Service Employees International Union
HEALTH AND WELFARE FUND

PLAN A

Effective 1/1/2024

HEALTH AND WELFARE FUND

1800 Massachusetts Avenue, NW • Washington, DC 20036
(202) 730-7548 • (800) 251-1777 • (202) 639-0471 Fax

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CONTACT INFORMATION

Benefit Administrators	
Medical	**United HealthCare by UMR** **PO Box 30541** **Salt Lake City, UT 84130-0541** **(888)309-7348** **www.umr.com** **"Choice Plus" Network**
Prescription Drug	**Caremark** **9501 E. Shea Boulevard Scottsdale, AZ 85260-6419** **(800) 966-5772** **www.caremark.com**
Dental	**Delta Dental** **PO Box 2105** **Mechanicsburg, PA 17055** **(800) 932-0783** **www.deltadental.com**
Vision	**Eye Med** **Cigna Vision Claims Department** **c/o First American Administrators** **PO Box 8504** **Mason, OH 45040-7111** **(888)353-2653**

SEIU Health and Welfare Fund Office	
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SCHEDULE OF BENEFITS

A. MEDICAL BENEFITS – United HEALTH CARE by UMR

	In-Network	Out-of-Network
Lifetime Maximum Benefit	None	
Annual Maximum Benefit	None	
Annual Out-of-Pocket Maximum Medical	$5,000 – Single $10,000 - Family	No maximum
Annual Out-of-Pocket Maximum Prescription Drug	$1,600 – Single $3,200 - Family	No Maximum
Annual Deductible	$100 for outpatient facility, X-ray/lab services	
	$100 for inpatient services	
Physician and Specialist Office Visit	$10 co-pay	You pay 50% Plan pays 50%
Allergy Treatment/Injections	Lesser of $10 co-pay or actual charge	You pay 50% Plan pays 50%
Allergy Serum (dispensed by physician in office)	No charge	You pay 50% Plan pays 50%
Preventive Care		
Well-child care	No Charge	You pay 50% Plan pays 50%
Immunizations	No Charge	You pay 50% Plan pays 50%
Annual Routine Physicals	No Charge	You pay 50% Plan pays 50%
Routine Preventive Care and Associated X-ray/Lab Maximum (Including colonoscopies, glucose testing, etc.)	No charge	You pay 50% Plan pays 50%
Mammograms	No charge	You pay 50% Plan pays 50%

	In-Network	Out-of-Network
Pap Test, PSA	No charge	You pay 50% Plan pays 50%
Pre-Admission Testing		
Outpatient Facility	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
Independent Lab and X-ray Facility	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
Inpatient Hospital Facility Services Semi-Private, Private and Special Care Units Room and Board	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
Outpatient Hospital Facility Services	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
Inpatient Hospital Services		
Physician Visits/Consultations	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
Inpatient or Outpatient Professional Services	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%

	In-Network	Out-of-Network
Emergency and Urgent Care Services		
Hospital Emergency Room	Plan pays 100% after $50 co-pay (Waived if admitted) *plan pays 50% of not a true emergency	Plan pays 100% after $50 co-pay (Waived if admitted) *plan pays 50% of not a true emergency
Urgent Care	Plan pays 100% after $50 co-pay	Plan pays 100% after $50 co-pay
Ambulance	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
Inpatient Services at Other Healthcare Facilities (including Skilled Nursing Facilities) Room and Board (Calendar Year Max: 90 days)	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
Home Healthcare (Calendar Year Max: 60 days)		
Hospice	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
Inpatient Facility, Outpatient Service		
Bereavement Counseling		
Inpatient Facility, Outpatient Services	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
Outpatient Short-Term Rehabilitative Therapy		
Physical, occupational, speech therapy, cardiac rehabilitation and chiropractic therapy (40 combined visits per calendar year)	$20 co-pay per visit	You pay 50% Plan pays 50%
Maternity Care Services		
Initial Confirmation Visit	$10 co-pay	You pay 50% Plan pays 50%

	In-Network	Out-of-Network
All subsequent prenatal visits, postnatal visits and physician delivery charges	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
Abortion		
Inpatient and Outpatient Facility	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
Family Planning		
Office visits including tests and counseling	Paid under office visit, outpatient or inpatient benefit. Based on location of service	Paid under office visit, outpatient or inpatient benefit. Based on location of service
Surgical services such as tubal ligation or vasectomy (excludes reversals)	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
Organ Transplants		
CIGNA Life Source Inpatient Facility	Plan pays 100%	Not Covered
Other Inpatient Hospital Facility	You pay 20% Plan pays 80%	Not Covered
Physician's Services/CIGNA Life Source Physician	Plan pays 100%	Not Covered
Non-Life Source Physician	You pay 20% Plan pays 80%	Not Covered
Travel Services—Only available for CIGNA Life Source Facilities	Up to $10,000	Not Covered
Durable Medical Equipment	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
External Prosthetic Appliances	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%

	In-Network	Out-of-Network
Routine Foot Care	Paid under office visit, outpatient or inpatient benefit. Based on location of service	You pay 50% Plan pays 50%
Mental Health/ Substance Abuse Inpatient	You pay 20% Plan pays 80%	You pay 50% Plan pays 50%
Mental Health/ Substance Abuse Outpatient	$10 co-pay	You pay 50% Plan pays 50%

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EXCLUSIONS

What's Not Covered (*not all-inclusive*)?

