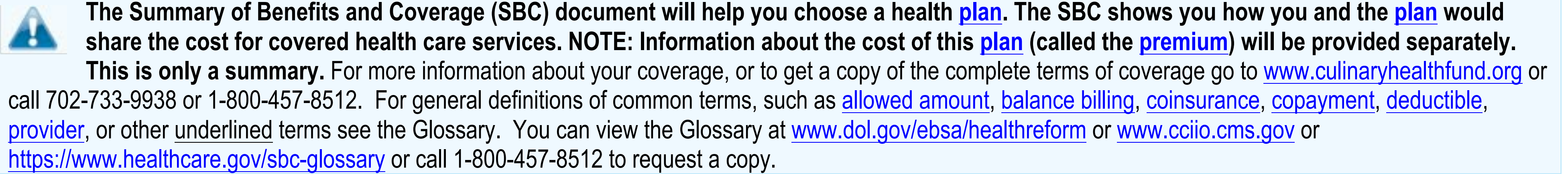
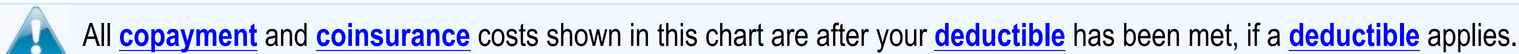


**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage go to www.culinaryhealthfund.org or call 702-733-9938 or 1-800-457-8512. 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.dol.gov/ebsa/healthreform or www.cciio.cms.gov or https://www.healthcare.gov/sbc-glossary or call 1-800-457-8512 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $0.00 | 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 | Not Applicable |
| **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 limit until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Dental copayments, expenses incurred out of network unless the Plan Administrator allows coverage at PPO rates provided an eligible person obtains prior authorization and the medical procedure is not available in the Las Vegas area, premiums, balance billing charges, and 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.culinaryhealthfund.org or call 702-733-9938 or 1-800-457-8512. | 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 labwork). 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) | Out-of-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 | $15 copay / visit | Not covered | ————none———— |
| | Specialist visit | $30 copay / visit | Not covered | ————none———— |
| | Preventive care/screening/ immunization | No charge | Not covered | Refer to www.healthcare.gov for a complete list of covered preventive health services. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | **XRAY:** $20 copay / visit at free-standing facility $30 copay / visit in dr's office $45 copay / visit in hospital outpatient dept **BLOOD WORK:** $0 copay / visit at free-standing facility No charge if in dr's office $15 copay / visit hospital outpatient dept | Not covered | Some services require prior authorization and will not be covered without such authorization. Copay for bloodwork done in a outpatient department of a hospital applies to hospital-based pre-operative or diagnostic services only |
| | Imaging (CT/PET scans, MRIs) | **CT/MRI:** $125 copay / visit **PET:** $175 copay / visit at free-standing facility $225 copay / visit in dr's office or hospital outpatient dept | Not covered | Some services require prior authorization and will not be covered without such authorization. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.culinaryhealthfund.org | Generic drugs (Tier 1) | $10 copay / prescription filled at a retail pharmacy | Not covered | No charge for prescriptions filled at the Culinary pharmacy. |
| | Preferred brand drugs (Tier 2) | $20 copay / prescription filled at a retail pharmacy | Not covered | |
| | Non-preferred brand drugs (Tier 3) | $35 copay / prescription filled at a retail pharmacy | Not covered | |
| | Specialty drugs (Tier 4) | 25% coinsurance | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $150 copay / surgery at ambulatory surgery center<br>$250 copay / surgery outpatient dept of hospital | Not covered | ————none———— |
| | Physician/surgeon fees | No charge | Not covered | ————none———— |
| **If you need immediate medical attention** | Emergency room care | $350 copay / visit | $350 copay / visit | ————none———— |
| | Emergency medical transportation | Ground ambulance:<br>25% coinsurance<br><br>Air ambulance:<br>$500 copay / person / incident | Ground ambulance:<br>25% coinsurance<br><br>Air ambulance:<br>$500 copay/ person / incident | ————none———— |
| | Urgent care | $40 copay / visit | Not covered | Copay includes all covered expenses related to the visit. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $250 copay / admission | $2,000 copay/ admission + 40% coinsurance of Allowable Charges | ————none———— |
| | Physician/surgeon fees | No charge | 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) | Out-of-Network Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | **OUTPATIENT THERAPY:** No copay first 5 visits, then $15 copay / visit **PARTIAL HOSPITAL ADMISSION:** $150 copay / treatment plan **INTENSIVE OUTPATIENT PROGRAM:** $150 copay / episode of care which means treatment of condition | Not covered | ————none———— |
| | Inpatient services | $250 copay / admission | $2,000 copay/ admission + 40% coinsurance of Allowable Charges | ————none———— |
| **If you are pregnant** | Office visits | No charge | Not covered | No coverage is provided for pregnancy of a dependent child, except as required under the Affordable Care Act. Additional co-pay may apply for additional services. |
