

 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.uhh.org or call 1-855-405-FUND (3863). 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 1-855-405-FUND (3863) 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. | This 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 ? | Medical limit: \$2,000 individual / \$6,000 family Prescription drug limit: \$1,600 individual / \$3,200 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, and 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 . | 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. |



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 | \$20 copay /visit | 50% coinsurance | None |
| | Specialist visit | \$40 copay /visit | 50% coinsurance | None |
| | 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) | \$20 copay /visit (non-hospital); \$80 copay /visit (hospital) | 50% coinsurance | Benefits may be denied if the prior authorization program is not followed. |
| | Imaging (CT/PET scans, MRIs) | \$150 copay /visit (non-hospital); \$250 copay /visit (hospital) | 50% 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 | \$5 copay /prescription (retail and mail order) | Not covered | No charge for certain preventive care drugs and supplies. Specialty drugs must be obtained through the specialty mail order pharmacy. Effective January 1, 2022, if you take Specialty drugs as part of your HIV treatment plan, you may be able to receive an exception to use your network retail pharmacy instead of the specialty 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 prescription drug benefits. |
| | Preferred drugs | \$15 copay / prescription (retail and mail order) | Not covered | |
| | Select Specialty and select biosimilar drugs | Generic: \$5 copay / prescription (mail order) Brand: 25% coinsurance (mail order) | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$150 copay /visit (ambulatory surgery center); | 50% coinsurance | Benefits may be denied if the prior authorization program is not followed. |
| | Physician/surgeon fees | \$250 copay /visit (hospital) | | |

| 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 immediate medical attention | Emergency room care | \$150 copay /visit | \$150 copay /visit | Copay waived if admitted. No coverage for non-emergency care in a non-network emergency room. Network care that could be provided during routine office/ urgent care visit covered at 50% coinsurance . |
| | Emergency medical transportation | \$150 copay /trip | \$150 copay /trip | Coverage for ground ambulance limited to 2 trips/year. Benefits for air ambulance may be denied if the prior authorization program is not followed. |
| | Urgent care | \$40 copay /visit | 50% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$250 copay /day, up to \$750/admission | 50% 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 | \$20 copay /office visit; \$40 copay /day, up to \$750/episode of care for other outpatient services | 50% coinsurance | None |
| | Inpatient services | \$250 copay /day, up to \$750/admission | 50% coinsurance | None |
| If you are pregnant | Office visits | \$20 copay /visit | 50% coinsurance | No coverage provided for pregnancy of a dependent child other than preventive care . Inpatient benefits may be denied if the prior authorization program is not followed. Cost sharing does not apply to certain preventive services . Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | \$250 copay /day, up to \$750/admission | 50% coinsurance | |
| | Childbirth/delivery facility services | | | |

| 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 help recovering or have other special health needs | Home health care | No charge | 50% coinsurance | Coverage limited to 30 visits/year. Benefits may be denied if the prior authorization program is not followed. |
| | Rehabilitation services | \$20 copay /visit (non-hospital); \$40 copay /visit (hospital) | 50% coinsurance | Coverage for speech therapy limited to 30 visits/year. Coverage for physical/occupational therapy limited to 60 visits/year. Benefits may be denied if the prior authorization program is not followed. |
| | Habilitation services | | | |
| | Skilled nursing care | \$250 copay /day, up to \$750/admission | 50% coinsurance | Coverage limited to 30 days/year. Benefits may be denied if the prior authorization program is not followed. |
| | Durable medical equipment | 25% coinsurance | Not covered | Benefits may be denied if the prior authorization program is not followed for items over \$500. |
| | Hospice services | No charge | 50% coinsurance | 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](#).)

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery (unless medically necessary) • Cosmetic surgery • Dental care (Adult) (may be provided separately) • Dental care (Child) (may be provided separately) • Hearing aids | <ul style="list-style-type: none"> • 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) | <ul style="list-style-type: none"> • Routine eye care (Child) (may be provided separately) • Routine foot care • 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.)

- Chiropractic Care (limited to [network providers](#) and 12 visits/year)

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: U.S Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and 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: UNITE HERE HEALTH at 1-855-405-FUND (3863), or the U.S Department of Labor, Employee Benefits Security Administration at 1-866-444-3372 or www.dol.gov/ebsa/healthreform. You may also contact the Trust Administration Office at 1-800-331-6158.

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 Value Standards](#), 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 1-855-405-FUND (3863).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-405-FUND (3863).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-405-FUND (3863).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-405-FUND (3863).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 | \$40 |
| ■ Hospital (facility) copayment | \$250 |
| ■ Other coinsurance | 20% |

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: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$600 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$50 |
| The total Peg would pay is | \$650 |

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 | \$40 |
| ■ Hospital (facility) copayment | \$250 |
| ■ Other coinsurance | 20% |

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: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$800 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$200 |
| The total Joe would pay is | \$1,000 |

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

| | |
|---|-------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$40 |
| ■ Hospital (facility) copayment | \$150 |
| ■ Other coinsurance | 20% |

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: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$500 |
| Coinsurance | \$10 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$510 |