Local No. 1 Health Fund
SEIU United for Good Jobs and Strong Communities

Service Employers Local No. 1 SEIU-CLC
Apartment Building Owners and Managers Association
1431 Opus Place, Suite 350
Downers Grove, IL 60515

Phone: (630) 288-6868
Toll Free: (866) 844-0488
Administered by Wilson-McShane Corporation

February 2025

Dear Participant:

We are pleased to announce that the Plan of Benefits provided by the Local No. 1 Health Fund has been amended to reflect several enhancements to the vision benefits as described below.

We also write to inform you that pre-pandemic Plan eligibility and coverage provisions are being reinstated, except that the Plan will continue to cover up to four (4) over-the-counter (OTC) COVID-19 tests every 30 days per covered individual.

Vision Benefit Improvements

Effective January 1, 2025, the following benefit improvements were implemented:

- Lower copays when you buy lenses for your glasses (e.g., $0 copays for bifocals).
- Increased annual frame allowance from $120 to $150.

Please see the enclosed Summary of Benefits from Eye Med detailing the new copayments and the increased allowance.

Please note that you can receive benefits for both new frames and contact lenses or new frames and new lenses to go in the frames each year. If you get new contact lenses, new frames and new lenses for the glasses in the same year, you will have to pay for the lenses for your glasses out of pocket, subject to a 20% discount. However, if your old lenses fit in the new frames, you may be able to skip buying new lenses entirely.

Initial Eligibility

This change only affects new employees and employees transferring to a full-time position on or after July 1, 2025.

Effective July 1, 2025, pre-pandemic initial eligibility requirements will be reinstated. Employees of Contributing Employers who commence employment on or after July 1, 2025, will be eligible for benefits as of the first day of the month following three full months of Contributions from the Employer to the Fund on their behalf. For example, if you are hired July 18, and your employer makes contributions to the Fund on your behalf for August, September, and October, you will be eligible for coverage under the Plan as of November 1. Also, if you are employed by a Contributing Employer and transferred to a full-time position, you will become

eligible as of the first of the month following three full months of Contributions from your Employer.

Note: Full-time covered employment is defined in the applicable Collective Bargaining Agreement and generally means that you are regularly scheduled and expected to work 120 hours per month or more.

Coverage for COVID-19 Testing and Treatment

The Fund will cover both testing and treatment for COVID-19 subject to applicable Deductibles, Coinsurance, and/or Copayments.

Note: The Plan continues to provide coverage without cost sharing also for four over-the counter test kits per person every 30 days when purchased from Participating Pharmacies.

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Please file this notice together with your Summary Plan Description ("SPD") booklet.

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

Sincerely,

Board of Trustees

Local No. 1 Health & Pension Funds

United for Good Jobs and Strong Communities

Service Employees Local No. 1 SEIU-CLC

Apartment Building Owners and Managers Association

September 2024

Dear Participant:

We are pleased to announce that the Plan of Benefits provided by the Local No. 1 Health Fund has been amended to reflect several changes and clarifications as noted below. Additionally, we wish to inform you that the federal government is once again preparing to offer free at-home COVID test kits.

COMING SOON: ADDITIONAL FREE COVID TEST KITS AVAILABLE!

Starting in late September, all U.S. households will be eligible to order four free COVID-19 tests at COVIDTests.gov. According to the Department of Health and Human Services, the new COVID-19 Tests will detect current COVID-19 variants and can be used through the end of the year.

Be sure to order your test kits when they become available!

PLAN CHANGES AND CLARIFICATIONS

Coverage for COVID Vaccination

Until further notice, vaccination for COVID-19 will continue to be paid by the Fund at 100% without cost sharing.

Coverage for COVID-19 Testing

Until further notice, testing and all other services related to testing for COVID-19 will continue to be paid by the Fund at 100% without cost sharing. In other words, deductibles, co-payments, and coinsurance will not apply to the testing or any related services. Also, there will be no pre-certification, prior authorization, or other medical management requirements for this testing.

Coverage for testing also includes coverage for four over-the-counter at-home diagnostic COVID-19 test kits per covered individual per month provided they are purchased at Participating Pharmacies. (And starting in late September, remember that you can order additional test kits from the federal government at no charge, delivered straight to your home.)

As further communicated previously, this coverage without cost sharing applies only when the testing is being performed for diagnostic purposes. There is no coverage for testing performed for public health surveillance or employment purposes (such as screening for general workplace health and safety or to meet return to work requirements or other requirements established by the employer or required by law) or for any other purposes not related to the individualized diagnosis or treatment of an individual.

