Service Employees' International Union

SEIU Michigan Health and Welfare Fund

SBC

2024 Summary of Benefits and Coverage
for
Participating Members and Dependants of the Fund

SEIU MICHIGAN HEALTH AND WELFARE FUND

May 2024

TO: *All Eligible Participants and Beneficiaries in the SEIU Michigan Health and Welfare Fund*

Enclosed is the Summary of Benefits and Coverage ("SBC") for the SEIU Michigan Health and Welfare Fund. ***Please share the SBC and this letter with your family members who are eligible for coverage under the Plan***.

The Federal health care reform law- the Patient Protection and Affordable Care Act- requires that all group health plans, such as the Fund, provide participants and beneficiaries with the SBC.

The SBC is a document designed to provide a general description of some of the benefits provided by the Fund. The Federal government has issued a strict form template and detailed rules on the format and content of the SBC, meaning that we are not permitted to customize the SBC. For this reason, the SBC does not cover all of the benefits provided by the Fund and it does not contain any information regarding eligibility. We recommend that you refer to the Fund's Insurance Benefit Guide for a more complete description of the benefits provided by the Fund, as well as the eligibility rules. Please contact the Fund Office for a copy of the Benefit Guide. You can also find a copy of the SBC on the Fund's website at www.seiumichiganbenefits.org.

Although the requirement to have health care coverage that qualifies as "minimum essential coverage" or pay a tax penalty has been repealed effective in 2019, the SBC (and the IRS Form 1095-B you will receive for your tax returns) confirms that the Fund does provide "minimum essential coverage" and does meet the minimum value standard for the benefits it provides.

Receipt of this document does not constitute a determination of your eligibility, nor is it a contract. Additional limitations and exclusions may apply. If you have any questions about your benefits, please call the Fund Office at (248) 645-6550.

Sincerely,

BOARD OF TRUSTEES
SEIU MICHIGAN HEALTH AND WELFARE FUND

30700 Telegraph Road • Suite 2400
Bingham Farms, MI 48025
Office (248) 645-6550 • FAX (248) 645-6557

2024

MEDICAL COVERAGE

Group #114512

HealthComp

Third-Party Administrator (TPA)

Processing Medical Claims

Confirming your Eligibility for Coverage

Aetna, PPO

Select your doctor and hospital from the Aetna Network

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 https://hconline.healthcomp.com or by calling **1-800-843-3831**. 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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-866-444-EBSA (3272) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers: **$200** Individual / **$400** Family Out-of-Network providers: **No Coverage**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, urgent care, office visits and emergency care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network providers: **$2,200** Individual / **$4,400** Family Out-of-Network providers: **No Coverage**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. See https://hconline.healthcomp.com or call **1-800-843-3831** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay per visit deductible does not apply	No Coverage	Co-pay applies to the Office Visit charge only. Other services rendered during the office visit, are subject to the deductible & 20% co-insurance.
	Specialist visit	$30 co-pay per visit deductible does not apply	No Coverage	
	Preventive care/screening/ immunization	No Charge	No Coverage	You may have to pay for services that are not preventive. Ask your provider if services needed are preventive, then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	No Coverage	Some services require preauthorization.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	No Coverage	Services require preauthorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.EHIM.com	Generic drugs	Not Covered	No Coverage	Prescription drugs covered under another program.
	Preferred brand drugs	Not Covered	No Coverage	Prescription drugs covered under another program.
	Non-preferred brand drugs	Not Covered	No Coverage	Prescription drugs covered under another program.
	Specialty drugs	Not Covered	No Coverage	Prescription drugs covered under another program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	No Coverage	Some services require preauthorization.
	Physician/surgeon fees	20% coinsurance after deductible	No Coverage	---none---
If you need immediate medical attention	Emergency room care	$250 co-pay per visit deductible does not apply	Network Benefits Apply	Co-pay waived if admitted. Non-Emergency Room Care is not covered.
	Emergency medical transportation	20% coinsurance after deductible	Network Benefits Apply	Emergency medical transportation only.
	Urgent care	$30 co-pay per visit deductible does not apply	Network Benefits Apply	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	No Coverage	Inpatient Admissions require preauthorization within 48 hours of admission. Failure to preauthorize within 48 hours could result in the denial of charges

