UNITE HERE HEALTH

Las Vegas Plan 150

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 04/01/2013

Coverage for Family Plan Type: PPO

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?	Yes. **$250**/person-**$500**/family shared with **preferred** inpatient hospital, **non-preferred** inpatient hospital in Las Vegas geographical area, skilled nursing, home healthcare, inpatient rehab; **$125**/person-**$250**/family shared with all **non-preferred** outpatient, physician & ER services; **$75**/person for **preferred provider** outpatient hospital services; there are other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$500**/person for certain preferred outpatient hospital services, **$300**/person-**$600**/family for preferred DME, oxygen, prosthetics & orthotic appliances; **$1,000**/person for mental health counseling.	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?	**Premiums**, **balance-billed** charges, certain **co-insurances**, **co-pays**, **deductibles**, and health care this **plan** doesn't cover. **Preferred provider** diagnostic services and sleep studies also not included.	Even though you pay these expenses, they don't count towards the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes, $2 million.	This **plan** will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of

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Important Questions	Answers	Why this Matters:
		office visits.
Does this plan use a network of providers?	Yes. For a list of **preferred providers**, see www.culinaryhealthfund.org or call **702-733-9938** or **1-800-457-8512**.	If you use a 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 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 5. See your policy or **plan** document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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 **preferred providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$14 **co-pay**/visit	40% coinsurance	**Non-preferred provider** coverage limited to $20/visit & $1,000 ann. max
	Specialist visit	$20 **co-pay**/visit	40% co-insurance	**Non-preferred provider** coverage limited to $20/visit & $1,000/ann. max
	Other practitioner office visit	$14 **co-pay**/visit for Chiropractor	Not covered for Chiropractor	Coverage limited to number of visits approved by **plan**
	Preventive care/screening/ immunization	$14 **co-pay**/visit for preventive care; **co-pays** for screenings vary; $6 **co-pay**/ injection	Not covered	See Section 3.19 of your Summary Plan Description for a list of covered preventive care.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Preferred Provider	Non-Preferred Provider	
If you have a test	Diagnostic test in practitioner office (x-ray, blood work)	$12 **co-pay**/x-ray $5 **co-pay**/lab visit	40% **co-insurance**	**Non-preferred provider** coverage is limited to $1000 ann. max
	Imaging (CT/PET scans, MRIs)	$55 **co-pay**/CT or MRI/ visit $155 **co-pay**/PET	Not covered	No coverage without prior authorization; $155 **co-pay** applies for a combined PET/CT
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.culinaryhealthfund.org**.	Generic drugs	$10 **co-pay**/prescription (retail & mail order)	Not covered	No charge for prescriptions filled at the Culinary pharmacy. See Summaries of Material Modifications dated Jan 1, 2013 & Dec 2010 & Section 3.20 of the Summary Plan Description for more information about your Prescription Drug Program.
	Preferred brand drugs	$20 **co-pay**/prescription (retail & mail order)	Not covered	
	Non-preferred brand drugs	$35 **co-pay**/prescription (retail & mail order)	Not covered	
	Specialty drugs	$35 **co-pay**/prescription (retail & mail order)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$77 **co-pay**/procedure	Not covered	——————none——————
	Physician/surgeon fees	$0	Not covered	
If you need immediate medical attention	Emergency room services	$150 **co-pay** (emergency) $150 **co-pay** & 40% **co-insurance** (non emergency)	40% **co-insurance** (emergency) $50 **co-pay** & 40% **co-insurance** (non emergency)	Coverage for **preferred provider** non-ER services limited to $500/visit Coverage for **non-preferred provider** ER services limited to $200/visit
	Emergency medical transportation	20% **co-insurance** (ground); No charge after $500/person-$1,000/family **deductible** (air ambulance)	20% **co-insurance** (ground); No charge after $500/person-$1,000/family **deductible** (air ambulance)	Coverage limited to 3 ground transports/year & 1 air transport/life time
	Urgent care	$20 **co-pay**/visit	40% **co-insurance**	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a Preferred Provider	Your cost if you use a Non-Preferred Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after **deductible**	$500 copay and 40% **co-insurance**	Coverage for **non-preferred provider** is limited to $15,000/admission
	Physician/surgeon fee	$0 **co-pay**	40% **co-insurance**	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge for first 5 visits, then $15 **co-pay**/visit; $5 **co-pay**/visit for group therapy	Not covered	Coverage limited to 40 individual visits/year. No **co-pay** for up to the first 5 visits per diagnosis/year in the Culinary Care Assistance Program (CCAP) (visits do not apply to 40-visit limit).
	Mental/Behavioral health inpatient services	$250 **co-pay**/admission and 10% **co-insurance**	Not covered	$1000/person/year **out-of-pocket limit.** Coverage limited to 40 days/year
	Substance use disorder outpatient services	No charge	Not covered	——————none——————
	Substance use disorder inpatient services	No charge 1st admission 20% **co-insurance** 2nd admission	Not covered	Coverage limited to 2 admissions/ lifetime
If you are pregnant	Prenatal and postnatal care	No charge	40% **co-insurance**	No coverage is provided for pregnancy of a dependent child. Additional **co-pays** may apply for additional services. **Non-preferred provider** coverage limited to $20/visit & $1,000 annual max for **physician services** and $15,000 for **non-preferred** hospital services.
	Delivery and all inpatient services	No charge after **deductible**	$500 **co-pay**/ admission & 40% **co-insurance**	
If you need help recovering or have other special health needs	Home health care	No charge after **deductible**	Not covered	Coverage limited to 60 days/year included with infusion therapy services
	Rehabilitation services	No charge after **deductible** for inpatient	Not covered	Coverage limited to 60 days/year for inpatient

