UNITE HERE HEALTH

Summary Plan Description

Greater Boston Local 26 Health Plan

Plan 108

May 2014

This Summary Plan Description supercedes and replaces all materials previously issued.

The **Plan Administrator and the agent for service of legal process** is the Chief Executive Officer (CEO) of UNITE HERE HEALTH.

Service of legal process may also be made on any Plan Trustee.

The CEO's address and phone number are:

UNITE HERE HEALTH
Chief Executive Officer
P. O. Box 6020
Aurora, IL 60598-0020
(630) 236-5100

About Your Plan

UNITE HERE HEALTH (the Fund) was created to provide benefits for you and your covered dependents. UNITE HERE HEALTH serves participants working for employers in the hospitality industry and is governed by a Board of Trustees composed of an equal number of union and employer trustees. Each employer contributes to UNITE HERE HEALTH according to a specific contract, called a Collective Bargaining Agreement, between the employer and the union.

Your Plan, Plan 108, has been adopted by the Trustees for the payment of medical and other health and welfare benefits from UNITE HERE HEALTH. This booklet is your Summary Plan Description (SPD). It is a summary of the Plan's rules and regulations and describes:

- How you become eligible;
- When your dependents are covered;
- What benefits you have;
- Limitations and exclusions;
- How to file claims; and
- How to appeal denied claims.

If information contained in the SPD is inconsistent with those rules and regulations, the rules and regulations will govern. If information contained in the SPD is inconsistent with any insurance contract governing benefits, those insurance contracts will govern.

No contributing employer, employer association, labor organization, or any individual employed by one of these organizations has the authority to answer questions or interpret any provisions of this Summary Plan Description on behalf of UNITE HERE HEALTH.

Who Pays for Your Benefits?

Employers participating in the Plan are required to make contributions for their employees. These contributions are controlled by the terms of the Collective Bargaining Agreements negotiated by your local union. Depending on your Collective Bargaining Agreement, you may also be required to contribute towards the cost of coverage. The Plan is supported by employer contributions and any required contributions you make.

What Benefits Are Provided Through Insurance Companies?

The Plan self-funds your medical and prescription drug benefits, the dental benefits and the vision benefits. Self-funded means that this benefit is not funded by insurance contracts. Benefits and associated administrative expenses are paid directly from UNITE HERE HEALTH. However, the Plan contracts with Tufts Health Plan (Tufts) to administer the medical and prescription drug benefits, Delta Dental of Illinois (Delta Dental) to administer the dental benefits, and with Davis Vision (Davis) to administer the vision benefits. Modern Assistance Programs, Inc. (MAP) administers the Plan's mental health and substance abuse benefits, Alternative Care Benefits, and Adoption Assistance Benefit. The Plan also contracts with The Guardian Life Insurance Company of America (Guardian) to administer the Life Insurance and Accidental Death and Dismemberment Benefits, and the Short Term Disability Benefits.

Important Phone Numbers	
Tufts Health Plan Member Services (Tufts) *For medical and prescription drug questions and to find a network doctor*	**(800) 462-0224** **(866) 201-7919** - BETTER Nurse Hotline **(800) 868-5850** - TDD www.tuftshealthplan.com/local26
Modern Assistance Programs, Inc. (MAP) *For mental health and substance abuse treatment and Alternative Care Benefits*	**(800) 878-2004** or **(617) 774-0331**
Delta Dental of Illinois (Delta Dental) *For dental benefit questions and to find a network dentist*	**(800) 323-1743** www.deltadentalil.com
Davis Vision (Davis) *For vision benefit questions and to find a network provider*	**(800) 999-5431** www.davisvision.com
The Guardian Life Insurance Company *To file Life, AD&D and Short Term Disability claims*	**(800) 267-4325**

How Can I get help?

To request enrollment or election forms, report changes in your employment or family status, inquire about claims, or request additional information, contact the Boston UNITE HERE HEALTH office:

33 Harrison Avenue, Suite 500
Boston, MA 02111-2040
(844) 267-4325
TTY Phone: **855-FUNDTTY**

Office Hours
Monday – Friday, 9AM – 5PM

Visit our website at www.uniteherehealth.org

Set up an account on the UNITE HERE HEALTH website to check eligibility, update address information, add dependent information, and make COBRA payments online.

Este libro es un resumen, en inglés, de sus derechos y beneficios bajo su Plan, Unidad de Plan 108. Si Usted tiene dificultad comprendiendo cualquier parte de este libro, comuníquese a la Oficina del beneficios para asistencia. Número gratuito (844) 267-4325. La oficina está abierta de lunes a viernes desde las 9AM hasta las 5PM.

