Here's Your Summary of Benefits and Coverage!

Your Summary of Benefits and Coverage (SBC) summarizes your benefits for common medical care. Federal law requires you get the SBC at certain times so you can more easily compare benefits between plans. The SBC is not a detailed description of your benefits or how they work. If there is a conflict between this SBC and your Plan's documents, the Plan's documents govern.

- Your SBC shows the benefits available to you even if you choose not to enroll. (You may or may not be allowed to waive coverage.)
- The SBC primarily reflects your medical benefits. You may have additional vision or dental benefits not shown in the SBC. You may also have life, accidental death and dismemberment, or short-term disability benefits.
- The SBC includes a section called *Coverage Examples.* This section shows the estimated average cost and benefits paid for common medical procedures.
    - The costs reflect national averages, but may not reflect actual plan payments.
    - The coverage examples are based on certain assumptions. It is important to note these are examples only. You shouldn't use these examples to estimate your actual costs under the Plan.

Need More Information?

If you have questions about your SBC, your benefits under the Plan, or what enrollment options you may have, please contact UNITE HERE HEALTH at the phone number shown on your SBC.

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 1-866-686-0003. 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 1-866-686-0003 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network services: $0 Non-network services: $200/individual or $400/family	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Network services and the following non-network services: treatment in an emergency room, vision care, anesthesiology, or second or third surgical opinions.	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?	Yes. $100 for ambulance transportation and $100 for non-replaced blood and blood plasma (not applicable if overall deductible is met). There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$6,350 individual / $12,700 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, vision care, or 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. All transplant & CAR-T services: Fund-designated	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

	network must be used or won't be covered; see uhh.org.	(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	$10 copay/visit	20% coinsurance	None.
	Specialist visit	$10 copay/visit with referral from a primary care provider; $20 copay/visit without referral from a primary care provider	20% coinsurance	You pay $15/visit for network podiatry.
	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)	No charge	20% coinsurance	Benefits may be denied if the prior authorization program is not followed.
	Imaging (CT/PET scans, MRIs)	No charge	20% 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 and some brand drugs	$15 copay/prescription (retail); $10 copay/prescription (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 PPO option's prescription drug benefits.
	Preferred drugs	$25 copay/prescription (retail); $10 copay/prescription (mail order)	Not covered	
	Non-preferred drugs	$35 copay/prescription (retail); $10 copay/prescription (mail order)	Not covered	
	Select specialty drugs and	Generic: $10	Not covered	

* 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)	
	select biosimilars	copay/prescription (mail order); Brand: 25% coinsurance (mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance; Deductible does not apply to anesthesiology	Benefits may be denied if the prior authorization program is not followed.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	No charge	No charge; Deductible does not apply	None.
	Emergency medical transportation	No charge after $100 ambulance deductible	No charge after $100 ambulance deductible	None.
	Urgent care	$20 copay/visit	20% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% 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	$10 copay/office visit; No charge for other outpatient services	20% coinsurance	Benefits may be denied if the prior authorization program is not followed.
	Inpatient services	No charge	20% coinsurance	Benefits may be denied if the prior authorization program is not followed.
If you are pregnant	Office visits	$10 copay/visit	20% coinsurance; Deductible does not apply to anesthesiology	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Benefits may be denied if the prior authorization program is not followed.
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Coverage limited to 200 visits/year. Benefits may be denied if the prior authorization program is not followed.
	Rehabilitation services	No charge	20% coinsurance	Benefits may be denied if the prior authorization program is not followed.
	Habilitation services			
	Skilled nursing care	No charge	20% coinsurance	Coverage limited to 70 days/year. Benefits may be denied if the prior authorization

* 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)	
				program is not followed.
	Durable medical equipment	No charge	20% coinsurance	Benefits may be denied if the prior authorization program is not followed.
	Hospice services	No charge	20% coinsurance	Coverage limited to 210 days/lifetime. 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.)

- Bariatric surgery (unless medically necessary)
- Cosmetic surgery
- Dental care (Adult) (may be provided separately)
- Dental care (Child) (may be provided separately)
- 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)
- 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.)

- Acupuncture (limited to 25 visits/year, including up to 20 non-network visits)
- Chiropractic care
- Hearing aids (limited to $3,000/3 calendar years)
- Routine foot care

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 1-866-686-0003, or the 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.**

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

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 1-866-686-0003.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-686-0003.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-686-0003.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-686-0003.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-866-686-0003 uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-866-686-0003.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-866-686-0003.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-866-686-0003.

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	$10
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$80**

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	$10
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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*	$100
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$130**

Note: These numbers assume referrals from a PCP were obtained for specialty care. This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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