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.seiu1 benfunds.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.seiu1 benfunds.org or call 1-312-233-8888 to request a copy.

| Important Questions | Answers | Why this Matters: |
| :--- | :--- | :--- |
| What is the overall <br> deductible? | \$0 In Plan - This means medical <br> services must be provided by <br> Union Health Service (UHS) | A covered person is considered to be In Plan if he receives his medical care at a UHS Center, or if <br> the care is performed or arranged by <br> for UHS dour costs for services this plan covers. <br> Out of Plan means that a UHS doctor did NOT provide, recommend, refer or arrange for the care or <br> treatment; therefore not covered. |
| Are there services <br> covered before you meet <br> your deductible? | In Plan - No deductible <br> Out-of-Plan - - No | In Plan - All services are provided with no deductible amounts. <br> Out-of-Plan - - No benefits paid without referral from Union Health Service |
| Are there other <br> deductibles for specific <br> services? | No. | There are no specific deductibles for specific services. |

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) | 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 | Generic drugs (Tier 1) | \$10 copay/Formulary prescription (retail and mail order) | Not covered | You must pay the full price for nonFormulary medications, although your cost for certain drugs may be discounted if you use a participating pharmacy. <br> 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 |  |
| More information about prescription drug coverage is available at www.seiu1benfunds.org or www.unionhealth.org | 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 |  |  |
| :---: | :---: | :---: | :---: | :---: |
|  |  | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, \& Other Important Information |
| 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 | $\begin{gathered} \$ 500 \\ \text { deductible, } \\ \hline \text { then } 20 \% \end{gathered}$ | ---none--- |
|  | Physician/surgeon fee | \$0 with referral | Not covered | ---none--- |


| Common Medical Event | Services You May Need | What You Will Pay |  |  |
| :---: | :---: | :---: | :---: | :---: |
|  |  | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Limitations, Exceptions, \& Other Important Information |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$0 with referral | Not covered | ---none--- |
|  | Inpatient services | \$0 with referral | $\begin{gathered} \$ 500 \\ \text { deductible, then } \\ 20 \% \end{gathered}$ | ---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 female member |
| 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 | \$0 with referral | Not covered | ---none--- |
|  | 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 | Not covered | Not covered | ---none--- |
|  | Children's glasses | Not covered | Not covered | ---none--- |
|  | Children's dental check-up. | Not covered | Not covered | ---none--- |

## Excluded Services \& Other Covered Services:

Services Your Plan Generally Does NOT Cover (Please refer to plan or policy document at www.seiu1benfunds.org for more information and a list of any other excluded services.)

| - Acupuncture | - Hearing aids | - Non-emergency care when traveling outside the U.S. |
| :--- | :--- | :--- | :--- |
| - Bariatric surgery | - Infertility treatment | - Organ transplants other than a cornea or bone marrow |
| - Cosmetic surgery | - Long-term care | - Prive-duty nursing |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please refer to the plan or policy document at www.seiu1benfunds.org)

- 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) 233-8888 for more information.

## Current COBRA Rate: 4/1/2023-3/31/2024 \$479.90 (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, $17^{\text {th }}$ Floor or
Chicago, Illinois 60601
(312) $233-8899$

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.


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

| In this example, Peg would pay:  <br> Cost Sharing  <br> 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 <br> (a year of routine in-network care of a wellcontrolled condition)

The plan's overall deductible
Specialist copayment
$\square$ Specialist copayment $\quad \$ 0$
$\square$ 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 | $\$ 0$ |
| Limits or exclusions | $\$ 0$ |
| The total Joe would pay is |  |

## 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:
supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Total Example Cost ..... $\$ 0$
In this example, Mia would pay:

| Cost Sharing |  |
| :--- | :--- |
| Deductibles | $\$ 0$ |
| Copayments | $\$ 0$ |
| Coinsurance | $\$ 0$ |
| What inn'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.