[* For more information about limitations and exceptions, see the plan or policy document at https://hconline.healthcomp.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance after deductible	No Coverage	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Same as any other illness	No Coverage	Some services require preauthorization.
	Inpatient services	Same as any other illness	No Coverage	Services require preauthorization.
If you are pregnant	Office visits	$20 co-pay per visit. deductible does not apply No Charge for Prenatal care.	No Coverage	Cost sharing doesn't apply to preventive services. Depending on the type of service(s), a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	20% coinsurance after deductible	No Coverage	
	Childbirth/delivery facility services	20% coinsurance after deductible	No Coverage	Some services requires preauthorization.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	No Coverage	Calendar Year Maximum 200 visits. Services require preauthorization.
	Rehabilitation services	20% coinsurance after deductible	No Coverage	Calendar Year Maximum 60 combined visits: applies to Physical, Speech and Occupational Therapy visits.
	Habilitation services	20% coinsurance after deductible	No Coverage	Calendar Year Maximum 60 combined visits: applies to Physical, Speech and Occupational Therapy **Note:** Visit maximum does not apply to treatment of Autism. Services require preauthorization.
	Skilled nursing care	20% coinsurance after deductible	No Coverage	Calendar Year Maximum 100 days. Services require preauthorization.
	Durable medical equipment	30% coinsurance after deductible	No Coverage	Limited to the lesser of the purchase price and the anticipated rental charges. Charges over $1,500 (including rentals / repairs) require preauthorization.
	Hospice services	20% coinsurance after deductible	No Coverage	Lifetime Maximum 210 days.
If your child needs dental or eye care	Children's eye exam	No Charge	No Coverage	Routine eye exam; No Charge. Limited to one (1) eye exam including refraction per calendar year.
	Children's glasses	Not Covered	No Coverage	---none---
	Children's dental check-up	Not Covered	No Coverage	---none---

[* For more information about limitations and exceptions, see the plan or policy document at https://hconline.healthcomp.com.]

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

☐Acupuncture	☐Infertility Treatment	☐Private Duty Nursing
☐Cosmetic Surgery	☐Long-Term Care	☐Routine Foot Care
☐Dental Care	☐Non-emergency Care when traveling outside the U.S	☐Weight Loss Programs
☐Hearing Aids		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

☐Bariatric Surgery (Limited to one (1) procedure per lifetime)	☐Chiropractic Care (Calendar Year Maximum 20 visits, limited to one set of x-rays per condition)	☐Routine Eye Care (Coverage limited to an eye exam including refraction, Adult - Children)

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's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or www.dol.gov/ebsa/healthreform or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or www.cciio.cms.gov. 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**.

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: the Plan at **1-800-843-3831** or your state insurance department or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the 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 1-800-843-3831.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-843-3831.]
[Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-843-3831.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-843-3831.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at https://hconline.healthcomp.com.]

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** **$200**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,270**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$200**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$4,100**

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

- **The plan's overall deductible** **$200**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$910**

The plan would be responsible for the other costs of these EXAMPLE covered services.

2024

PRESCRIPTION COVERAGE

EHIM

Employee Health Insurance Management

Group No. 50001539-01

A separate ID card for prescription

This is only a summary. If you want more detail about your prescription coverage and costs, you can get the complete terms in the policy or plan document at www.ehimrx.com or by calling 1-800-311-3446.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	See Medical Plan	There are no deductibles specific to the Prescription Plan. Refer to your medical SBC for information regarding your medical coverage.
Are there services covered before you meet your deductible?	See Medical Plan	See Medical Plan
Are there other deductibles for specific services?	See Medical Plan	See Medical Plan
What is the out-of-pocket limit for this plan?	$2,500 per single $5,000 per family	The most you pay in prescription copays during the Coverage Period before your Prescription Plan begins to pay 100% of the allowed amount is $2,500 per Single and $5,000 per Two-Person/Family. This out-of-pocket limit applies to all covered prescriptions that are a part of your Prescription Plan.
What is not included in the out-of-pocket limit?	Premium, Balance Billed Charges, Non-Covered Medications	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	See Medical Plan	For a list of participating pharmacies, see www.ehimrx.com or call 800-311-3446.
Do you need a referral to see a specialist?	See Medical Plan	See Medical Plan

