1199SEIU Greater New York Benefit Fund

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: Beginning 06/01/2021
Coverage for: Eligibility Classes I & II
Plan Type: Taft-Hartley Trust Fund

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered healthcare services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, including a copy of the Fund's Summary Plan Description (SPD), call (646) 473-9200 or visit www.1199SEIUBenefits.org. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider or other underlined terms, see the Glossary. You can view the Glossary at www.1199SEIUBenefits.org or call (646) 473-9200 to request a copy.

Eligibility Class I members receive all of the benefits listed below for themselves and their eligible family members.

Eligibility Class II members receive benefits for themselves and their eligible family members, except for dental care and most prescriptions, as indicated in the Limitations, Exceptions & Other Important Information column.

Check your 1199SEIU Health Benefits ID card to confirm your Eligibility Class.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This plan covers all items and services without a deductible. But a co-payment may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	2021: $8,550 individual/ $17,100 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges and healthcare this plan does not cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Services, procedures, equipment, admissions and medications that are not pre-approved in accordance with the terms of the SPD will not be covered.
Will you pay less if you use a network provider?	Yes. See www.1199SEIUBenefits.org or call (646) 473-9200 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Services, procedures, equipment, admissions and medications that are not pre-approved in accordance with the terms of the SPD will not be covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Provider charges	If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Specialist visit	No charge	Provider charges	Allergy: Up to 20 treatments/year, including up to two testing visits Dermatology: Up to 20 treatments/year If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Preventive care/ screening/ immunization	No charge	Provider charges	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
If you have a test	Diagnostic test (X-ray, blood work)	No charge	Provider charges	Prior approval is required for certain procedures to be covered. See the "For Providers" tab at www.1199SEIUBenefits.org for a list of procedures that require prior approval. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Imaging (CT/PET scans, MRIs, MRAs)	No charge	Provider charges	Prior approval is required for these services to be covered. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.1199SEIUBenefits.org	Generic drugs	No charge	Provider charges	Eligibility Class II coverage is limited to contraceptive medication; medically necessary aspirin, statins and bowel preps; certain medically necessary vaccines, preventive care supplements and medications; and smoking cessation products. Participating Providers are pharmacies that accept Express Scripts. If you use a Non-Participating Pharmacy, you may be charged the amount the provider bills above the Fund's payment. For drugs not on the Fund's Preferred Drug List (non-preferred drugs), you must also pay the difference between the preferred and non-preferred drug price. Prior approval is required for certain medications to be covered. Certain medications are subject to clinical program management. Prescriptions for chronic conditions must be filled through *The 1199SEIU 90-Day Rx Solution*. For the Preferred Drug List and other important information, visit www.1199SEIUBenefits.org.
	Preferred brand drugs	No charge	Provider charges	
	Non-preferred brand drugs	You will be charged a differential	Provider charges	
	Specialty drugs	You will be charged a differential for non-preferred brand drugs	Provider charges	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge for use of facility	Provider charges	Prior approval is required for certain procedures to be covered. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Physician/ surgeon fees	No charge	Provider charges	Prior approval is required for certain procedures to be covered. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
If you need immediate medical attention	Emergency room care	$75 co-pay if not admitted to hospital	$75 co-pay if not admitted to hospital	A hospital emergency room should be used only in the case of a legitimate medical emergency, and must occur within 72 hours of an injury or the onset of a sudden and serious illness. If you go to a Non-Participating Hospital emergency room, you may incur additional out-of-pocket costs.
	Emergency medical transportation	No charge	Provider charges	Use of emergency medical transportation in non-emergency situations is not covered. If you use an emergency medical transportation provider with which the Fund does not have a contract, you may incur additional out-of-pocket costs. Prior approval is required for hospital-to-hospital transfers.
	Urgent care	No charge	Provider charges	If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	**Non-Participating Provider** (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge for use of facility	Provider charges	Prior approval is required for non-emergency admissions to be covered. Notification is required within 48 hours of an emergency admission. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Physician/ surgeon fees	No charge	Provider charges	If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment. Even when you go to a Participating Hospital, the surgeons and anesthesiologists may be Non-Participating Providers.
If you need mental health, behavioral health or substance abuse services	Outpatient services	No charge	Provider charges	Prior approval is required for transcranial magnetic stimulation (TMS) and certain drug testing. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Inpatient services	No charge	Provider charges	Prior approval is required for non-emergency admissions, partial hospitalization programs and intensive outpatient programs to be covered. Notification is required within 48 hours of an emergency admission. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
If you are pregnant	Office visits	No charge	Provider charges	If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Childbirth/delivery professional services	No charge	Provider charges	If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Childbirth/delivery facility services	No charge	Provider charges	Prior approval is required for inpatient stays longer than 48 hours (natural delivery) or 96 hours (cesarean delivery) to be covered. Prior approval is required for hospital-grade breastfeeding equipment to be covered. Lactation consulting is limited to three visits and is covered only when provided by certified providers. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	Provider charges	Prior approval is required for these services to be covered. Coverage is limited to 60 visits/year based on medical necessity. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Rehabilitation services	No charge	Provider charges	Prior approval is required for inpatient rehabilitation to be covered. Coverage for inpatient rehabilitation is limited to 30 days/year in a hospital for acute care. Coverage for outpatient physical/occupational/speech therapy is limited to 25 visits/discipline/year. Prior approval is required for additional visits to be covered. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Habilitation services	No charge	Provider charges	Coverage is for outpatient habilitation services only. Coverage for physical/occupational/speech therapy is limited to 25 visits/discipline/year. Prior approval is required for additional visits to be covered. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Skilled nursing care	No charge	Provider charges	Prior approval is required for these services to be covered. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Durable medical equipment	No charge	Provider charges	Prior approval is required for certain items to be covered. Excludes vehicle modifications, home modifications, exercise and bathroom equipment. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Hospice services	No charge	Provider charges	Prior approval is required for inpatient hospice services to be covered. Coverage is limited to 210 days of hospice care/lifetime in a Medicare-certified hospice program in a hospice center, hospital, skilled nursing facility or for outpatient home services provided by an accredited hospice organization. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider (You will pay the least)	**Non-Participating Provider** (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge when using a Participating Provider in the Vision Care network	Provider charges. You are eligible to receive a reimbursement of $18.	Maximum of one exam every two years. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Children's glasses/ contact lenses	No charge for frames or lenses that are included in the Fund's program	Provider charges. You are eligible to receive a reimbursement of $32.	Coverage is limited to one pair of Fund program prescription glasses or one order of contact lenses every two years. Payment for exam and glasses or contact lenses that are not included in the Fund's program will be limited up to the Fund's allocation of $50. Scratch-resistant and ultraviolet lens treatments are not covered. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.
	Children's dental check-up	No charge	Provider charges	Coverage is for Eligibility Class I only. See the SPD for applicable annual benefit limits, network restrictions and other exclusions. For certain upgrades and materials, co-payments may apply. If you use a Non-Participating Provider, you may be charged the amount the provider bills above the Fund's payment.

