Culinary Health Fund

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www.culinaryhealthfund.org

April 13, 2015

Dear Culinary Participant,

Enclosed in this mailing you will find the "Summary of Benefits and Coverage" (SBC) for your health benefits starting April 1, 2015.

The SBC is a quick outline of some of your copayments. It also explains what services are covered by the Plan as well as some of those that are not covered. By law, we have to mail the SBC to you whenever there are changes to your benefits and copayments.

You should read this whole document carefully. It has a lot of important information.

Please call the Culinary Health Fund customer service office at 702-733-9938 if you do not understand the SBC. They will be able to answer all your questions.

Sincerely,

Culinary Health Fund

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.culinaryhealthfund.org or by calling 702-733-9938 or 1-800-457-8512.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. $6,350/person $12,700/family	The **out–of–pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses
What is not included in the out–of–pocket limit?	Expenses incurred out-of-network, premiums, balance billed charges, dental **copayments** and health care this plan does not cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, see www.culinaryhealthfund.org or call **702-733-9938** or **1-800-457-8512**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital (hosp) may use an out-of-network **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: Call 702-733-9938 or 1-800-457-8512 or visit us at www.culinaryhealthfund.org for more information, including a copy of your Plan's Summary Plan Description. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 702-733-9938 or 1-800-457-8512 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
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——————
	Other practitioner office visit	$25 **copay**/visit for chiropractic	Not covered for Chiropractor	Coverage limited to number of visits approved by **plan**
	Preventive care/screening/ immunization	No charge	Not covered	Refer to www.healthcare.gov for a complete list of covered preventive health services.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	**XRAY:** $20 **copay** free-standing facility $30 **copay** in dr's office $45 **copay** hosp outpatient dept **BLOOD WORK:** $0 **copay** free-standing facility $10 **copay** in dr's office $15 **copay** hosp 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 hosp applies to hosp-based pre-operative or diagnostic services only
	Imaging (CT/PET scans, MRIs)	**CT/MRI:** $125 **copay** **PET:** $175 **copay** free-standing facility $225 **copay** office visit or hosp outpatient dept	Not covered	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.culinaryhealthfund.org	Generic drugs (including specialty)	$10 **copay**/prescription	Not covered	No charge for prescriptions filled at the Culinary pharmacy.
	Preferred brand drugs (including specialty)	$30 **copay**/prescription filled at a retail pharmacy	Not covered	
	Non-preferred brand drugs (including specialty)	$50 **copay**/prescription	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee	$150 **copay –** ambulatory surgery center $250 **copay** - hosp	Not covered	——————none——————
	Physician/surgeon fees	$0 **copay**	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$350 **copay**/visit	$350 **co-pay/**visit	——————none——————
	Emergency medical transportation	Ground ambulance: 25% **coinsurance** Air ambulance: $500 per person per incident	Ground ambulance: 25% **coinsurance** Air ambulance: $500 per person per 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 **co-pay**/admission + 40% of Allowable Charges	——————none——————
	Physician/surgeon fee	No charge	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**OUTPATIENT THERAPY:** No **copay** first 5 visits, then $15 **copay**/visit **PARTIAL HOSPITAL ADMISSION:** $150 **copay**/treatment plan **INTENSIVE OUTPATIENT PROGRAM:** $150/episode of care which means treatment of condition	Not covered	————————none————————
	Mental/Behavioral health inpatient services	$250 **copay**/admission	$2,000 **co-pay**/admission + 40% of Allowable Charges	
	Substance use disorder outpatient services	$150 **copay**/visit	Not covered	
	Substance use disorder inpatient services	$250 **copay**/admission	$2,000 **co-pay**/admission + 40% of Allowable Charges	
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	No coverage is provided for pregnancy of a dependent child. Additional **co-pay** may apply for additional services.
	Delivery and all inpatient services	$250 **copay**/admission	$2,000 **co-pay**/admission + 40% of Allowable Charges	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$0 **copay**	Not covered	Coverage limited to 60 days/year
	Rehabilitation services	$250 **copay** for Inpatient	Not covered	Inpatient coverage limited to 60 days/year
		At a free-standing facility: • $0 **copay** for non-surgical and post-surgical physical therapy • $20 **copay** for occupational or speech therapy • $30 **copay** for cardio rehab Outpatient at a hospital after an admission: • $30 **copay** for physical, occupational, speech therapy • $40 **copay** cardio rehab		At a free-standing facility: • Occupational or speech therapy : limited to 30 visits per therapy type per year • Post-surgical physical therapy limited to 30 visits per event. Outpatient at a hospital after an admission: • Physical, occupational or speech therapy limited to 30 visits per therapy type per year Cardio rehab: limited to 30 visits per year at a free-standing facility or outpatient at a hospital.
	Habilitation services	$250 **copay**	Not covered	——————none——————
	Skilled nursing care	$250 **copay**	Not covered	——————none——————
	Durable medical equipment	10% **coinsurance**	Not covered	——————none——————
	Hospice service	No charge	Not covered	——————none——————
If your child needs dental or eye care	Eye exam	$20 **copay**/exam	Not covered	——————none——————
	Glasses	No charge	Not covered	Coverage limited to $150 maximum benefit/ 24 months

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Dental check-up	No charge	No charge	Coverage limited to $1500/year for non-preferred **provider**

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside of the U.S.
- Private duty nursing

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Dental care (adult)
- Hearing aids
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the **plan**, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the **plan** at 702-733-9938 or 1-800-457-8512. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Questions: Call 702-733-9938 or 1-800-457-8512 or visit us at www.culinaryhealthfund.org for more information, including a copy of your Plan's Summary Plan Description. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 702-733-9938 or 1-800-457-8512 to request a copy.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 702-733-9938 or 1-800-457-8512 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Office of Consumer Health Assistance, Governor's Consumer Health Advocate at 555 East Washington Ave #4800, Las Vegas, NV 89101, (702) 486-3587, (888) 333-1597, http://dhhs.nv.gov/Programs/CHA or cha@govcha.nv.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-457-8512

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-457-8512

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,260
- **Patient pays** $280

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**
Patient pays:	
Deductibles	$0
Copays	$280
Coinsurance	$0
Limits or exclusions	$0
Total	**$280**

Notes: While the mother is in the hospital, the baby's charges are paid as claims incurred by the mother. Lab tests are processed at contracted facilities. Culinary pharmacy and free flu clinic are used.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers: $5,400

- **Plan pays** $5,280
- **Patient pays** $120

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**
Patient pays:	
Deductibles	$0
Copays	$120
Coinsurance	$0
Limits or exclusions	$0
Total	**$120**

Notes: Lab tests are processed at contracted facilities. Culinary pharmacy is used for meds & diabetic medical equipment & supplies.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services(HHS), and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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