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Services provided through government programs
- Services that aren't medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit including services covered by worker's compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Infertility services
- Reversal of sterilization procedures
- Genetic screenings
- Custodial and other nonskilled services
- Weight loss programs
- Hearing aids
- Treatment of TMJ Disorder
- Acupuncture
- Treatment of sexual dysfunction
- Travel immunizations
- Eyeglass lenses and frames, contact lenses and surgical vision correction

B. Prescription Drug Benefits –Caremark/CVS

Tier Level	Drug Type	Co-pay
Annual Benefit Maximum	Unlimited	
Tier 1	Generic	$10
Tier 2	Preferred Brand Name	$20
Tier 3*	Non-Preferred Brand Name	$30*

* If a generic version of a nonpreferred brand name drug is available, the cost to you will be the generic co-payment plus the price difference between the generic drug and the brand name drug. In many cases, the cost will be greater than the Tier 3 co-payment. However, if your physician indicates, “no substitution allowed” or “dispense as written,” you will pay only the Tier 3 co-payment.

C. Dental Benefits – Delta Dental

DEDUCTIBLES, MAXIMUMS, AND SERVICES	In-Network	Out-of-Network *
Calendar Year Deductible **Does not apply to diagnostic, preventive or orthodontic services**	$50 per person with a family limitation of $150	
Calendar Year Maximum	$1,500 per person	$1,000 per person
Lifetime Maximum on Orthodontic Services	$1,000 per person (for Dependent children to age 19 only)	
Diagnostic Services (e.g., exams and X-rays)	Plan pays 100%	Plan pays 80%
Preventive Services (e.g., fluoride treatments to age 19, sealants to age 14, teeth cleaning for children and adults)	Plan pays 100%	Plan pays 80%
Basic Restorative Services (e.g., fillings)	Plan pays 80%	Plan pays 60%
Major Restorative Services (e.g., crowns)	Plan pays 50%	Plan pays 50%
Endodontic Services (e.g., root canal therapy)	Plan pays 80%	Plan pays 60%
Periodontal Services (treatment of gum disorders)	Plan pays 80%	Plan pays 60%

DEDUCTIBLES, MAXIMUMS, AND SERVICES	In-Network	Out-of-Network *
Prosthodontic Services (e.g., dentures, bridgework)	Plan pays 50%	Plan pays 50%
Oral Surgery (e.g., extractions)	Plan pays 80%	Plan pays 60%
Limited Occlusal Adjustment (i.e., "spot grinding") when necessary and customary as determined by the standards of generally accepted dental practice, limited to one occlusal adjustment per lifetime, and further limited to no more than the number of teeth in one quadrant	Plan pays 100%	Plan pays 80%
Orthodontic Services (straightening of teeth) for dependent children to age 19 Lifetime maximum of $1,000 per person	Plan pays 50%	Plan pays 50%

*The Plan provides benefits for out-of-network covered expenses at a percentage of the dental benefit administrator's allowances. You are responsible for paying the out-of-network dentist's actual charge, which may include amounts in addition to any applicable coinsurance and deductibles.

D. Vision Benefits – Cigna Vision Care

In-network providers include: Target, Lens Crafters, Pearle Vision, Costco, Wal-Mart

Type of Vision Service	In-Network Amount Paid by Plan	Out-of-Network Maximum Benefit Amount
Exam (one per calendar year)	100%	Up to $40
Frames (one set every two years)	Up to $90.00	Up to $45
Lenses* (one set per calendar year)		
Single	100%	Up to $36
Bifocal	100%	Up to $54
Trifocal	100%	Up to $66
Lenticular	100%	Up to $90
Standard Progressive	$50 Co-payment, then 100%	Up to $54
Contact Lenses** (Elective and Therapeutic)	Up to $40	Up to $36

Type of Vision Service	In-Network Amount Paid by Plan	Out-of-Network Maximum Benefit Amount
Lens Options	Eyewear Savings Plan***	Not Covered

*In-Network lenses include solid tints, ultra violet (UV) and standard scratch protection.

**Benefit is in lieu of spectacle lens and frame benefit.

***Discount program available through the vision benefit administrator after plan benefits have been exhausted.

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