

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 B

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 B Medical Claims	Claims Office	Local No. 1 Health Fund c/o Wilson-McShane, 1431 Opus Place, Suite 350, Downers Grove, IL 60515	866-606-6785	
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 B SCHEDULE OF BENEFITS

Comprehensive Major Medical Benefits	Coverage
No Overall Annual or Lifetime Maximums	
Non-Precertification/Failure to Notify Deductible¹	
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 Deductible²	
Before the Plan pays for most Covered Expenses, you pay:	
<i>For Network Providers</i>	\$500 per person each year; \$1,000 family maximum
<i>For Non-Network Providers</i>	\$800 per person each year; \$1,600 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).	
Coinsurance³	
Once you meet your annual Deductible, the Plan pays:	
<i>For Network Providers</i>	75%, up to the annual Out-of-Pocket Maximum
<i>For Non-Network Providers</i>	60%, 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:	
<i>For Network Providers</i>	\$3,500 per person; \$7,000 family maximum
<i>For Non-Network Providers</i>	\$5,600 per person; \$11,200 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/Failure-to-Notify Deductibles. A separate Out-of-Pocket maximum applies to prescription drugs.	
Emergency Care	Network Provider Coinsurance rate as listed above if an
The Plan pays	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 Treatment⁵	
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.	

Comprehensive Major Medical Benefits	Coverage
Podiatry⁶	
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.
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:	
<i>Through a Network physician</i>	100%, with no Deductible required
<i>Through a Non-Network physician</i>	Covered as any other services: 60%, after the deductible

Prescription Drug Benefits	Coverage
<i>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.</i>	
<i>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.</i>	
Out-of-Pocket Maximum	
<i>Per person</i>	\$3000
<i>Per family</i>	\$6000

Retail Pharmacy Program (For Short-Term Medications)

Non-Supplemental Plan B

Prescription Drug Benefits**Coverage****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 (not applicable to generics)

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

20% of the cost, with minimum Copayment of \$40

(for up to a 30 day supply)

Mail Pharmacy/Retail 90 Program (For Long-Term Medications)**Coinsurance/Copayment**

Once you meet your annual Deductible, you pay

Generic

20% of cost, with minimum Copayment of \$20 (up to \$40 max)

Preferred Brand

20% of cost, with minimum Copayment of \$50 (up to \$100 max)

Non-Preferred Covered Brand

20% of cost, with minimum Copayment of \$80 (up to \$160 max)

(for up to a 90 day supply)

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 Plans 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