As always, if you are in Plan A, you must see a Union Health Services provider or you must receive a referral from a Union Health Services (UHS) provider to receive coverage for a provider for services provided outside of UHS.

Telehealth Coverage

Effective May 1, 2023, the Fund will continue to cover telehealth visits, but such visits will be subject to cost sharing (i.e., application of the deductible and any applicable coinsurance or copayments).

Initial Eligibility

Certain changes made by the Trustees in 2020 with respect to initial eligibility for Employees are continued indefinitely until further notice. Specifically, Employees of Contributing Employers become initially eligible for benefits under the Plan as of the first of the month following the Employee's date of hire if the Employee is hired into full-time Covered Employment and provided that the Contributing Employer is obligated to and does contribute with respect to such Employee.

Note: Full-time covered employment is defined in the applicable Collective Bargaining Agreement, and generally means that you are regularly scheduled and expected to work 120 hours per month or more. Also, if you are employed by a Contributing Employer and transferred to a full-time position, you will become initially eligible as of the first of the month following the date of the transfer provided that your Employer is obligated to contribute on your behalf as of such date.

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Please file this notice together with your Summary Plan Description ("SPD") booklet.

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

Sincerely,

Board of Trustees

Local No. 1 Health Fund

United for Good Jobs and Strong Communities

August 2023

Dear Participant:

We are pleased to announce that the Plan of Benefits provided by the Local No. 1 Health Fund has been amended to reflect an increase in the maximum dollar amount applicable to dental benefits. We also write to clarify certain points regarding your dental benefits.

Dental Plan Maximum

Effective January 1, 2024, the Calendar Year Maximum Benefit per person with respect to dental benefits (excluding orthodontia) will be $3,000 (increased from $2,000), regardless of what provider you use.

Clarifications re Deductibles

The deductible applies to basic, restorative, and major services but does not apply to preventive/diagnostic services.

Clarifications re Benefits for Services Received from Network vs Non-network Providers

As a reminder, deductibles are lower, and the Plan's Coinsurance Percentage is higher with respect to Delta Dental PPO or Delta Dental Premier dentists as compared to non-network Providers. Since dentists in the Delta Dental PPO and Delta Dental Premier network have agreed to charge negotiated, discounted rates, your out-of-pocket expenses are less than if you use a non-network dentist. Also, when you see a Delta Dental PPO or Delta Dental Premier dentist, you pay only the patient share (i.e., any remaining deductible, the applicable coinsurance, any amount over the annual maximum, or any amounts for services that the Plan does not cover) at the time of treatment, and the Plan will pay its share directly to the dentist. These dentists will not balance bill you for amounts above the negotiated/discounted rate (in the case of Delta Dental PPO dentists) or the amount set forth on a "schedule of maximum allowances" (in the case of Delta Dental Premier dentists). A non-network dentist has not agreed to accept discounted amounts for services and may bill you for the full amount of charges, which may be above the amount eligible for payment under the Plan.

What provider you use is your decision. However, remember that neither the Plan nor the dental network administrator (Delta Dental) are liable for any act or omission of any provider. The fact that a provider is a PPO Provider or Premier dentist is not a recommendation or referral, nor is it a statement as to the ability or quality of that provider by the Plan or dental network administrator. In addition, the fact that a provider is a Non-PPO Provider is not a statement as to the provider's skill or quality by the Plan or dental network administrator.

Also, what care you receive is a decision to be made by you in consultation with your treating dentist. A determination of benefits relates only to the level of payment that the Plan is required to make and is not a medical determination as to care.

To take advantage of the savings the network provides, you should check to see if your provider is in the network (providers participating in the network change periodically). In addition, you must show your ID card at the time that you receive services.

To locate the nearest participating Delta Dental PPO provider:

- Ask your provider if he/she participates in the Delta Dental PPO or Delta Dental Premier network.
- Contact Delta Dental directly by phone at 1-800-323-1743.
- Consult the Delta Dental website at www.deltadentalil.com. Periodically the list is updated. When you call for an appointment, verify with your provider that he or she participates in the Delta Dental PPO program.

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

Sincerely,

Board of Trustees

Appendix A: Dental Plan Exclusions

EXCLUSIONS THAT APPLY TO DIAGNOSTIC SERVICES:

- Pulp vitality tests billed in conjunction with any service except for an emergency exam or palliative treatment are not a covered benefit.

- Panoramic x-ray for a patient under age 6 is not a covered benefit

EXCLUSIONS THAT APPLY TO PREVENTIVE SERVICES:

- Recementation of a space maintainer within six months of initial placement is not a covered benefit.

