PLAN UNIT 173 RETIREES — *Under age 65*

Benefits at a Glance

UNITE HERE! *Staff*

Have benefit or healthcare questions?

Care Coordinators are ready to help you

Sometimes we call you — call us back so we can help you!

Call us BEFORE you see a specialist or get a service listed on the back of your ID card!

- Save money on specialist copays by getting a referral from your primary care provider (PCP). When your PCP calls us **BEFORE** your specialist visit, your copay gets lowered by half.
- Have your doctor call us **BEFORE** you get a service listed on the back of your ID card. If you don't, in certain cases, your claim may not be paid at all.

Call Monday – Friday 8:30 AM – 10 PM EST

(866) 686-0003 • www.uhh.org

Medical — Blue Cross Blue Shield PPO	You pay	
Calendar Year Deductible	$200 per person $600 per family	$400 per person $800 per family
Basic Inpatient and Outpatient Benefits	**Network**	**Non-Network**
Inpatient Hospitalization	$0 after deductible	40% after deductible
Hospital Outpatient and Diagnostic Services	$0 after deductible	40% after deductible
Ambulatory Surgical Services	$0 after deductible	40% after deductible
Skilled Nursing Facility — *Up to 70 total days per person each year*	$0 after deductible	40% after deductible
Home Healthcare Services — *Up to 200 total visits per person each year*	$0 after deductible	40% after deductible
Hospice Care — *Up to 210 total lifetime visits per person*	$0 after deductible	40% after deductible
Hospital Emergency Room — *True emergency*	$0 after deductible	$0 after deductible
Hospital Emergency Room — *Non-emergency/routine care*	20% after deductible	60% after deductible

UNITE HERE HEALTH

This is an easy-to-read summary and does not include all benefits. If there is a conflict between this summary and your plan documents, then your plan documents are correct. For more details about your benefits or to find out which treatments/services require prior authorization, please refer to your Summary Plan Description (SPD) or call us at (866) 686-0003.

Medical and Surgical Benefits	Network	Non-Network
Lifetime Maximum Benefit per Person	$1,000,000	
Preventive Care		
Well Baby Care — *For children up to 18 months of age*	$0	Not Covered
Immunizations	$20 copay	Not Covered
Routine Colonoscopy or Routine PSA Tests — *Frequency limits and age restrictions apply*	$0	Not Covered
Preventive Exam — *1 per person each year*	$0	Not Covered
Office Visits		
Primary Care Provider (PCP)	$10 copay	40% after deductible
Specialist — *When your PCP calls the Care Coordinators first*	$10 copay	40% after deductible
Specialist — *When your PCP DOESN'T call the Care Coordinators first*	$20 copay	40% after deductible
Mental Health/Substance Abuse Office Visit	$20 copay	40% after deductible
Chiropractic	$20 copay	40% after deductible
Routine Podiatric	$20 copay	40% after deductible
Urgent Care		
Urgent Care Center	$20 copay	40% after deductible
Ambulance	First $50 in charges — $0 After first $50 in charges — 40% after deductible	
Other Services and Supplies		
Certified Diabetes Educator — *Up to $200 per person each year*	$0	Not Covered
Registered Dietitian — *Up to $200 per person each year*	$0	Not Covered
Speech and Physical Therapy — *Speech therapy for children limited to $2,500 per person each year*	$0 after deductible	40% after deductible
Durable Medical Equipment	$0 after deductible	40% after deductible
Formulary Prescription Drug Benefits — Hospitality Rx ***Available at most pharmacies; not available at CVS/Longs or Wal-Mart***	**Retail** ***Up to a 34-day supply***	**Mail Order** ***Up to a 60-day supply***
Annual Maximum Benefit — *Families with at least one person age 65 or older during the year*	$12,500 per family	
Annual Maximum Benefit — *Families with no one age 65 or older during the year*	$7,500 per family	
Preventive Healthcare Services Drugs	$0	
Generic Drugs	$15 copay	$15 copay
Brand Name Drugs	$30 copay	$30 copay
Specialty and Biosimilar Drugs	**Generic:** $15 copay **Brand:** 25% coinsurance	
Non-Formulary Prescription Drugs and Supplies	Not Covered	

Vision — Davis Vision

Covered person	Maximum benefit
Retirees and spouses	The Plan pays $75 every 24 months
Dependent children age 19 and older	The Plan pays $75 every 24 months
Dependent children under age 19	The Plan pays $75 every 12 months

Life Insurance

Only available to certain grandfathered retirees

Life Insurance	The Plan pays $5,000

Dental — Delta Dental PPO

Only available to certain grandfathered retirees and their dependents

Covered services	You Pay
Calendar Year Deductible	$25 per person $100 per family
Dental Services (Non-Orthdontic) Calendar Year Maximum Benefit	$2,000 per person
Diagnostic and Preventive Services	$0
Emergency Palliative Services	$0
Minor & Major Restorative Services	20% after deductible
Prosthodontic Services	20% after deductible
Orthodontic Services *Children under age 19 only*	40%
Orthodontic Lifetime Maximum Benefit	$500 per child