



## Here's Your Summary of Benefits and Coverage!

Your Summary of Benefits and Coverage (SBC) summarizes your benefits for common medical care. The SBC is required under federal law to let you 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](http://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](http://www.cciio.cms.gov) or call 1-866-686-0003 to request a copy.


Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network</a> services: \$0 Non-network services: \$200/individual or \$400/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Network</a> services and the following non-network services: treatment in an emergency room, vision care, anesthesiology, or second or third surgical opinions.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> 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 <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$6,350 individual / \$12,700 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, non-network expenses, vision care, or penalties for failure to obtain <a href="#">prior authorization</a> for services.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1-800-810-2583 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	None.
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> /visit with <a href="#">referral</a> from a <a href="#">primary care provider</a> ; \$20 <a href="#">copay</a> /visit without <a href="#">referral</a> from a <a href="#">primary care provider</a> .	20% <a href="#">coinsurance</a>	You pay \$15/visit for <a href="#">network</a> podiatry.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	20% <a href="#">coinsurance</a>	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	Imaging (CT/PET scans, MRIs)	No charge	20% <a href="#">coinsurance</a>	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.hospitalityrx.org">www.hospitalityrx.org</a>	Generic and some brand drugs	\$15 <a href="#">copay</a> /prescription (retail); \$10 <a href="#">copay</a> /prescription (mail order)	Not covered	No charge for certain preventive care drugs and supplies. <a href="#">Specialty drugs</a> must be obtained through the specialty mail order pharmacy. Coverage limited to drugs on the <a href="#">formulary</a> , unless <a href="#">formulary</a> exception is approved. Quantity limits, <a href="#">prior authorization</a> requirements and other cost-containment programs may apply. *See section PPO option's prescription drug benefits.
	Preferred drugs	\$25 <a href="#">copay</a> /prescription (retail); \$10 <a href="#">copay</a> /prescription (mail order)	Not covered	
	Non-preferred drugs	\$35 <a href="#">copay</a> /prescription (retail); \$10 <a href="#">copay</a> /prescription (mail order)	Not covered	
	Select <a href="#">specialty drugs</a> and select biosimilars	Generic: \$10 <a href="#">copay</a> /prescription (mail	Not covered	

\* For more information about limitations and exceptions, see the plan or policy document at [www.uhh.org](http://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)	
		order); Brand: 25% <a href="#">coinsurance</a> (mail order)		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	20% <a href="#">coinsurance</a> ; <a href="#">Deductible</a> does not apply to anesthesiology	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	Physician/surgeon fees			
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	No charge	No charge; <a href="#">Deductible</a> does not apply	None.
	<a href="#">Emergency medical transportation</a>	No charge after \$100 ambulance <a href="#">deductible</a>	No charge after \$100 ambulance <a href="#">deductible</a>	None.
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a>	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	20% <a href="#">coinsurance</a>	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	Physician/surgeon fees			
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$10 <a href="#">copay</a> /office visit; No charge for other outpatient services	20% <a href="#">coinsurance</a>	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	Inpatient services	No charge	20% <a href="#">coinsurance</a>	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
<b>If you are pregnant</b>	Office visits	\$10 <a href="#">copay</a> /visit	20% <a href="#">coinsurance</a> ; <a href="#">Deductible</a> does not apply to anesthesiology	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	Childbirth/delivery professional services	No charge	20% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge	20% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	20% <a href="#">coinsurance</a>	Coverage limited to 200 visits/year. Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	<a href="#">Rehabilitation services</a>	No charge	20% <a href="#">coinsurance</a>	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	<a href="#">Habilitation services</a>			
	<a href="#">Skilled nursing care</a>	No charge	20% <a href="#">coinsurance</a>	Coverage limited to 70 days/year. Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.

\* For more information about limitations and exceptions, see the plan or policy document at [www.uhh.org](http://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)	
	<a href="#">Durable medical equipment</a>	No charge	20% <a href="#">coinsurance</a>	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	<a href="#">Hospice services</a>	No charge	20% <a href="#">coinsurance</a>	Coverage limited to 210 days/lifetime. Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
<b>If your child needs dental or eye care</b>	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](#).)**

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Bariatric surgery (unless <a href="#">medically necessary</a>)</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult) (may be provided separately)</li> <li>• Dental care (Child) (may be provided separately)</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult) (may be provided separately)</li> <li>• Routine eye care (Child) (may be provided separately)</li> <li>• Weight loss programs (unless for treatment of morbid obesity under direct supervision of a healthcare professional)</li> </ul> |
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Acupuncture (limited to 25 visits/year, including up to 20 non-network visits)</li> <li>• Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids (limited to \$3,000/3 calendar years)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care</li> </ul> |
|---|--|---|

**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](http://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](http://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](http://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](#).

\* For more information about limitations and exceptions, see the plan or policy document at [www.uhh.org](http://www.uhh.org).

**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, kwijigo holne' 1-866-686-0003.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$80</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,020</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$100
<a href="#">Copayments</a>	\$30
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$130</b>

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.