

 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.hospitalityplan.org](http://www.hospitalityplan.org) or call 1-855-405-3863. 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 1-855-405-3863 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not Applicable.	This <a href="#">plan</a> does not have a deductible.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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> .
Will you pay less if you use a <a href="#">network provider</a> ?	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 network provider might use an out-of-network provider for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$20 <a href="#">copay</a> /visit (non-hospital); \$80 <a href="#">copay</a> /visit (hospital)	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)	\$150 <a href="#">copay</a> /visit (non-hospital); \$250 <a href="#">copay</a> /visit (hospital)	50% <a href="#">coinsurance</a>	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.hospitalityrx.org">www.hospitalityrx.org</a>	Generic and some Brand drugs	\$5 <a href="#">copay</a> /prescription (retail and mail order)	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. Effective January 1, 2022, if you take <a href="#">Specialty drugs</a> 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 <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.
	Preferred drugs	\$15 <a href="#">copay</a> /prescription (retail and mail order)	Not covered	
	Non-preferred drugs	\$30 <a href="#">copay</a> /prescription (retail and mail order)	Not covered	
	Select Specialty and select biosimilar drugs	Generic: \$5 <a href="#">copay</a> /prescription (mail order) Brand: 25% <a href="#">coinsurance</a> /prescription (mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <a href="#">copay</a> /visit (ambulatory surgery center);	50% <a href="#">coinsurance</a>	Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	Physician/surgeon fees	\$250 <a href="#">copay</a> /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	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> /visit	\$150 <a href="#">copay</a> /visit	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	\$150 <a href="#">copay</a> /trip	\$150 <a href="#">copay</a> /trip	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>	\$40 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <a href="#">copay</a> /day, up to \$750/admission	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	\$20 <a href="#">copay</a> /office visit; \$40 <a href="#">copay</a> /day, up to \$750/episode of care for other outpatient services	50% <a href="#">coinsurance</a>	None
	Inpatient services	\$250 <a href="#">copay</a> /day, up to \$750/admission	50% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	\$20 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	No coverage provided for pregnancy of a dependent child other than <a href="#">preventive care</a> . 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	\$250 <a href="#">copay</a> /day, up to \$750/admission	50% <a href="#">coinsurance</a>	
	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)	
<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/per person each year. Benefits may be denied if the <a href="#">prior authorization</a> program is not followed.
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> /visit (non-hospital); \$40 <a href="#">copay</a> /visit (hospital)	50% <a href="#">coinsurance</a>	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 <a href="#">authorization program</a> is not followed.
	<a href="#">Habilitation services</a>			
	<a href="#">Skilled nursing care</a>	\$250 <a href="#">copay</a> /day, up to \$750/admission	50% <a href="#">coinsurance</a>	Coverage limited to 30 days/per person each 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 for items over \$500.
	<a href="#">Hospice services</a>	No charge	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](#).)

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery (unless <a href="#">medically necessary</a>)</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult) (may be provided separately)</li> <li>• Dental care (Child) (may be provided separately)</li> <li>• Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult) (may be provided separately)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Child) (may be provided separately)</li> <li>• Routine foot care</li> <li>• Weight loss programs (unless for treatment of morbid obesity under direct supervision of a healthcare professional)</li> </ul> |
|--|---|---|

##### 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)
- Hearing aids (\$3000 limit / every 3 years)

**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 1-855-405-3863, 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 [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 1-855-405-3863.

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

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

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

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-855-405-3863 uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-405-3863.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-405-3863.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, á'gang 1-855-405-3863.

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*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>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other <a href="#">coinsurance</a>	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)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$50
<b>The total Peg would pay is</b>	<b>\$650</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>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other <a href="#">coinsurance</a>	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)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$0
What isn't covered	
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>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$150
■ Other <a href="#">coinsurance</a>	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)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$10
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$510</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.