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, visit www.uhh.org or call 1-855-405-FUND (3863). 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.cciio.cms.gov or call 1-855-405-FUND (3863) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	The plan does not have a deductible.
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?	Medical limit: $2,000 individual / $6,000 family Prescription drug limit: $1,600 individual / $3,200 family	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-billing charges, health care this plan doesn't cover, non-network expenses, and penalties for failure to obtain prior authorization for services.	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 www.bcbsil.com or call 1-800-810-2583 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.

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 copay/visit	50% coinsurance	You pay $15 copay/visit for Doctor on Demand (telehealth) visit.
	Specialist visit	$40 copay/visit	50% coinsurance	You pay $15 copay/visit for Doctor on Demand (telehealth) visit.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Benefits may be denied if the prior authorization program is not followed.
If you have a test	Diagnostic test (x-ray, blood work)	$20 copay/visit (non-hospital); $80 copay/visit (hospital)	50% coinsurance	Benefits may be denied if the prior authorization program is not followed.
	Imaging (CT/PET scans, MRIs)	$150 copay/visit (non-hospital); $250 copay/visit (hospital)	50% coinsurance	Benefits may be denied if the prior authorization program is not followed.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hospitalityrx.org	Generic drugs on the formulary	$5 copay/prescription (retail and mail order)	Not covered	No charge for certain preventive care drugs and supplies. Specialty drugs must be obtained through the specialty mail order pharmacy. Coverage limited to drugs on the formulary, unless formulary exception is approved. Quantity limits, prior authorization requirements, and other cost-containment programs may apply. *See section prescription drug benefits.
	Brand name Drugs on the formulary Brand name Diabetes oral medications, insulin and supplies on the formulary	$30 copay/ prescription (retail and mail order) $15 copay/prescription (retail and mail order)	Not covered	
	Generic Specialty and biosimilar drugs on the formulary Brand Name Specialty Drugs and biosimilar drugs on the formulary	$5 copay/prescription (retail and mail order) 25% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	$150 copay/visit (ambulatory surgery center); $250 copay/visit (hospital)	50% coinsurance	Benefits may be denied if the prior authorization program is not followed.

* For more information about limitations and exceptions, see the plan or policy document at www.uhh.org.

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 need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Copay waived if admitted. No coverage for non-emergency care in a non-network emergency room. Network care that could be provided during routine office/urgent care visit covered at 50% coinsurance.
	Emergency medical transportation	$150 copay/trip	$150 copay/trip	Coverage for ground ambulance limited to 2 trips/year. Benefits for air ambulance may be denied if the prior authorization program is not followed.
	Urgent care	$40 copay/visit	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/day, up to $750/admission	50% coinsurance	Benefits may be denied if the prior authorization program is not followed.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/office visit; $40 copay/day, up to $750/episode of care for other outpatient services	50% coinsurance	None.
	Inpatient services	$250 copay/day, up to $750/admission	50% coinsurance	None.
If you are pregnant	Office visits	$20 copay/visit	50% coinsurance	No coverage provided for pregnancy of a dependent child other than preventive care. Inpatient benefits may be denied if the prior authorization program is not followed. Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$250 copay/day, up to $750/admission	50% coinsurance	
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	Coverage limited to 30 visits/year. Benefits may be denied if the prior authorization program is not followed.
	Rehabilitation services	$20 copay/visit (non-hospital); $40 copay/visit (hospital)	50% coinsurance	Coverage for speech therapy limited to 30 visits/year. Coverage for physical/occupational therapy limited to 60 visits/year.
	Habilitation services			

* For more information about limitations and exceptions, see the plan or policy document at www.uhh.org.

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)	
	Skilled nursing care	$250 copay/day, up to $750/admission	50% coinsurance	Coverage limited to 30 days/year. Benefits may be denied if the prior authorization program is not followed.
	Durable medical equipment	25% coinsurance	Not covered	Benefits may be denied if the prior authorization program is not followed.
	Hospice services	No charge	50% coinsurance	Benefits may be denied if the prior authorization program is not followed.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Vision benefits may be provided separately.
	Children's glasses			
	Children's dental check-up	Not covered	Not covered	Dental benefits may be provided separately.

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
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Dental care (Adult) (may be provided separately)
- Dental care (Child) (may be provided separately)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult) (may be provided separately)
- Routine eye care (Child) (may be provided separately)
- Routine foot care
- Weight loss programs (unless for treatment of morbid obesity under direct supervision of a healthcare professional)

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

- Chiropractic care (limited to network providers and 12 visits/year)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: UNITE HERE HEALTH at 1-855-405-FUND (3863), or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

* For more information about limitations and exceptions, see the plan or policy document at www.uhh.org.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-855-405-FUND (3863).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-405-FUND (3863).

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-855-405-FUND (3863).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-405-FUND (3863).

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 www.uhh.org.

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	$0
Specialist copayment	$40
Hospital (facility) copayment	$250
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist 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	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$660

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$250
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$100
The total Joe would pay is	$1,100

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

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$150
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$410

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