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 6, 2016

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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	See Medical Plan	See Medical Plan	See Medical Plan
	Specialist visit	See Medical Plan	See Medical Plan	See Medical Plan
	Preventive care/screening/ immunization	See Medical Plan	See Medical Plan	See Medical Plan
If you have a test	Diagnostic test (x-ray, blood work)	See Medical Plan	See Medical Plan	See Medical Plan
	Imaging (CT/PET scans, MRIs)	See Medical Plan	See Medical Plan	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 800-311-3446	Generic drugs (Tier 1)	$8.00 / per Rx	$8.00 / per Rx	Covers up to 30 day supply; 2x copay for approved 90 day supplies; Quantity Limitations on certain medications; prior authorization may apply
	Preferred brand drugs (Tier 2)	$50.00 / per Rx	$50.00 / per Rx	Covers up to 30 day supply; 2x copay for approved 90 day supplies; Quantity Limitations on certain medications; prior authorization may apply
	Non-preferred brand drugs (Tier 3)	$100.00 / per Rx	$100.00 / per Rx	Covers up to 30 day supply; 2x copay for approved 90 day supplies; Quantity Limitations on certain medications; prior authorization may apply
	Specialty drugs (Tier 4)	Excluded	Excluded	N/A
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	See Medical Plan	See Medical Plan	See Medical Plan
	Physician/surgeon fees	See Medical Plan	See Medical Plan	See Medical Plan
If you need immediate medical attention	Emergency room care	See Medical Plan	See Medical Plan	See Medical Plan
	Emergency medical transportation	See Medical Plan	See Medical Plan	See Medical Plan

[*For more information about limitations and exceptions, see your plan administrator]

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)	
	Urgent care	See Medical Plan	See Medical Plan	See Medical Plan
If you have a hospital stay	Facility fee (e.g., hospital room)	See Medical Plan	See Medical Plan	See Medical Plan
	Physician/surgeon fees	See Medical Plan	See Medical Plan	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	See Medical Plan	See Medical Plan	See Medical Plan
	Inpatient services	See Medical Plan	See Medical Plan	See Medical Plan
If you are pregnant	Office visits	See Medical Plan	See Medical Plan	See Medical Plan
	Childbirth/delivery professional services	See Medical Plan	See Medical Plan	See Medical Plan
	Childbirth/delivery facility services	See Medical Plan	See Medical Plan	
If you need help recovering or have other special health needs	Home health care	See Medical Plan	See Medical Plan	See Medical Plan
	Rehabilitation services	See Medical Plan	See Medical Plan	
	Habilitation services	See Medical Plan	See Medical Plan	
	Skilled nursing care	See Medical Plan	See Medical Plan	
	Durable medical equipment	See Medical Plan	See Medical Plan	
	Hospice services	See Medical Plan	See Medical Plan	
If your child needs dental or eye care	Children's eye exam	See Medical Plan	See Medical Plan	See Medical Plan
	Children's glasses	See Medical Plan	See Medical Plan	See Medical Plan
	Children's dental check-up	See Medical Plan	See Medical Plan	See Medical Plan

[*For more information about limitations and exceptions, see your plan administrator]

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
☐ Anti-obesity	☐ Fertility drugs	• Oral Immunosuppressives
☐ Cosmetic drug	☐ Growth hormones	• All Specialty Medications (Oral & Self-injectable)
☐ Diabetic Supplies	☐ HIV Specific	
☐ Experimental drugs	☐ Injectable allergens/immunizations/blood/prod.	
	☐ Medical appliances/devices	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- ☐ Select Over the Counter Drugs for $0 copay per 30 day fill. Must present valid prescription.
- ☐ Oral impotency agents & injectable impotency agents
- ☐ Dental fluorides
- ☐ Prenatal Vitamins
- ☐ Smoking Cessation

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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.

