

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.culinaryhealthfund.org or call 702-733-9938 or 1-800-457-8512. 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.dol.gov/ebsa/healthreform or www.cciio.cms.gov or <https://www.healthcare.gov/sbc-glossary> or call 1-800-457-8512 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0.00	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Not Applicable	Not Applicable
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$6,350 individual / \$12,700 family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Dental <u>copayments</u> , expenses incurred out of network unless the Plan Administrator allows coverage at PPO rates provided an eligible person obtains prior authorization and the medical procedure is not available in the Las Vegas area, <u>premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.culinaryhealthfund.org or call 702-733-9938 or 1-800-457-8512.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's PPO <u>network</u> . You will pay the most if you use a Non-PPO <u>provider</u> , and you might receive a bill from a Non-PPO <u>provider</u> for the difference between the Non-PPO <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your PPO <u>network provider</u> might use a Non-PPO <u>provider</u> for some services (such as labwork). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> / visit	Not covered	No <u>copay</u> for visits at the Culinary Health Center. The participant and his/her eligible dependents (excluding minor children) must see a doctor at the Culinary Health Center as your primary care physician.
	<u>Specialist</u> visit	\$30 <u>copay</u> / visit	Not covered	—————none—————
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	Refer to www.healthcare.gov for a complete list of covered preventive health services.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	XRAY: \$20 <u>copay</u> / visit at free-standing facility \$30 <u>copay</u> / visit in dr's office \$45 <u>copay</u> / visit in hospital outpatient BLOOD WORK: \$0 <u>copay</u> / visit at free-standing facility No charge if in dr's office \$15 <u>copay</u> / visit hospital outpatient	Not covered	Some services require prior authorization and will not be covered without such authorization. <u>Copay</u> for bloodwork done in an outpatient department of a hospital applies to hospital-based pre-operative or diagnostic services only. No <u>copay</u> for X-rays or labwork done at the Culinary Health Center.
	Imaging (CT/PET scans, MRIs)	CT/MRI: \$125 <u>copay</u> / visit PET: \$175 <u>copay</u> / visit at free-standing facility \$225 <u>copay</u> / visit in dr's office or hospital outpatient	Not covered	Some services require prior authorization and will not be covered without such authorization.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.culinaryhealthfund.org	Generic drugs (Tier 1)	\$10 <u>copay</u> /prescription (retail and mail order)	Not covered	No charge for prescriptions filled at the Culinary pharmacy or at the Culinary Health Center. Quantity limits, prior authorization requirements, and other cost-containment programs may apply.
	Preferred brand drugs (Tier 2)	\$20 <u>copay</u> /prescription (retail and mail order)	Not covered	
	Non-preferred brand drugs (Tier 3)	\$35 <u>copay</u> /prescription (retail and mail order)	Not covered	
	Specialty drugs (Tier 4)	25% <u>coinsurance</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 <u>copay</u> /surgery (ambulatory surgery center); \$250 <u>copay</u> /surgery (hospital)	Not covered	Benefits may be denied if the prior authorization program is not followed.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	\$350 <u>copay</u> /visit	\$350 <u>copay</u> /visit	No coverage for non-emergency care in a Non-PPO emergency room in the Las Vegas geographic area.
	Emergency medical transportation	25% <u>coinsurance</u> (ground); \$500 <u>copay</u> /person/incident (air)	25% <u>coinsurance</u> (ground); \$500 <u>copay</u> /person/incident (air)	—————none—————
	Urgent care	\$40 <u>copay</u> /visit	\$40 <u>copay</u> /visit	No coverage for services at Non-PPO Urgent Care in the Las Vegas geographic area. <u>Copay</u> includes all covered services related to the visit. No <u>copay</u> for visits at the Culinary Health Center.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> / admission	\$2,000 <u>copay</u> / admission + 40% <u>coinsurance</u> of Allowable Charges	Benefits may be denied if the prior authorization program is not followed for Non-PPO Providers.
	Physician/surgeon fees	No charge	Not covered	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient Therapy: No <u>copay</u> first 5 visits, then \$15 <u>copay</u> / visit Partial Hospital Admission: \$150 <u>copay</u> / treatment plan Intensive Outpatient Program: No charge	Not covered	Some services require prior authorization and will not be covered without such authorization.
	Inpatient services	\$250 <u>copay</u> / admission	\$2,000 <u>copay</u> / admission + 40% <u>coinsurance</u> of Allowable Charges	Benefits may be denied if the prior authorization program is not followed for Non-PPO <u>Providers</u> .