EXCLUSIONS THAT APPLY TO RESTORATIVE SERVICES:

- Fillings are not a covered benefit when crowns are allowed for the same teeth.

- Replacement of any existing cast restoration (crowns, onlays, ceramic restorations) with any type of cast restoration within 60 months following initial placement of existing restoration is not a covered benefit.

- Replacement of a stainless steel crown with any type of cast restoration is not a covered benefit by the same office within 24 months following initial placement.

- A cast restoration is a covered benefit only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a covered benefit.

- When there is radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a covered benefit.

- The repair of any component of a cast restoration is not a covered benefit.

- Recementation of inlays, onlays, partial coverage restorations, cast and prefabricated posts and cores and crowns by the same office within six months of initial placement is not a covered benefit.

- Additional procedures to construct a new crown under the existing partial denture framework within six months following initial placement is not a covered benefit.

- When a sedative filling is requested or placed on the same date as a permanent filling, the sedative filling is not a covered benefit.

- Major restoratives for a patient under age 12 is not a covered benefit.

EXCLUSIONS THAT APPLY TO ENDODONTIC SERVICES:

- When a benefit has been issued for endodontic services, retreatment of the same tooth within two years is not a covered benefit.

- Endodontic procedures performed in conjunction with complete removable prosthodontic appliances are not a covered benefit.

EXCLUSIONS THAT APPLY TO PERIODONTIC SERVICES:

- Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions or periradicular surgery/apicoectomy is not a covered benefit.

- Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a covered benefit.

- Bone replacement grafts performed in conjunction with extractions or implants are not a covered benefit.

- Periodontal splinting to restore occlusion is not a covered benefit.

EXCLUSIONS THAT APPLY TO PROSTHODONTIC SERVICES:

- Replacement of any existing prosthodontic appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontic appliance within 60 months following initial placement of existing appliance is not a covered benefit.

- When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a covered benefit.

- Any prosthodontic appliance connected to an implant is not a covered benefit.

- Reline or rebase of an existing appliance within six months following initial placement is not a covered benefit.

- Fixed or removable prosthodontics for a patient under age 16 is not a covered benefit.

- Tissue conditioning is not a covered benefit.

- When the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth, a pontic is not a covered benefit.

EXCLUSIONS THAT APPLY TO ORAL SURGERY:

- Mobilization of an erupted or malpositioned tooth to aid eruption or placement of a device to facilitate eruption of an impacted tooth performed in conjunction with other oral surgery is not a covered benefit.

GENERAL EXCLUSIONS THAT APPLY TO ALL PROCEDURES:

Coverage is NOT provided for:

- Services compensable under Worker's Compensation or Employer's Liability laws.

- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.

- Services performed to correct developmental malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and congenitally missing teeth. This exclusion does not apply to *newborn infants.*

- Services performed for purely cosmetic purposes, including, but not limited to, tooth-colored veneers, bonding, porcelain restorations and microabrasion. Orthodontic care benefits shall fall within this exclusion unless such benefits are provided by endorsement.

- Charges for services completed prior to the date the person became covered under this program.
- Services for anesthetists or anesthesiologists.

- Temporary procedures.

- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.

- Services performed on non-functional teeth (second or third molar without an opposing tooth).

- Services performed on deciduous (primary) teeth near exfoliation.

- Drugs or the administration of drugs, except for general anesthesia and intravenous conscious sedation.

- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.

- Services with respect to any disturbance of the temporomandibular joint (jaw joint).

- Procedures, techniques or materials related to implantology or edentulous (toothless) ridge enhancement.

- Procedures that Delta Dental considers to be included in the fees for other procedures. For such procedures, a separate payment will not be made by this group dental plan. A Dentist in the Delta Dental PPO or Delta Dental Premier network may not bill the patient for such procedures.

- The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.

- Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.

- Broken appointments.

- Services and supplies for any illness or injury occurring on or after the *covered individual's effective date of coverage* as a result of war or an act of war.

- Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.

- Services and supplies received from either a *covered individual's* or *covered individual's* spouse's relative, any individual who ordinarily resides in the *covered individual's* home or any such similar person.

- Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.

- Charges for services for inpatient/outpatient hospitalization.

- Services or supplies for oral hygiene or plaque control programs.

- Services or supplies to correct harmful habits.

