

 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](http://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](http://www.cciio.cms.gov) or call 1-855-405-FUND (3863) to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$750/individual or \$1,500/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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Emergency treatment in an emergency room, <a href="#">network</a> services the <a href="#">plan</a> covers at 100% or for which you pay a <a href="#">copayment</a> , and <a href="#">prescription drugs</a> are covered before you meet your deductible.	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	Medical limit: <b>\$2,000</b> individual / <b>\$6,000</b> family Prescription drug limit: <b>\$1,600</b> individual / <b>\$3,200</b> 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, non-network expenses, and 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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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 <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit; <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	You pay \$15 <a href="#">copay</a> for Teladoc (telehealth) visit.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit; <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	You pay \$15 <a href="#">copay</a> for Teladoc (telehealth) visit.
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">Deductible</a> does not apply	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$25 <a href="#">copay</a> /visit (non-hospital); \$100 <a href="#">copay</a> /visit (hospital); <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	Imaging (CT/PET scans, MRIs)	\$175 <a href="#">copay</a> /visit (non-hospital); \$300 <a href="#">copay</a> /visit (hospital); <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic Drugs	\$5 <a href="#">copay</a> /prescription (retail and mail order); <a href="#">Deductible</a> does not apply	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 prescription drug benefits.
	Brand Name Drugs	\$30 <a href="#">copay</a> / prescription (retail and mail order); <a href="#">Deductible</a> does not apply	Not covered	
	Brand Name Diabetes oral medications, insulin and supplies	\$15 <a href="#">copay</a> /prescription (retail and mail order); <a href="#">Deductible</a> does not apply	Not covered	
	Select Specialty Drugs and Select Biosimilars	Generic: \$5 <a href="#">copay</a> /prescription (retail and mail order); <a href="#">Deductible</a> does not apply Brand: 25% <a href="#">coinsurance</a> , <a href="#">Deductible</a> does not apply	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> (ambulatory surgery center); 30% <a href="#">coinsurance</a> (hospital)	50% <a href="#">coinsurance</a>	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	Physician/surgeon fees			
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> /visit; <a href="#">Deductible</a> does not apply	\$200 <a href="#">copay</a> /visit; <a href="#">Deductible</a> does not apply	<a href="#">Copay</a> waived if admitted. No coverage for non-emergency care in a non-network emergency room. <a href="#">Network</a> care that could be provided during routine office/ <a href="#">urgent care</a> visit covered at 50% <a href="#">coinsurance</a> .
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a> (ground); 20% <a href="#">coinsurance</a> (air)	30% <a href="#">coinsurance</a> (ground); 20% <a href="#">coinsurance</a> (air)	Coverage for ground ambulance limited to 2 trips/year. Benefits for air ambulance may be denied if the <a href="#">prior authorization</a> program is not followed.
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit; <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copay</a> /office visit; No charge for other outpatient services; <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	Inpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	\$25 <a href="#">copay</a> /visit; <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	No coverage provided for pregnancy of a dependent child other than preventive care. Inpatient benefits may be denied if the <a href="#">prior authorization</a> program is not followed. <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> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

\* 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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	50% <a href="#">coinsurance</a>	Coverage limited to 30 visits/year. Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	<a href="#">Rehabilitation services</a>	\$30 <a href="#">copay</a> /visit (non-hospital); \$60 <a href="#">copay</a> /visit (hospital); <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	Coverage for speech therapy limited to 30 visits/year. Coverage for physical/occupational therapy limited to 60 visits/year.
	<a href="#">Habilitation services</a>			
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage limited to 30 days/year. Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	<a href="#">Durable medical equipment</a>	25% <a href="#">coinsurance</a>	Not covered	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	<a href="#">Hospice services</a>	No charge; <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	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](#).)

- Acupuncture
- Bariatric surgery (unless [medically necessary](#))
- Cosmetic surgery
- Dental care (Adult) (may be provided separately)
- Dental care (Child) (may be provided separately)
- Hearing aids
- 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)
- 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](http://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](http://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](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 1-855-405-FUND (3863), or the U.S Department of Labor, Employee Benefits Security Administration at 1-866-444-3372 or [www.dol.gov/ebsa/healthreform](http://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 [plan](#), [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? 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.*—————

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

#### 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>	\$750
<a href="#">Copayments</a>	\$90
<a href="#">Coinsurance</a>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$3,190</b>

### Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

#### 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>	\$800
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Joe would pay is</b>	<b>\$1,000</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$200
■ Other <a href="#">coinsurance</a>	30%

#### 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>	\$750
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,220</b>