GREATER METROPOLITAN HOTEL EMPLOYERS-EMPLOYEES HEALTH AND WELFARE FUND

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services **Coverage Period: January 1, 2026 – December 31, 2026**

Coverage for: Participants & Dependents | **Plan Type:** PPO

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, contact the Plan's Administrator, Wilson-McShane Corporation at 1-800-535-6373 or 952-854-0795. 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.com or call 1-800-444-EBSA (3272) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** in-network **$200** out-of-network	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes.	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 the **deductible**.
Are there other deductibles for specific services?	Yes. **$50** for out-of-network accidental dental services.	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.
What is the out-of-pocket limit for this plan?	Yes. **$1,200** combined for in-network and out-of-network coverage.	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, and health care this plan doesn't cover.	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.	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 the provider for the difference between the provider's charge and what the plan pays (balance billing). Be aware, your network provider may use an out-of-network provider for some services (such as lab work). Check with your provider before you obtain services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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)	Out-of-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	$15 copay/visit	$15 copay/visit & 20% coinsurance	The Plan provides 100% coverage for all forms of in-network telehealth services including Teladoc at www.teladoc.com
	Specialist visit	$15 copay/visit	$15 copay/visit & 20% coinsurance	----------none----------
	Preventive care/screening/ immunization	No Charge	Not Covered	Routine cancer screening procedures by out-of-network providers are covered, requiring $15 copay/visit & 20% coinsurance.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com **You must use a pharmacy in the CVS Caremark Network of approved pharmacies to fill your prescriptions.**	Generic drugs	Retail or Mail Order 30-Day Supply: Copay is greater of $5 or 10% per drug, not to exceed $20. Retail or Mail Order 31-90 Day Supply: Copay is greater of $10 or 10% per drug not to exceed $40.	Retail 30-Day Supply: Copay is greater of $5 or 10% per drug, not to exceed $20. Retail or Mail Order 31-90 Day Supply: Copay is greater of $10 or 10% per drug not to exceed $40.	Specialty drugs are available exclusively through the Caremark Exclusive Specialty Plus Network at www.caremark.com or by phone at 1-866-818-6911.
	Preferred brand drugs	Retail or Mail Order 30-Day Supply: Copay is greater of 20% or $50 per drug. Retail or Mail Order 31-90 Day Supply: Copay is greater of 20% or $100 per drug.	Retail 30-Day Supply: Copay is greater of 20% or $50 per drug. Retail or Mail Order 31-90 Day Supply: Copay is greater 20% or $100 per drug.	Specialty drugs are available through the Caremark Exclusive Specialty Plus Network at www.caremark.com or by phone at 1-866-818-6911.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Birth control drugs and devices	Subject to standard generic/brand copays (oral & barrier)/20% coinsurance (injectable & implantable)	20% coinsurance	Copay per three-cycle supply or device. Implantable drugs/devices limited to one every five years.
	Insulin, injections and infertility drugs	Subject to standard generic/brand copays (insulin) /20% coinsurance (infertility)	20% coinsurance	Insulin copay per vial or box of cartridges.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	----------none----------
	Physician/surgeon fees	$15 copay/visit	$15 copay/visit & 20% coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	$50 copay/visit	$50 copay/visit	Copayment waived if admitted for the same condition within 24 hours.
	Emergency medical transportation	$20% coinsurance	20% coinsurance	No coinsurance for pre-authorized, in-network transfers. No coverage for pre-authorized, out-of-network transfers.
	Urgent care	$50 copay/visit	20% coinsurance for first $2,500	Copay waived if admitted for the same condition within 24 hours. The Plan provides 100% coverage for all forms of in-network telehealth services including via Teladoc.at www.teladoc.com.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No coverage	Limited to 365 day maximum per period of confinement. Maximum covered charge is the Hospital's average semi-private room rate, or 90% of Hospital's private room rate if no semi-private rooms are available.
	Physician/surgeon fees	$15 copay/day	No coverage	----------none----------

[* For more information about limitations and exceptions, see the plan or policy document at [www.dol.gov/ebsa/healthreform.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit (outpatient) or day (inpatient)	$15 copay & 20% coinsurance	----------none----------
	Inpatient services	$15 copay	No coverage	----------none----------
If you are pregnant	Office visits	No Charge	No coverage	----------none----------
	Childbirth/delivery professional services	$15 copay/visit	No coverage	----------none----------
	Childbirth/delivery facility services	No charge	No coverage	----------none----------
If you need help recovering or have other special health needs	Home health care	$15 copay/visit	$15 copay/visit & 20% coinsurance	Maximum of 120 visits (in-network) / 60 visits (out-of-network) per year.
	Rehabilitation services	$15 copay/visit	$15 copay/visit & 20% coinsurance	Maximum of 120 visits (in-network) / 60 visits (out-of-network) per year.
	Habilitation services	$15 copay/visit	$15 copay/visit & 20% coinsurance	Maximum of 120 visits (in-network) / 60 visits (out-of-network) per year.
	Skilled nursing care	$15 copay/visit	$15 copay/visit & 20% coinsurance	Maximum of 120 visits (in-network) / 60 visits (out-of-network) per year.
	Durable medical equipment	20% coinsurance	20% coinsurance	----------none----------
	Hospice services	$15 copay/visit	Not Covered	30-day limit for continuous and respite care combined. 20% coinsurance applies for in-network respite care, which is limited to 5 days per episode.
If your child needs dental or eye care	Children's eye exam	100%	Not Covered	
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	100%	100%	The maximum Dental Benefit is $2,000. Dependent Children under age 19, are not subject to the $2,000 maximum benefit for Dental Benefits.

[* For more information about limitations and exceptions, see the plan or policy document at [www.dol.gov/ebsa/healthreform.]

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	• Hearing aids	• Private-duty nursing
• Cosmetic surgery	• Long-term care	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Infertility treatment	• Routine eye care (Adult)
• Chiropractic care (if prescribed for rehabilitation purposes)	• Most coverage provided outside the United States	• Routine foot care (must meet criteria for medically necessary care)
• Dental 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: U.S. Department of Laborer's Employee Benefit Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: The Plan's Administrator, Wilson-McShane Corporation at 1-800-535-6373 or 952-854-0795. You may also contact the U.S. Department of Laborer's Employee Benefit 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.

[* For more information about limitations and exceptions, see the plan or policy document at [www.dol.gov/ebsa/healthreform.]

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 *[cost sharing]*** **$15**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$35
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$95**

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 *[cost sharing]*** **$15**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$660
Coinsurance	$190
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$850**

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

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$15**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$85
Coinsurance	$240
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$325**

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