Excluded Services and Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your SPD for more information and a list of any other excluded services.)

- Care provided in a skilled nursing facility or nursing home
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Weight-loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your SPD.)

- Abortion services
- Acupuncture by licensed medical physicians or licensed acupuncturists: Coverage limited to 25 treatments/year
- Bariatric surgery (subject to prior approval)
- Chiropractic care: Coverage limited to 12 treatments/year
- Dental care (adult): Eligibility Class I only; Maximum benefit of $1,200/person/year
- Hearing aids: Once every three years (co-pays may apply); Maximum benefit of $750 ($375 for each ear)
- Non-emergency care when traveling outside the U.S. (some restrictions may apply)
- Private-duty nursing (subject to prior approval and some restrictions apply)
- Routine eye care (adult): One eye exam every two years; One pair of glasses or one order of contact lenses every two years
- Routine foot care: Coverage limited to 15 treatments/year

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The Fund's plan at (646) 473-9200. You may also contact the U.S Department of Labor's Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, or the U.S. Department of Health and Human Services' Center for Consumer Information and Insurance Oversight at (877) 267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or grievance for any reason to your plan. For more information about your rights, this notice or assistance, contact: The Fund's Appeals Department at (646) 473-8951. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services in Spanish (Español): Para obtener asistencia en español, llame al (646) 473-9200.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge and many other factors. Focus on the cost-sharing amounts (deductibles, co-payments and co-insurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

The plan's overall deductible	$0
Specialist co-payment	$0
Hospital (facility) co-insurance	0%
Other co-insurance	0%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/delivery professional services
Childbirth/delivery facility services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)
Total Example Cost **$12,700**

In this example, Peg would pay*:

Cost Sharing	
Deductibles	$0
Co-payments	$0
Co-insurance	$0
What Isn't Covered	
Limits or exclusions	$15
The total Peg would pay is	**$15**

*Note: These numbers assume Peg is in Eligibility Class I. Eligibility Class II is covered for prenatal vitamins but is not covered for most prescriptions.

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist co-payment	$0
Hospital (facility) co-insurance	0%
Other co-insurance	0%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)
Total Example Cost **$5,600**

In this example, Joe would pay*:

Cost Sharing	
Deductibles	$0
Co-payments	$0
Co-insurance	$0
What Isn't Covered	
Limits or exclusions	$0
The total Joe would pay is	**$0**

*Note: These numbers assume Joe is in Eligibility Class I.

Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

The plan's overall deductible	$0
Specialist co-payment	$0
Hospital (facility) co-insurance*	$75
Other co-insurance	0%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic tests (*X-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)
Total Example Cost **$2,800**

In this example, Mia would pay:**

Cost Sharing	
Deductibles	$0
Co-payments	$75
Co-insurance	$0
What Isn't Covered	
Limits or exclusions	$0
The total Mia would pay is	**$75**

*Emergency room co-payment
**Note: Services covered for *both* Eligibility Class I and II.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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