Ce livret rédigé en anglais, contient un résumé des droits et des allocations dont vous pouvez bénéficier grâce à votre Plan Unit 108. Si vous rencontrez des difficultés et que vous ne comprenez pas certaines parties de ce livret, veuillez contacter le bureau de Boston (844) 267-4325. Heures de bureau sont du lundi au vendredi 9h – 17h.

本宣传册包含您在 108 号计划下权益的英文摘要。若对本宣传册的理解有任何问题，请联系波士顿办公室获得帮助。(844) 267-4325. 辦公時間為週一至週五上午9點到下午5點。辦公時間從星期一至星期五早上9時到下午5時

BETTER Benefits

Get a PCP

- ✓ Except in emergencies and for certain urgent care, no benefits are payable if the care is not provided by or referred by your primary care provider (PCP).

You and each of your dependents should have a PCP. You should get to know your PCP so he or she can help you get, and stay, healthier. Your PCP can observe your overall health, answer questions for you, and help coordinate your care.

Your PCP can also help you track when you need preventive care.

- ✓ Call Tufts at **(800) 462-0224** for help finding a PCP.

Get Preventive Care

Your Plan pays 100% for certain kinds of preventive care (*See pages D-8 to D-10*). Getting recommended preventive care can help you stay healthy, and helps your PCP find out if you may be developing a health condition.

Re-Think Emergency Room Care

Is it really an emergency? If not, you will pay less for a visit to a doctor's office or an urgent care center. You pay nothing out of pocket for a network office visit or a network urgent care center visit. If you use a hospital emergency room, you will pay a $100 copay (the copay is waived if you are admitted to the hospital).

- ✓ If you think you are having an emergency, call 911 or go to the emergency room.

Call UNITE HERE HEALTH

UNITE HERE HEALTH staff are here to help you. They can help you find a provider, answer questions about your Plan benefits and eligibility, and help you file claims.

- ✓ Call the UNITE HERE HEALTH Boston regional office at **(844) 267-4325**.

Use Network Providers

Be sure you use network providers.

Except in emergencies or for certain urgent care, the Plan does not pay benefits for services and supplies when a non-network provider is used.

The Plan pays higher benefits for dental and vision care when network providers are used.

- Tufts Health Plan provides access to a network of doctors, hospitals, pharmacies, and other healthcare providers.
- Modern Assistance Programs, Inc. provides access to a network of mental health/ substance abuse providers and alternative care providers.
- Davis Vision provides access to a national network of vision care providers.
- Delta Dental provides access to a national network of dental care providers.

✓ *See page A-2* for contact information for the Plan's network providers.

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Benefits at a Glance

About Your Medical & Prescription Drug Benefits

UNITE HERE HEALTH has contracted with Tufts Health Plan (Tufts) to administer your medical benefits, including your prescription drug benefits. The Tufts contract governs how Tufts administers your medical and prescription drug benefits, including benefits, coverage terms, exclusions and limitations, claim filing and appeal provisions, and utilization management programs.

Your benefits are summarized on the Benefits at a Glance on the following pages. If there is any discrepancy between any information provided by UNITE HERE HEALTH about how Tufts administers your medical and prescription drug benefits and the Tufts contract, the Tufts contract will govern.

You must have a Primary Care Provider (PCP) in order to have benefits paid on your behalf. The only exception is that you can obtain certain emergency and urgent care without a designated PCP (*See pages D-1 to D-2*).

Medical care will only be covered if it is provided by a Tufts doctor, hospital, or health care provider except that in certain cases, emergency care or urgent care provided by non-network providers may be covered (*See page D-1*).

You must use a Caremark network pharmacy in order to obtain pharmacy benefits. (*See pages D-11 to D-15*)

Tufts Health Plan
(800) 462-0224
www.tuftshealthplan.com/local26

About Your Other Benefits

UNITE HERE HEALTH also provides dental, vision, short term disability, and life and accidental death & dismemberment (AD&D) benefits. These benefits are summarized *on page B-5*.

If you have any questions about your eligibility or benefits, call the Boston UNITE HERE HEALTH regional office.

UNITE HERE HEALTH
(844) 267-4325
www.uniteherehealth.org

You can also contact the contracted providers that administer your benefits with questions. *See page A-2* for contact information.

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Medical and Prescription Drug Benefits

Precertification of certain services and supplies may be required (*See pages C-1 to C-6*).
In most cases, Plan benefits are not payable for benefits unless you use a Tufts EPO/HMO Select Network provider. Your care must be coordinated and approved by your PCP.