If you are pregnant	Office visits	No charge	Not covered	No coverage is provided for pregnancy of a dependent child, except as required under the Affordable Care Act. Additional <u>copay</u> may apply for additional services. Benefits may be denied if the prior authorization program is not followed.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$250 <u>copay</u> / admission	\$2,000 <u>copay</u> / admission + 40% <u>coinsurance</u> of Allowable Charges	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Coverage limited to 60 days/year. Benefits may be denied if the prior authorization program is not followed.
	Rehabilitation services	\$250 <u>copay</u> / admission for Inpatient	Not covered	Inpatient coverage limited to 60 days/year. Benefits may be denied if the prior authorization program is not followed.
		At a free-standing facility: <ul style="list-style-type: none"> • No charge for non-surgical and post-surgical physical therapy • \$20 <u>copay</u> / visit for occupational or speech therapy • \$30 <u>copay</u>/visit for cardio rehab 	Not covered	At a free-standing facility: <ul style="list-style-type: none"> • Occupational or speech therapy: limited to 30 visits per therapy type per year for individuals age 18 and older • Occupational or speech therapy; limited to 60 visits per therapy type per year for individuals under the age of 18 • Post-surgical physical therapy limited to 30 visits per event.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
		Outpatient at a hospital after an admission: <ul style="list-style-type: none"> • \$30 <u>copay</u> / visit for physical, occupational, speech therapy • \$40 <u>copay</u> / visit for cardio rehab 	Not covered	Outpatient at a hospital after an admission: <ul style="list-style-type: none"> • 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. Some services require prior authorization and will not be covered without such authorization.
	Habilitation services			
	Skilled nursing care	\$250 <u>copay</u> / admission	Not covered	Limited to 60 days per calendar year. Benefits may be denied if the prior authorization program is not followed.
	Durable medical equipment	10% <u>coinsurance</u>	Not covered	The Fund pays 100% for formula and medical food for enteral nutrition services. Prior authorization required for items over \$500.
	Hospice services	No charge	Not covered	—————none—————
If your child needs dental or eye care	Children's eye exam	\$20 <u>copay</u> / exam	Not covered	There is a \$10 <u>copay</u> if the exam is done at the Culinary Health Center.
	Children's glasses	Basic eyeglass lenses (not including upgrades or optional add-ons)- No charge	Not covered	Coverage for frames and contact lenses limited to \$150 maximum benefit/ 24 months.
		Frames and contact lenses-No charge	Not covered	There is an additional benefit of \$150 per lifetime for eyeglasses following cataract surgery. A child is an eligible person under age 19.
	Children's dental check-up	No charge	Varies depending on the cost	Coverage limited to \$1500/year for Non-PPO <u>provider</u> .

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

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](#).)

- | | | |
|-------------------------|---|------------------------|
| ● Bariatric surgery | ● Long term care | ● Private duty nursing |
| ● Cosmetic surgery | ● Non-emergency care when traveling outside of the U.S. | ● Weight loss programs |
| ● Infertility treatment | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | | |
|-----------------------|----------------|----------------------------|
| ● Chiropractic care | ● Hearing aids | ● Routine eye care (Adult) |
| ● Dental care (Adult) | ● Acupuncture | ● Routine foot care |

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: The [plan](#) at 702-733-9938 or 1-800-457-8512, US Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the 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: US Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-457-8212.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-457-8212.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-457-8212.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne'1-800-457-8212.

[* For more information about limitations and exceptions, see the plan or policy document at www.culinaryhealthfund.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](#) \$0
- [Specialist](#) copay \$0
- Hospital (facility) [copays](#) \$250
- Other [cost sharing](#) \$70

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	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$280
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$40
The total Peg would pay is	\$320

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) copays \$50
- Hospital (facility) [copay](#) \$0
- Other [copays](#) \$130

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	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$180
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$180

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) copays \$60
- Hospital (facility) copays \$350
- Other coinsurance/copays \$130

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	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$440
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$540

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