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?	$750/individual or $1,500/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency treatment in an emergency room, network services the plan covers at 100% or for which you pay a copayment, and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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	$25 copay/visit; Deductible does not apply	50% coinsurance	You pay $15 copay for Teladoc (telehealth) visit.
	Specialist visit	$50 copay/visit; Deductible does not apply	50% coinsurance	You pay $15 copay for Teladoc (telehealth) visit.
	Preventive care/screening/ immunization	No charge; Deductible does not apply	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)	$25 copay/visit (non-hospital); $100 copay/ visit (hospital); Deductible does not apply	50% coinsurance	Benefits may be denied if the prior authorization program is not followed.
	Imaging (CT/PET scans, MRIs)	$175 copay/visit (non-hospital); $300 copay/ visit (hospital); Deductible does not apply	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.caremark.com	Generic Drugs	$5 copay/prescription (retail and mail order); Deductible does not apply	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 prescription drug benefits.
	Brand Name Drugs	$30 copay/ prescription (retail and mail order); Deductible does not apply	Not covered	
	Brand Name Diabetes oral medications, insulin and supplies	$15 copay/prescription (retail and mail order); Deductible does not apply	Not covered	
	Select Specialty Drugs and Select Biosimilars	Generic: $5 copay/ prescription(retail and mail order); Deductible does not apply Brand: 25% coinsurance, Deductible does not apply	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at 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% coinsurance (ambulatory surgery center); 30% coinsurance (hospital)	50% coinsurance	Benefits may be denied if the prior authorization program is not followed.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	$200 copay/visit; Deductible does not apply	$200 copay/visit; Deductible does not apply	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	30% coinsurance (ground); 20% coinsurance (air)	30% coinsurance (ground); 20% coinsurance (air)	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	$50 copay/visit; Deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	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	$25 copay/office visit; No charge for other outpatient services; Deductible does not apply	50% coinsurance	None
	Inpatient services	30% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	$25 copay/visit; Deductible does not apply	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	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services			

* For more information about limitations and exceptions, see the plan or policy document at 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 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	$30 copay/visit (non-hospital); $60 copay/visit (hospital); Deductible does not apply	50% coinsurance	Coverage for speech therapy limited to 30 visits/year. Coverage for physical/occupational therapy limited to 60 visits/year.
	Habilitation services			
	Skilled nursing care	30% coinsurance	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.
	Hospice services	No charge; Deductible does not apply	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.)

- 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)

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

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 Coverae 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, kwiijigo 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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* 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	$750
Specialist copayment	$50
Hospital (facility) coinsurance	30%
Other coinsurance	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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$90
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$3,190**

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

The plan's overall deductible	$750
Specialist copayment	$50
Hospital (facility) coinsurance	30%
Other coinsurance	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)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
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	$750
Specialist copayment	$50
Hospital (facility) copayment	$200
Other coinsurance	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)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$400
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,220**

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