LOCAL NO. 1 HEALTH FUND
1431 Opus Place, Suite 350
DOWNERS GROVE, ILLINOIS 60515
Local (630) 288-6868 – Toll Free (866) 844-0488

April 2022

Dear Participant:

We write to share additional information and clarifications regarding coverage under the Plan of Benefits provided by the Local No. 1 Health Fund for drug testing required as part of treatment for substance abuse.

Coverage for Drug Testing

Coverage under the Plan includes coverage of miscellaneous services and supplies provided by a Hospital, Skilled Nursing Facility, Chemical Dependency Treatment Facility, network Outpatient Surgical Center, or Emergency Treatment Center on an inpatient or outpatient basis, including, but not limited to, clinical and pathological laboratory examinations, including, but not limited to drug testing as part of treatment for substance abuse. More generally, Plan coverage includes laboratory examinations, tests, or analyses made for diagnostic or treatment purposes, including for purposes of treatment of substance abuse.

Drug tests will be covered pursuant to the applicable Schedule of Benefits and subject to the deductible, coinsurance, and out-of-pocket maximums set forth therein.

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Please file this notice together with your Summary Plan Description ("SPD") booklet.

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

Sincerely,

Board of Trustees

4886-5407-2091.v1

LOCAL NO. 1 HEALTH FUND
1431 Opus Place, Suite 350
DOWNERS GROVE, ILLINOIS 60515
Local (630) 288-6868 – Toll Free (866) 844-0488

Responding to COVID-19

August 2021

Dear Fund Participant,

We recognize that you continue to work on the front line during these very challenging times. During this global health emergency, we are here to support you and your family. Please read this letter carefully as it includes important announcements and reminders.

COVID-19 Treatment Coverage

During this ongoing time of crisis, we are committed to removing barriers that might prevent you and your family from accessing care.

If you and/or a covered Dependent need to be treated for the coronavirus, the Fund will continue to cover 100% of the Reasonable and Customary Charge for in-network treatment of COVID-19 without cost-sharing. In other words, no Copayment, Coinsurance Percentage, or Deductible will apply for care received from in-Network Providers.

In addition, the Fund will continue to cover 100% of the cost for Emergency non-Network treatment of COVID-19 under minimum payment standards applicable under the Affordable Care Act. This means that the Fund will cover an amount equal to the greatest of the following three amounts:

- The median of the amount negotiated with Network Providers for Emergency services without regard to Copayments or Coinsurance Percentages;

- The amount the Plan generally pays for non-Network services, such as the Reasonable and Customary Charge, but without regard to in-Network Copayments or Coinsurance Percentages and without reduction for the Plan's usual cost-sharing for non-Network services; or

- The amount that would be paid under Medicare Parts A and B, without regards to copayments and coinsurance.

If you receive care from a non-Network Provider on a non-Emergency basis, however, the Plan's standard Copayments, Coinsurance Percentages, and Deductible will apply as set forth in the applicable Schedule of Benefits that accompanies your Summary Plan Description. Additionally, a non-Network Provider may balance bill you for the difference between what the Plan pays and its billed charge.

This expanded coverage for COVID-19 treatment began April 1, 2020, and has been extended through December 31, 2021. Thereafter, the Plan's standard Copayments, Coinsurance Percentages, and Deductibles will apply

COVID-19 Testing Coverage

Testing and all other services related to testing for COVID-19 will continue to be paid by the Fund at 100% without cost sharing through December 31, 2021. This includes coverage for the cost of the related office visit (including in-person and telehealth visits), urgent care clinic visit, or ER visit, and

any items and services provided during such visit that relate to the provision of testing. In other words, deductibles, co-payments, and coinsurance will not apply to the testing or any such services. If you see a PPO Provider, the Plan will pay the negotiated rate for the services in full. If you see a non-PPO Provider, the Plan will pay the cash price for such service as listed by the Provider on a public internet website, or the Plan may negotiate a rate with the Provider for less than such cash price, with either rate to be paid in full by the Plan. This means that regardless of whether you see a PPO Provider or non-PPO Provider, you will pay nothing for testing.

Also, there will be no pre-certification, prior authorization, or other medical management requirements for this testing.

As always, if you are in Plan A, you must see a Union Health Services provider or you must receive a referral from a Union Health Services (UHS) provider to receive coverage for a provider for services provided outside of UHS.

Note, this coverage does not apply to testing performed for public health surveillance or employment purposes

Telehealth Coverage

The Fund will continue to cover 100% of the Reasonable and Customary Charge for all telehealth visits through December 31, 2021.

If your provider offers telehealth services, we encourage you to take advantage of this service. You can save time and get the care you need without having to schedule a doctor's appointment or be exposed to others while sitting in a waiting room.

