Dear Participant:

We are pleased to provide you with an updated Schedule Of Benefits as of January 1, 2019. This schedule describes the benefits that are available to you through the Local No. 1 Health Fund.

Included as part of this schedule are a(n):

- *Important Contact Information page*, which provides contact information for the various benefits provided by your Plan;
- *Schedule Of Benefits*, which is a summary of the benefits available to you under the Plan; and
- Certificates of insurance for insured benefits.

Please read this information carefully and store other important information you receive about the Plan in the pocket of your Summary Plan Description Booklet.

If you have any questions about the information contained in this mailing or about your benefits in general, please do not hesitate to contact the Fund Office.

Sincerely,

Board of Trustees

IMPORTANT CONTACT INFORMATION FOR NON-SUPPLEMENTAL PLAN A

The chart that follows shows the contact information for the various organizations that provide services under the Local No. 1 Health Fund.

If You Have A Question Or Need Information About	Contact	Address	Phone Number	Web Site
Eligibility	Fund Office	Local No. 1 Health Fund c/o Wilson-McShane 1431 Opus Place, Suite 350 Downers Grove, IL 60515	866-844-0488	
Benefits	Fund Office	Local No. 1 Health Fund c/o Wilson-McShane 1431 Opus Place, Suite 350 Downers Grove, IL 60515	866-844-0488	
Precertification/ Medical Review	Med-Care Management		800-845-SEIU (7348)	
Plan A Medical Claims	Union Health Service	UHS 1634 W. Polk Street Chicago, IL 60612	312-423-4200	
PPO or Network Providers	BlueCross BlueShield of Illinois (BCBSIL)		800-810-2583	www.bcbsil.com
Prescription Drug Benefits	Express Scripts		888-397-0627	www.express-scripts.com/welcome
Specialty Pharmacy Benefits	Express Scripts/Accredo		888-397-0627	www.express-scripts.com/welcome
Dental Benefits	BlueCare Dental HMO		866-431-1601	www.bcbsil.com
Vision Benefits	EyeMed Vision Care		866-723-0514	www.eyemedvision.com

NON-SUPPLEMENTAL PLAN A SCHEDULE OF BENEFITS

Comprehensive Major Medical Benefits	Coverage

Most Physicians' services and other routine health care received at UHS facilities are paid at 100%. ***Plan A does not cover any medical care that is not approved by a UHS Physician.***

Amounts shown on the following Schedule Of Benefits *are the maximum amounts the Plan will pay for certain other Covered Expenses if care is approved by a UHS Physician.*

No Overall Annual or Lifetime Maximums

Non-Precertification/Failure to Notify Deductible[1]

If you do not call for precertification, as required, you pay	$250 per occurrence

[1] You must call for precertification before all Hospital admissions, outpatient surgery, and home health care. However, if you are not able to call for precertification prior to an Emergency Hospital admission, you must call within 48 hours to notify the Plan of the admission. If you do not call for precertification or provide notification as required, you are responsible for payment of the Non-Precertification/Failure to Notify Deductible before the Plan pays any benefits. Amounts you pay toward this Deductible do not apply to your Out-of-Pocket Maximum.

Annual Deductible[2]

Before the Plan pays for most Covered Expenses, you pay:

For Network Providers	$200 per person each year; $400 family maximum
For Non-Network Providers	$300 per person each year; $600 family maximum

[2] The annual Deductible does not apply to routine in-Network physical examinations, hearing aids, in-Network preventive care, or prescription drugs (the latter being subject to a separate deductible described below).

Coinsurance[3]

UHS Physician

The Plan pays	100%, no Deductible required

Mental Health/Substance Abuse Office Visits

The Plan pays	100%, no Deductible required

All Other UHS Approved Covered Services

Once you meet your annual Deductible, the Plan pays:

For Network Providers	80%, up to the annual Out-of-Pocket Maximum
For Non-Network Providers	70%, up to the annual Out-of-Pocket Maximum

[3] This coinsurance applies unless specifically listed otherwise. The Plan does not cover expenses incurred at a **Non-Network** Outpatient Surgical Center.

Annual Out-Of-Pocket Maximum (Medical)[4]

The Plan pays 100% for the remainder of the year, once you reach your Out-of-Pocket Maximum of:

For Network Providers	$2,500 per person; $5,000 family maximum
For Non-Network Providers	$3,900 per person; $7,800 family maximum

[4] The annual Out-of-Pocket Maximum includes your Deductible and the percentage you pay (when the Plan pays less than 100%). However, the maximum does not include amounts you pay for non-essential health benefits such as (but not limited to) non-essential chiropractic care, acupuncture, non-surgical TMJ treatment, and certain podiatry expenses, as well as amounts you pay for prescription drugs, dental care, and vision care, and Non-Precertification Deductibles. A separate Out-of-Pocket maximum applies to prescription drugs.