Tufts Health Plan Member Services	
Covered Service	You Pay (Tufts Network)
Outpatient Care	
Office Visits	
To diagnose and treat an injury or illness	No charge
Outpatient surgery in a provider's office	No charge
Urgent care clinic or center	No charge
Early intervention services for a dependent child *Limited to children under age 3*	No charge
Spinal manipulation *Limited to 20 visits per person per year*	No charge
Day Surgery *Other than in a provider's office*	No charge
Nutritional Counseling *Limited to 12 visits per year*	No charge
Chemotherapy and Radiation Therapy	No charge
Scalp hair prostheses or wigs for cancer or leukemia patients *Limited to $350 per person per year*	No charge
Physical and Occupational Therapy	No charge
Respiratory, Pulmonary, and Cardiac Rehabilitation Therapy	No charge
Hemodialysis	No charge
Family Planning *Including procedures, services, and contraceptives for women*	No charge
Preventive Health Care Services	
Includes routine exams, immunizations, well woman visits, and other services and screenings. Frequency and age limits may apply (*See pages D-8 to D-10*).	No charge
Emergency Services	
Emergency Room Visits *Inside and outside the service area (copayment waived if admitted as an inpatient)*	$100 per visit
Outpatient X-ray, Laboratory and Special Procedures	
Laboratory Tests	No charge
Diagnostic Imaging *including CT, x-ray, ultrasound, MRI, PET scans, and nuclear cardiology*	No charge

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Tufts Health Plan Member Services	
Covered Service	You Pay (Tufts Network)
Other Services	
Ambulance Services	No charge
Home health care	No charge
Hospice care	No charge
Durable medical equipment, foot orthotics, and medical supplies	No charge
Special medical formulas	No charge
Prescription Drugs	
Up to a 90-day supply purchased at a Caremark network retail pharmacy or mail order pharmacy: Tier 1 drugs Tier 2 drugs Tier 3 drugs	 $4 $8 $12

Modern Assistance Programs, Inc. (MAP)	
Mental Health and Substance Abuse Treatment	You Pay
Contact MAP to manage mental health and substance abuse services. Benefits are not paid if MAP does not coordinate or manage the care.	
Inpatient Treatment	No charge
Outpatient Treatment	No charge
Alternative Care Benefits	You Pay
Contact MAP to manage Alternative Care Benefits. Benefits are not paid if MAP does not coordinate or manage the care.	
Acupuncture *Limited to 20 visits per person per year*	No charge
Naturopathy or Traditional Chinese medicine *Limited to 12 visits of each type per person per year*	No charge
Massage therapy *Limited to 12 visits per person per year*	No charge

B

Other Benefits

In general, Plan benefits distinguish between treatment provided by network providers and treatment provided by non-network providers, as shown below. You are responsible for paying any deductibles, copays, your share of allowable charges the Plan doesn't pay, any amount over the maximum benefits, and any expenses that are not covered by the Plan.

Delta Dental of Illinois (Delta Dental)		
You Pay	Delta Dental PPO Providers	Delta Dental Premier and Non-network Providers
Calendar Year Maximum Benefit	$2,000 per person per year (does not include exams for persons under age 19)	
Diagnostic and Preventive Care	No charge	20%
Restorative Care	No charge	20%
Periodontal and Endodontal Care	No charge	20%
Prosthodontic and Major Restorative Care	40%	60%
Orthodontiat *Limited to $3,000 lifetime maximum*	50%	50%

Davis Vision (Davis)		
You Pay	Davis Network Providers	Non-Davis Network Providers
Eye Exams	No charge	No charge - benefits limited to $16
Frames	No charge	No charge - benefits limited to $14
Lenses	No charge	No charge - benefits limited to $14 for single vision lenses, $23 for bifocal lenses, and $29 for trifocal lenses
Contact Lenses	No charge for plan contacts No charge up to $25 for non-plan contacts	No charge - benefits limited to $40
Benefits are payable once every 24 months. **Frames and lenses must be purchased on the same day.** You can purchase additional lens and frame options from a Davis network provider for a discounted fee.		

Short Term Disability Benefit *Non-work related injuries or sicknesses only*	
Weekly Benefit (Benefits begin 1st day due to injury, 8th day due to sickness); must be working 20 or more hours per week	2/3 of average weekly pay over previous 3 months Benefits last for 13 weeks for basic weekly income benefits, and 26 weeks for extended weekly income benefits (*See pages E-3 to E-7*) for information about eligibility for extended benefits)

Life and Accidental Death & Dismemberment Benefit	
Life Insurance	**Benefit**
Active Member Only	
With Less than 4 Years of Service	$5,000
With 4 – 10 Years of Service	$10,000
With More than 10 Years of Service	$35,000
Accidental Death & Dismemberment	
Active Member Only	
With Less than 4 Years of Service	$5,000
With 4 – 10 Years of Service	$10,000
With More than 10 Years of Service	$35,000

Adoption Assistance Benefit	
Plan Benefit for adoption expenses incurred for eligible adopted children	$2,000 each benefit year

Who's Eligible

Employees

✓ You must complete an election form within 30 days of hire in order to get coverage.