| | Childbirth/delivery professional services | No charge | Not covered | |
| | Childbirth/delivery facility services | $250 copay / admission | $2,000 copay/ admission + 40% coinsurance of Allowable Charges | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | Not covered | Coverage limited to 60 days/year |
| | Rehabilitation services | $250 copay / admission for Inpatient | Not covered | Inpatient coverage limited to 60 days/year |
| | | At a free-standing facility:<br>• No charge for non-surgical and post-surgical physical therapy<br>• $20 copay / visit for occupational or | | At a free-standing facility:<br>• Occupational or speech therapy : limited to 30 visits per therapy type per year<br>• Post-surgical physical therapy limited to 30 visits per event.<br>Outpatient at a hospital after an admission: |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | speech therapy<br>• $30 copay / visit for cardio rehab<br><br>Outpatient at a hospital after an admission:<br>• $30 copay / visit for physical, occupational, speech therapy<br>• $40 copay / visit for cardio rehab | | • Physical, occupational or speech therapy limited to 30 visits per therapy type per year<br><br>Cardio rehab: limited to 30 visits per year at a free-standing facility or outpatient at a hospital |
| | Habilitation services | $250 copay / admission | Not covered | Limited to 60 days per calendar year |
| | Skilled nursing care | $250 copay / admission | Not covered | Limited to 60 days per calendar year |
| | Durable medical equipment | 10% coinsurance | Not covered | The Fund pays 100% for formula and medical food for enteral nutrition services. |
| | Hospice services | No charge | Not covered | ——————none—————— |
| **If your child needs dental or eye care** | Children's eye exam | $20 copay / exam | Not covered | ——————none—————— |
| | Children's glasses | Basic eyeglass lenses (not including upgrades or optional add-ons)- No charge | Not covered | Coverage for frames and contact lenses limited to $150 maximum benefit/ 24 months<br><br>There is an additional benefit of $150 per lifetime for eyeglasses following cataract surgery<br><br>A child is an eligible person under age 19. |
| | | Frames and contact lenses-No charge | Not covered | |
| | Children's dental check-up | No charge | Varies depending on the cost | Coverage limited to $1500/year for non-preferred provider |

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

## 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<br>• Bariatric surgery<br>• Cosmetic surgery | • Infertility treatment<br>• Long term care<br>• Non-emergency care when traveling outside of the U.S. | • Private duty nursing<br>• Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Chiropractic care<br>• Dental care (Adult) | • Hearing aids | • Routine eye care (Adult)<br>• 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: The plan at 702-733-9938 or 1-800-457-8512, US Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323, x61565 or www.cciio.cms.gov. 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: US 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**

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 1-800-457-8212.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-457-8212.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-457-8212.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-457-8212.

## 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 copay** | **$0** |
| ■ **Hospital (facility) copays** | **$250** |
| ■ **Other [cost sharing]** | **$70** |

**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** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $280 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $40 |
| **The total Peg would pay is** | **$320** |

### 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 copays** | **$50** |
| ■ **Hospital (facility) copay** | **$0** |
| ■ **Other copays** | **$130** |

**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 | $180 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$180** |

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

| | |
|---|---|
| ■ **The plan's overall deductible** | **$0** |
| ■ **Specialist copays** | **$60** |
| ■ **Hospital (facility) copays** | **$350** |
| ■ **Other coinsurance/copays** | **$130** |

**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 | $440 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$540** |

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