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: [insert applicable contact information from instructions].

Language Access Services: Language Access Services

[*For more information about limitations and exceptions, see your plan administrator]

NOTES

2024

DENTAL COVERAGE

A.D.N. Administrators

Group #10190

Call A.D.N. for a participating dentist in your zip code!

888-236-1100

A separate ID card for dental coverage

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, contact the Fund Office at (248) 645-6550. 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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call (248) 645-6550 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	There are no deductibles specific to the dental plan.
Are there services covered before you meet your deductible?	Not Applicable	There are no deductibles specific to the dental plan.
Are there other deductibles for specific services?	Not Applicable	There are no deductibles specific to the dental plan.
What is the out-of-pocket limit for this plan?	Not Applicable	There is no out of pocket limit on your expenses for dental benefits.
What is not included in the out-of-pocket limit?	Not Applicable	There is no out of pocket limit on your expenses for dental benefits.
Will you pay less if you use a network provider?	Yes. See www.adndental.com or call 1-888-236-1100 for a list of network providers.	This plan uses a provider network. It is likely you will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing)..
Do you need a referral to see a specialist?	No	Following a routine dental exam, if it is necessary to be seen by a specialist, the examining dentist may refer you directly.

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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan
	Specialist visit	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan
	Preventive care/screening/ immunization	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan
If you have a test	Diagnostic test (x-ray, blood work)	See Medical SBC	See Medical SBC	These services are not part of your dental benefits plan
	Imaging (CT/PET scans, MRIs)	See Medical SBC	See Medical SBC	
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	See Prescription SBC		These services are not part of your dental benefits plan
	Preferred brand drugs (Tier 2)	See prescription SBC		
	Non-preferred brand drugs (Tier 3)	See Prescription SBC		
	Specialty drugs (Tier 4)	See Prescription SBC		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan
	Physician/surgeon fees	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan
If you need immediate medical attention	Emergency room care	See Medical SBC	See Medical SBC	These services are not part of your dental benefits plan
	Emergency medical transportation	See Medical SBC	See Medical SBC	
	Urgent care	See Medical SBC	See Medical SBC	

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 have a hospital stay	Facility fee (e.g., hospital room)	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan
	Physician/surgeon fees	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan
If you need mental health, behavioral health, or substance abuse services	Outpatient services	See Medical SBC	See Medical SBC	These services are not part of your dental benefits plan
	Inpatient services	See Medical SBC	See Medical SBC	
If you are pregnant	Office visits	See Medical SBC	See Medical SBC	These services are not part of your dental benefits plan
	Childbirth/delivery professional services	See Medical SBC	See Medical SBC	
	Childbirth/delivery facility services	See Medical SBC	See Medical SBC	
If you need help recovering or have other special health needs	Home health care	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan
	Rehabilitation services	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan
	Habilitation services	See Medical SBC	See Medical SBC	
	Skilled nursing care	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan
	Durable medical equipment	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan
	Hospice services	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan

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 your child needs dental or eye care	Children's eye exam	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan
	Children's glasses	See Medical SBC	See Medical SBC	This service is not part of your dental benefits plan
	Dental check-up	No Charge	50% of the Non-Network Dentist Fee	Prophylaxes (cleanings) are payable twice per calendar year. People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment. Benefits limited to $800 per person total per calendar year on diagnostic and preventive, basic services, and major services; $800 per person total per lifetime on orthodontics up to age 19.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
☐ See Medical SBC
☐ See Dental SPD

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
☐ Dental care (Adult)
☐ See Medical SBC

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 877-267-2323 x61565 or www.cciio.cms.gov. 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.

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: U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa.

