non-Participating Provider's treatment at a Participating facility, and (c) air ambulance services by Non-Participating Providers. If this organization decides to overturn our decision, we will provide coverage or payment for your healthcare item or service.

SECTION IX –DEFINITIONS – (p. 136)

Emergency Condition

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

"Emergency Services"

Services provided in connection with an "Emergency Condition," including screening and examination services provided to a member **or their eligible dependent** who requests medical treatment to determine if an Emergency Condition exists**, as well as such further medical examination and treatment as may be required for stabilization. Emergency care may also include post-stabilization services provided in connection with the Emergency Services visit. Emergency care includes healthcare procedures, treatments or services, including psychiatric stabilization and medical detoxification from drugs or alcohol, that are provided for an Emergency Condition.** ----------

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

The 1199SEIU National Benefit Fund for Home Care Employees believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). A grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted in 2010. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for an external review process for claims appeals. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan can be directed to the Plan Administrator at (646) 473-9200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or

www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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