Common Medical Event	Services You May Need	Your cost if you use a Preferred Provider	Your cost if you use a Non-Preferred Provider	Limitations & Exceptions
		No charge for outpatient	Not covered	Outpatient coverage limited to 60 visits/year/therapy type; Outpatient cardiac rehab limited to 40 visits/year/cardiac event. Exclusion: Speech therapy related to childhood developmental delay including autism spectrum disorder/pervasive development disorder.
	Habilitation services	No charge after **deductible**	Not covered	Coverage limited to 60 days/year/ therapy type
	Skilled nursing care	No charge after **deductible**	Not covered	Coverage limited to 60 days/year Exclusion: Custodial care
	Durable medical equipment	No charge diabetic supplies; 10% **co-insurance** insulin pumps & other **DME**	Not covered	Ann. max **out-of-pocket** $300/ person & $600/family
	Hospice service	No charge	Not covered	——————none——————
If your child needs dental or eye care	Eye exam	$20 **co-pay**	Not covered	——————none——————
	Glasses	No charge	Not covered	Coverage limited to $150 max benefit for corrective lenses/24 months
	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 the U.S.
- Private duty nursing
- Weight loss programs

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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/orthodontic care (adult)
- Hearing Aids
- Routine eye care (adult)
- Routine foot care

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.

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.

Para obtener asistencia en Español, llame al 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 Hospital delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,180
- **Patient pays** $360

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	$300
Co-pays	$60
Co-insurance	$0
Limits or exclusions	$0
Total	**$360**

Notes: While the mother is in the hospital, the baby's charges are paid as part of the mother's claim. Coverage is for eligible employee, eligible spouse or eligible domestic partner only.
Lab tests are processed at contracted facilities.
Culinary pharmacy and free flu clinic are used.

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,100
- **Patient pays** $300

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
Co-pays	$100
Co-insurance	$0
Limits or exclusions	$200
Total	**$300**

Notes: The patient is assumed to be an eligible person.
Lab tests are processed at contracted facilities.
Culinary pharmacy is used for medications and diabetic medical equipment & supplies.
Exclusions include diabetic dietician and pneumococcal vaccine.

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, 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 **preferred providers**. If the patient had received care from **non-preferred providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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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