2024

VISION COVERAGE

Eye Med

Group #1008033

"Advantage Network"

Call 888-203-7437 for assistance finding a vision center

A separate "paper" ID card for vision

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, contact the Fund Office at (248) 645-6550. 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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call (248) 645-6550 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Not applicable**	There are no deductibles specific to the Vision Plan
Are there services covered before you meet your deductible?	**Not applicable**	There are no deductibles specific to the Vision Plan
Are there other deductibles for specific services?	**Not applicable**	There are no deductibles specific to the Vision Plan
What is the out-of-pocket limit for this plan?	**Not applicable**	There is no out of pocket limit on your expenses for vision benefits.
What is not included in the out-of-pocket limit?	**Not applicable**	There is no out of pocket limit on your expenses for vision benefits.
Will you pay less if you use a network provider?	Yes – Average 83% savings vs	Member subject to full retail charges with an Out of Network Provider
Do you need a referral to see a specialist?	Retail No	Following a routine eye exam, if it is necessary to be seen by a specialist, the examining doctor may refer you directly

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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Specialist visit	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Preventive care/screening/ immunization	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
If you have a test	Diagnostic test (x-ray, blood work)	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Imaging (CT/PET scans, MRIs)	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
If you need drugs to treat your illness or condition See Rx SBC for more information.	Generic drugs	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Preferred brand drugs	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Non-preferred brand drugs	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Specialty drugs	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Physician/surgeon fees	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
If you need immediate medical attention	Emergency room care	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Emergency medical transportation	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Urgent care	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Facility fee (e.g., hospital room)	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan

For more information about limitations and exceptions, contact the Fund Office at 248-645-6550.

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 have a hospital stay	Physician/surgeon fees	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Inpatient services	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
If you are pregnant	Office visits	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Childbirth/delivery professional services	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Childbirth/delivery facility services	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
If you need help recovering or have other special health needs	Home health care	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Rehabilitation services	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Habilitation services	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Skilled nursing care	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Durable medical equipment	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
	Hospice services	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan
If your child needs dental or eye care	Children's eye exam	$0 copay/visit	Up to $40	Coverage limited to one exam/year.
	Children's glasses	$130.00 Frame Allowance $15.00 Co-pay on standard lenses	$91.00 Frame Allowance	Coverage limited to one pair of glasses every other year.
	Children's dental check-up	**Not applicable**	**Not applicable**	This service is not part of your vision benefits plan

For more information about limitations and exceptions, contact the Fund Office at 248-645-6550.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
☐ See Medical SBC

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
☐ See Medical SBC

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For more information about limitations and exceptions, contact the Fund Office at 248-645-6550.

Fund Website

www.seiumichiganbenefits.org

SEIU Michigan Health and Welfare Fund

TIC International Corporation
30700 Telegraph Road, Suite 2400
Bingham Office Center--Between 12 & 13 Mile--Heading North
Bingham Farms, Michigan 48025

248-645-6550
Fax: 248-645-6557
8:15 AM – 4:30 PM EST
Benefit Office
www.seiumichiganbenefits.org

SEIU Local 1, Detroit Union Office

2211 East Jefferson Avenue, 3rd Floor
Corner of Jefferson & Chene
Detroit, Michigan 48207

313-567-3900
Fax: 313-567-3921
9 AM – 5 PM EST
www.seiu1.org

SEIU Local 1, Chicago Union Office

Main Office for Local 1
111 East Wacker Drive, Suite 1700
Chicago, Illinois 60601

312-240-1600
9 AM – 5 PM CST
www.seiu1.org

Member Resource Center

For ALL Local 1 Members (Chicago, Detroit, Ohio)
Grievances, Dues, and COPE

877-233-8880
9 **AM – 5 PM CST**

Open Enrollment

Closed Thanksgiving Weekend
For New Enrollees Only
Or if Adding a Spouse or Dependent up to age 26

November 1 – 30
Benefits begin January 1
www.seiumichiganbenefits.org

SEIU National Industry Pension Fund (NIPF)

1800 Massachusetts Ave NW, Suite 301
Washington, D.C. 20036
(Plan for your retirement 3-4 months in advance.)

1-800-458-1010 ***(call center)***
www.seiufunds.org
Fax: 202-747-2906

U.S. Social Security Administration

Official website

1-800-772-1213
https://www.ssa.gov

Medicare

Official website

1-800-633-4227
https://medicare.gov