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 health care 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 go to www.seiu1benfunds.org or call 1-312-233-8888. For general definitions of common terms, such as **allowed amount**, **balance billing**, **coinsurance**, **copayment**, **deductible**, **provider**, or other underlined terms see the Glossary. You can view the Glossary at www.seiu1benfunds.org or call 1-312-233-8888 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0 **In Plan** - This means medical services must be provided by Union Health Service (UHS) $500/Individual - **Out of Plan**	A covered person is considered to be **In Plan** if he receives his medical care at a UHS Center, or if the care is performed or arranged by a UHS doctor. See the Common Medical Events chart below for your costs for services this **plan** covers. **Out of Plan** means that a UHS doctor did NOT provide, recommend, refer or arrange for the care or treatment.
Are there services covered before you meet your deductible?	**In Plan** – No **deductible** **Out-of-Plan** - No	**In Plan** – All services are provided with no deductible amounts. **Out-of-Plan** – No, any services would first be applied to the **deductible**.
Are there other deductibles for specific services?	No.	There are no specific **deductibles** for specific services.
What is the out–of–pocket limit for this plan?	**In Plan** – Does not apply **Out-of-Plan** – No limit	**In Plan** – Covered charges are paid at 100% **Out of Plan** – Patient pays 20% of all covered charges
What is not included in the out–of–pocket limit?	**In Plan** - Does not apply **Out-of-Plan** – This **plan** has no **out-of-pocket limit**	**In Plan** - Does not apply **Out-of-Plan** – Not applicable because there is no **out-of-pocket limit** on your portion
Will you pay less if you use a network provider?	Yes. You must use a Union Health Service physician. See www.unionhealth.org for a list of physicians or call 1-312-423-4200.	If you use a Union Health Service (**In Plan**) doctor, this **plan** will pay all of the costs of covered services. Lesser coverage, or no coverage, may be available for out-of-plan **providers**. Be aware, your **in plan** doctor or hospital may use an **out-of-plan provider** for some services (such as lab work). No coverage will be available for **out-of-plan**
Do you need a referral to see a specialist?	Yes.	This **plan** will pay all of the costs to see a **specialist** for covered services, but only if you have the plan's permission before you see the **specialist**.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	---none---
	Specialist visit	No charge	Not covered	
	Preventive care/**screening**/immunization	No charge	Not covered	
If you have a test	**Diagnostic test** (x-ray, blood work)	No charge	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.seiu1benfunds.org or www.unionhealth.org	Generic drugs (Tier 1)	$10 copay/Formulary prescription (retail and mail order)	Not covered	You must pay the full price for non-Formulary medications, although your cost for certain drugs may be discounted if you use a participating pharmacy. This Plan does not distinguish between preferred and non-preferred brand drugs.
	Preferred brand drugs (Tier 2)	$20 copay/Formulary prescription (retail and mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	$20 copay/Formulary prescription (retail and mail order)	Not covered	
	Specialty drugs (Tier 4)	$20 copay/Formulary prescription (retail and mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge with UHS referral	Not covered	UHS primary care physician must direct care
	Physician/surgeon fees	No charge with UHS referral	Not covered	UHS primary care physician must direct care

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	**Emergency room care**	No charge if emergency definition is met	No charge if emergency – see definition. **Out-of-Plan** - $500 **deductible**, then 20%	A medical condition which, if immediate medical attention is not provided, can reasonably be expected to lead to death, serious dysfunction of any bodily organ or part or other serious 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, metabolic, respiratory, nervous, gastrointestinal or urinary system. In no event will a condition be considered an emergency if the first treatment by a Physician is provided more than 24 hours after the onset of the symptoms.
	Emergency medical transportation	No charge if emergency definition is met	No charge if emergency – see definition.	
	Urgent care	No charge if emergency definition is met	No charge if emergency – see definition. **Out-of-Plan** - $500 **deductible**, then 20%	
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 with referral	$500 **deductible,** then 20%	---none---
	Physician/surgeon fee	$0 with referral	Not covered	---none---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 with referral	Not covered	---none---
	Inpatient services	$0 with referral	$500 **deductible**, then 20%	---none---
If you are pregnant	Office visits Childbirth/delivery professional services Childbirth/delivery facility services	$0 with referral	Not covered Delivery facility services - $500 **deductible**, then 20%	Benefit limited to member or spouse
If you need help recovering or have other special health needs	**Home health care**	$0 up to $10,000/year	Not covered	*Annual maximum is $10,000*
	Rehabilitation services	$0 with referral	Not covered	---none---
	Habilitation services	Not covered	Not covered	No coverage of habilitation services.
	Skilled nursing care	$0 up to 30 days/year	$500 deductible then 20%	Annual maximum is 30 days
	Durable medical equipment	$0 with referral	Not covered	---none---
	Hospice service	Up to $10,000	Not covered	Lifetime maximum benefit is $10,000
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	---none---
	Children's glasses	Discounts on eyewear	Not covered	---none---
	Children's dental check-up.	$0 if you use an in-network provider. See www.bcbsil.com or call 1-866-431-1594	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list for any other excluded services.)		
• Acupuncture • Bariatric surgery • Cosmetic surgery • Habilitation services	• Hearing aids • Infertility treatment • Long-term care • Medications not listed on Formulary	• Non-emergency care when traveling outside the U.S. • Organ transplants other than a cornea or bone marrow • Private-duty nursing • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic treatment • Dental care (Adult)	• Routine eye care (Adult) • Routine foot care	

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: your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 1-800-318-2596. You can also contact the **Plan** COBRA coordinator at (312) 233-8814 for more information.

Current COBRA Rate: 4/1/2021 – 3/31/2022 $836.04 (Rates subject to change every April)

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 to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact:

SEIU Local 1 & Participating Employers Health Trust
Claims Department
111 E. Wacker Drive, 17th Floor
Chicago, Illinois 60601
(312) 233-8899

or

Department of Labor
Employee Benefits Security Administration
1-866-444-EBSA (3272)
www.dol.gov/ebsa/healthreform

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:
Spanish (Español): Para obtener asistencia en Español, llame al 1-312-233-8899
Polish (Polski): Po pomoc w jezyku polskim dzwon 1-312-233-8899

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**, **copayments** and **coinsurance**) 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 pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	$0
Other coinsurance	$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 **$0**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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 copayment	$0
Hospital (facility) coinsurance	$0
Other coinsurance	$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 **$0**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$0**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	$0
Other coinsurance	$0

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost **$0**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

Note: These numbers assume the patient is participating in the plan's diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: Union Health Service at (312) 423-4200.