Comprehensive Major Medical Benefits	Coverage
Emergency Care The Plan pays	Network Provider Coinsurance rate as listed above if an Emergency (even if the Provider in fact is Non-Network) and notification of the visit is provided within 48 hours; if not an Emergency, Plan pays 50%. In addition, if you do not provide notice, the Non-Precertification/Failure to Notify Deductible applies.
Chiropractic Care/Acupuncture/Non-Surgical TMJ Treatment[5] The Plan pays	50%, up to $1,000 combined per person each year (Network and Non-Network combined)
[5] Amounts you pay for these benefits do not apply to your Out-of-Pocket Maximum.	
Podiatry[6] The Plan pays	50%, up to $1,000 per person each year (Network and Non-Network combined; maximum not applicable to podiatry services considered to be Essential Health Benefits under the Affordable Care Act.)
[6] Amounts you pay for these benefits do not apply to your Out-of-Pocket Maximum except to the extent that they are Essential Health Benefits. For podiatry expenses that result from and are incurred within 48 hours of an accidental Injury, the Plan pays the copayment listed for most other Covered Expenses and the above copayment and maximums do not apply.	
Skilled Nursing Facility Care The Plan pays the copayment listed on page 3 up to	90 days per person each year (Network and Non-Network combined); $250 deductible if you do not precertify
Home Health Care The Plan pays the copayment listed on page 3	$250 deductible if you do not precertify
Durable Medical Equipment The Plan pays the copayment listed on page 3 up to	$10,000 each year (except that the limit does not apply to any such equipment that would be considered an Essential Health Benefit under the Affordable Care Act)
Prosthesis The Plan pays the copayment listed on page 3 up to	$25,000 per device once in any five-year period or, for a Dependent child under age 19, when necessary due to growth.
Hearing Aids Plan pays up to	$1,000 per person once every three years
Routine Physical Examinations/Preventive Care (including cancer screenings, well child care, and any other services, all to the extent required under the Affordable Care Act as set forth at https://www.healthcare.gov/preventive-care-benefits/**)** The Plan pays:	
Through a network physician	100%, with no Deductible required
Through a non-network physician	Covered as any other services: 70%, after the deductible

Prescription Drug Benefits	Coverage
Prescription Drug Benefits are provided through Express Scripts; you must use an Express Scripts Participating Pharmacy or the Mail Service Program for prescription drug expenses to be covered under the Plan. If you receive a brand name medication when your Physician approves substitution with its generic equivalent, in addition to your copayment listed below, you are responsible for the difference in cost between the brand name medication and its generic equivalent.	
With respect to Generic medications only, the Deductible, Copayment, and Coinsurance requirements set forth below are not applicable to preventive medications to the extent required under the Affordable Care Act as set forth at https://www.healthcare.gov/preventive-care-benefits/.) If no Generic is available or the Generic is medically inappropriate, then the Deductible, Copayment, and Co-insurance requirements will not apply to the preventive Brand name medication.	
Out-of-Pocket Maximum	
Per person	$3,000
Per family	6,0000
Retail Pharmacy Program (For Short-Term Medications)	
Annual Deductible	
Before the Plan pays for Covered Expenses for brand name drugs purchased at retail, you pay (no deductible applicable to non-brand)	$50 per person; $100 family maximum (Not applicable to generic drugs)
Coinsurance/Copayment Once you meet your annual Deductible, you pay	
Generic	20% of the cost, with minimum Copayment of $10
Preferred Brand	20% of the cost, with minimum Copayment of $25
Non-Preferred Covered Brand (for up to a 30 day supply)	20% of the cost, with minimum Copayment of $40
Mail Pharmacy/Retail 90 Program (For Long-Term Medications; also available through CVS retail)	
Coinsurance/Copayment Once you meet your annual Deductible, you pay:	
Generic	20% of the cost, with minimum Copayment of $20 (up to $40 max)
Preferred Brand	20% of the cost, with minimum Copayment of $50 (up to $100 max)
Non-Preferred Covered Brand (for up to a 30 day supply)	20% of the cost, with minimum Copayment of $80 (up to $160 max)
Specialty Pharmacy (For Specialty Medications; available only through Accredo)	
Coinsurance/Copayment Once you meet your annual Deductible, you pay	20% of the cost, with minimum Copayment of $100 and maximum Copayment of $250 (for up to a 90 day supply) ***Note:*** Higher Copayments will apply with respect to specialty medications included in the SavOn SP program. For a list of the included drugs and applicable copayments, please visit: www.saveonsp.com/SEIU.

Dental Benefits	Coverage
Dental Benefits are provided through an insured contract with Blue Cross Blue Shield of Illinois. Services must be provided by a Blue Care Dental HMO provider, except in cases of emergency or upon written authorization from your BlueCare Dental HMO provider, and benefits are paid according to a schedule of maximum amounts. The following is a summary of Covered Expenses; see the Blue Care Dental Schedule Of Benefits *included with this Schedule of Benefits for more detailed information. Under the Dental HMO, you may be required to pay a copayment for services, and all services must be approved by your primary care dentist.*	
Diagnostic and Preventive Care	For most Covered Expenses, after you pay any copayment or coinsurance, the Plan pays up to the scheduled maximum amount, plus lab costs where applicable
Oral Surgery, Restorative Care, Periodontics, and Endodontics	For most Covered Expenses, after you pay any copayment or coinsurance, the Plan pays up to the scheduled maximum amount
Prosthodontics	For most Covered Expenses, after you pay any copayment or coinsurance, the Plan pays up to the scheduled maximum amount
Orthodontics	For most Covered Expenses, after you pay any copayment or coinsurance, the Plan pays up to the scheduled maximum amount

Vision Benefits	Coverage
Vision Benefits are provided through an insured contract with EyeMed. Benefits are paid according to a schedule of maximum amounts. The following is a summary of Covered Expenses; see the EyeMed Vision Schedule Of Benefits *included with this Schedule Of Benefits for more detailed information.*	
Eye Examination	For most Covered Expenses, after you pay any copayment or coinsurance, the Plan pays once in each 12-month period
Vision Supplies	For most Covered Expenses, after you pay any copayment or coinsurance, the Plans pays up to the scheduled maximum amount once in each 12-month period