Initial Eligibility

Finally, effective April 1, 2020, the Plan had been amended to allow Employees of Contributing Employers to become initially eligible for benefits under the Plan as of the Employee's date of hire if the Employee is hired into full-time Covered Employment and provided that the Contributing Employer is obligated to and does contribute with respect to such Employee as of the date of hire. This waiver of the initial waiting period that otherwise applies also has been extended until December 31, 2021. Full-time covered employment is defined in the applicable Collective Bargaining Agreement, and generally means that you are regularly scheduled and expected to work 120 hours per month or more. Also, if you are employed by a Contributing Employer and transferred to a full-time position, you will become initially eligible as of the date of the transfer provided that your Employer is obligated to contribute on your behalf as of such date.

If you have questions about your benefits, call the Fund Office at 630-288-6868 or 866-844-0488.

We will continue to update you as things change.

Sincerely,

LOCAL NO. 1 HEALTH FUND
1431 Opus Place, Suite 350
DOWNERS GROVE, ILLINOIS 60515
Local (630) 288-6868 – Toll Free (866) 844-0488

The Board of Trustees

Please file this notice together with your Summary Plan Description ("SPD") booklet.

Local No. 1
SEIU Health Fund
United for Good Jobs and Strong Communities

Service Employees Local No. 1 SEIU-CLC
Apartment Building Owners and Managers Association

UPDATED Response to the Coronavirus (COVID-19): Changes to Initial Eligibility

May 2020

The Fund recognizes your hard work under challenging circumstances. During this global health emergency, the Trustees want to make sure that the Fund is here to support you .

Please read this letter carefully as it includes an important announcement of a change with respect to earning initial eligibility to participate in the Fund.

Initial Eligibility

During this time of crisis, we want to make sure that workers and their families have access to health care. Effective April 1, 2020, through December 31, 2020, Employees of Contributing Employers shall become initially eligible for benefits as of the Employee's date of hire if the Employee is hired into full-time Covered Employment, provided that the Contributing Employer is obligated to and does contribute with respect to such Employee as of the date of hire. Full-time covered employment is defined in the applicable Collective Bargaining Agreement, and generally means that you are regularly scheduled and expected to work 120 hours per month or more. Also, if you are employed by a Contributing Employer and transferred to a full-time position, you will become initially eligible as of the date of the transfer provided that your Employer is obligated to contribute on your behalf as of such date.

If you have questions about your benefits, call the Fund Office at 630-288-6868 or 866-844-0488. Due to social distancing recommendations, please do NOT visit the Fund Office. We will continue to update you as the situation develops.

Sincerely,

The Board of Trustees

Local No. 1
SEIU Health Fund
United for Good Jobs and Strong Communities

Service Employees Local No. 1 SEIU-CLC
Apartment Building Owners and Managers Association

January 2019

Dear Plan A Participants:

We are writing you to notify you of two changes with respect to receiving services under the plan of benefits ("Plan") provided by the Local No. 1 Health Fund ("Fund") to participants in Plan A, as set forth below. Please note: these changes pertain primarily to *where* you receive services and will not result in a reduction in benefits. Your benefits are either not changing or are improving.

Mental Health and Substance Abuse Treatment

The Plan provides coverage for mental health and substance abuse services generally as specified in the Summary Plan Description. Effective January 1, 2019, the Plan will not apply the deductible or coinsurance or copayments to outpatient mental health and substance abuse services received by Plan A participants. Additionally, effective January 1, 2019, all such services must be received from a Union Health Services (UHS) Provider. To initiate receipt of such services going forward, please contact your UHS primary care Physician for a referral. However, if prior to January 1, 2019, you were currently receiving ongoing outpatient mental health and/or substance abuse treatment from a non-UHS provider, you may continue to do so until further notice.

Dialysis

The Plan generally will continue to cover dialysis subject to the same terms and conditions as before. However, effective January 1, 2019, Plan A participants must obtain such services only from a Provider that has a contract with Union Health Services to provide such services. Currently, most dialysis that is provided to Plan A participants is already provided by such a Provider. However, if you need to switch to a different dialysis provider, UHS will be (or already has been) in touch with you to assist you in making the switch so that you can continue to receive coverage under the Plan for such services.

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Please file this notice together with your Summary Plan Description ("SPD") booklet.

If you have any questions about this notice, the information contained in the SPD, or about your benefits in general, please do not hesitate to contact the Plan Administrator.

Sincerely,

The Board of Trustees