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 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?	$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?	$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, dental/vision care, or health care this plan doesn't cover.	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.uhh.org or call 1-866-686-0003 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	Primary care visit to treat an	Not covered	Not covered	None.

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)	
care provider's office or clinic	injury or illness			
	Specialist visit	Not covered	Not covered	None.
	Preventive care/screening/ immunization	Not covered	Not covered	None.
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	None.
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	None.
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 select biosimilars	Generic: $10 copay/prescription (mail order); Brand: 25% coinsurance (mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	Not covered	Not covered	None.
	Emergency medical transportation	Not covered	Not covered	None.
	Urgent care	Not covered	Not covered	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	None.
	Physician/surgeon fees			

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 mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None.
	Inpatient services	Not covered	Not covered	None.
If you are pregnant	Office visits	Not covered	Not covered	None.
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	None.
	Rehabilitation services	Not covered	Not covered	None.
	Habilitation services			
	Skilled nursing care	Not covered	Not covered	None.
	Durable medical equipment	Not covered	Not covered	None.
	Hospice services	Not covered	Not covered	None.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None.
	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
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult) (may be provided separately)
- Dental care (Child) (may be provided separately)
- Diagnostic tests or imaging
- Durable medical equipment
- Emergency room visits, emergency medical transportation or urgent care
- Health care in an office or clinic, including primary care, specialists, other practitioner visits, or preventive care
- Hearing aids
- Home health care
- Hospital stays
- Hospice services
- Infertility treatment
- Long-term care
- Mental health, behavioral health or substance abuse services
- Non-emergency care when traveling outside the U.S.
- Outpatient surgery
- Pregnancy, including office visits and childbirth/delivery
- Private duty nursing
- Rehabilitation and habilitation services
- Routine eye care (Adult)
- Routine eye exams/glasses (Child)
- Routine foot care
- Skilled nursing care
- Weight loss programs

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

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

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.**
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? **No.**
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.

*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	$0
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	$12,670
The total Peg would pay is	**$12,700**

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	$0
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	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,300
The total Joe would pay is	**$2,200**

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

The plan's overall deductible	$0
Specialist copayment	$0
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: This condition is not covered, so patient pays 100 percent.

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