SERVICE EMPLOYEES INTERNATIONAL UNION
HEALTH AND WELFARE FUND

PLAN G
SCHEDULE OF BENEFITS

Effective
March 1, 2016

SEIU Health and Welfare Fund
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CONTACT INFORMATION

Benefit Administrators	
Medical	**CIGNA Health Care** PO Box 182223 Chattanooga, TN 37422 Member Services: (800) 433-5305 www.mycigna.com (Provider network is the "Open Access Plus" plan)
Prescription Drug	**Caremark** 9501 E. Shea Boulevard Scottsdale, AZ 85260-6419 (800) 966-5772 www.caremark.com

SEIU Health and Welfare Fund Office	
John DeVirgiliis – Administrator	**(202)730-7525** **John.DeVirgiliis@seiufunds.org**
Barbara Zeiss – Administrative Manager Member benefits, eligibility issues, claim questions	**(202)730-7548** **Barbara.Zeiss@seiufunds.org**
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SCHEDULE OF BENEFITS

A. MEDICAL BENEFITS – CIGNA HEALTH CARE

	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 Prescription Drug $1,600 Single $3,200 Family	No maximum
Annual Deductible	$500 for outpatient facility, X-ray/lab services	
	$1000 for inpatient services	
Primary Care Physician (PCP) Office Visit	$20 co-pay	Participant pays 50%
Specialist Office Visit	$40 co-pay	
Allergy Treatment/Injections	Lesser of $40 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%

	In-Network	Out-of-Network
Mammograms	No charge	You pay 50% Plan pays 50%
Pap Test, PSA	No charge	You pay 50% Plan pays 50%
Pre-Admission Testing		
Outpatient Facility	You pay 30% Plan pays 70%	You pay 50% Plan pays 50%
Independent Lab and X-ray Facility	You pay 30% Plan pays 70%	You pay 50% Plan pays 50%
Inpatient Hospital Facility Services Semi-Private, Private and Special Care Units Room and Board	You pay 30% Plan pays 70%	You pay 50% Plan pays 50%
Outpatient Hospital Facility Services	You pay 30% Plan pays 70%	You pay 50% Plan pays 50%
Inpatient Hospital Services		
Physician Visits/Consultations	You pay 30% Plan pays 70%	You pay 50% Plan pays 50%
Inpatient or Outpatient Professional Services	You pay 30% Plan pays 70%	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 30% Plan pays 70%	You pay 30% Plan pays 70%
Inpatient Services at Other Healthcare Facilities (including Skilled Nursing Facilities) Room and Board (Calendar Year Max: 90 days)	You pay 30% Plan pays 70%	You pay 50% Plan pays 50%
Home Healthcare (Calendar Year Max: 60 days)		
Hospice	You pay 30% Plan pays 70%	You pay 50% Plan pays 50%
Inpatient Facility, Outpatient Service		
Bereavement Counseling		
Inpatient Facility, Outpatient Services	You pay 30% Plan pays 70%	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	$40 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 30% Plan pays 70%	You pay 50% Plan pays 50%
Abortion		
Inpatient and Outpatient Facility	You pay 30% Plan pays 70%	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 30% Plan pays 70%	You pay 50% Plan pays 50%
Organ Transplants		
CIGNA Lifesource Inpatient Facility	Plan pays 100%	Not Covered
Other Inpatient Hospital Facility	You pay 30% Plan pays 70%	Not Covered
Physician's Services/CIGNA Lifesource Physician	Plan pays 100%	Not Covered
Non-Lifesource Physician	You pay 30% Plan pays 70%	Not Covered
Travel Services—Only available for CIGNA Lifesource Facilities	Plan pays 100%	Not Covered
Durable Medical Equipment	You pay 30% Plan pays 70%	You pay 50% Plan pays 50%
External Prosthetic Appliances $10,000 calendar year maximum	You pay 30% Plan pays 70%	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 30% Plan pays 70%	You pay 50% Plan pays 50%
Mental Health/ Substance Abuse Outpatient	$40 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
- Nonprescription and anti-obesity drugs
- Custodial and other nonskilled services
- Weight loss programs
- Hearing aids
- Treatment of TMJ Disorder
- Acupuncture
- Treatment of sexual dysfunction
- Travel immunizations
- Telephone, email and Internet consultations in the absence of a specific benefit
- 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*
Tier 4	Specialty	50% - Max co-pay of $250

* 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.