You are eligible for coverage if:

- You work for an employer who is required by a Collective Bargaining Agreement to contribute to UNITE HERE HEALTH on your behalf;
- The necessary contributions are received by UNITE HERE HEALTH; and
- You satisfy the Plan's eligibility rules (*See pages F-1 to F-4*).

Coverage is not free. Your employer will take payroll deductions for your share of the cost of benefits.

Dependents

Coverage for your dependents can not begin before your coverage begins.

Your dependents become eligible for coverage on the date you become eligible or on the date you acquire the dependent, whichever happens last. You must enroll your dependents within 30 days of the date you become eligible (60 days from the date of a special enrollment event - *See pages B-8 to B-9* for information about special enrollments).

Coverage for your dependents is not free. Your employer will take payroll deductions for your share of the cost of benefits for your dependents.

Who Your Dependents Are

For benefit purposes, your dependents are:

- Your husband or wife, but only if there is valid documentation (*See page B-8*);
- Your same-sex or opposite-sex domestic partner, under certain circumstances - contact UNITE HERE HEALTH for details. Children of domestic partners are not considered dependents and are not covered;
- Your children, including: natural children, step-children, adopted children, children placed with you for adoption and for whom you are legally required to provide support until the adoption is finalized, children entitled to coverage because of a Qualified Medical Child Support Order, or children for whom you are awarded legal guardianship or sole custody pursuant to state domestic relations law, who are under age 26.

  To be covered on or after their 26th birthday, your unmarried children must be unable to support themselves because of a mental or physical handicap that began before age 19 and while covered by the Plan on the day prior to their 19th birthday. *See pages F-5 to F-6* for more information on termination of Dependent Coverage or on continuing coverage for your children over 26.

A foster child will only be covered under UNITE HERE HEALTH if the foster child was covered under the Greater Boston Hotel Employees Local 26 Health and Welfare Fund as of April 30, 2014.

Federal law requires UNITE HERE HEALTH to honor Qualified Medical Child Support Orders. UNITE HERE HEALTH has established procedures for determining whether a divorce decree or a support order meets federal requirements and for enrollment of any child named in the Qualified Medical Child Support Order. To obtain a copy of these procedures at no cost, or for more information, contact UNITE HERE HEALTH.

Enrollment Requirements

✓ *See pages F-3 to F-4* for information about two-way coverage if your spouse would like to decline benefits as an employee and be covered as your dependent. (You must elect single plus one coverage or family coverage.)

Choice of Coverage Options

You may choose what level of coverage you would like:

- Coverage for just you (single coverage)
- Coverage for you plus one dependent (single plus one coverage)
- Coverage for you plus all of your dependents (family coverage)
- No coverage (waived coverage)

If you choose to waive coverage, you will have to wait for the next open enrollment or special enrollment period to re-enroll.

Enrolling Yourself and Your Dependents

If you do not enroll yourself or your dependents for coverage within 30 days, you will have to wait until the next open enrollment period or special enrollment period before you can enroll yourself or your dependents.

Once you have Dependent Coverage, you must still enroll newly acquired dependents and submit the required proof to UNITE HERE HEALTH.

To enroll your dependents you must complete and submit an enrollment form. The information required includes:

- **Your information:** name, Social Security number, birth date, home address, phone number, employer name, hire date.
- **Dependent information:** name, Social Security number, birth date. The Dependent Enrollment Form must be submitted to UNITE HERE HEALTH within 30 days of your date of hire.

Dependent Documentation

English translations for all documents must be provided as required.

In order to verify a person's dependent status for benefit purposes, in addition to the completed enrollment form, you must also provide, as appropriate, at least one of the following:

- A certified copy of your marriage license or marriage certificate;
- A commemoration of marriage issued by a generally recognized denomination of organized religion;
- A certified copy of the birth certificate;
- Baptismal certificate;
- Hospital birth records;
- Written proof of adoption or legal guardianship;
- Copies of court decrees that obligate an employee to provide medical benefits for a dependent child;
- Notarized copies of a participant's most recent Federal Income Tax return (Form 1040 or its equivalents);
- Certificates of Creditable Coverage issued in accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996, as amended;
- Documentation of dependent status issued and certified by the United States Immigration and Naturalization Service; or
- Documentation of dependent status issued and certified by a foreign embassy.

If any of the above documents are used to verify the dependent status of a child, they must contain the names of the child's parents.

You have 90 days to provide dependent documentation.

Enrollment Periods

Open Enrollment Periods

Open Enrollment Periods take place as designated by the Plan. They provide you with the opportunity to elect coverage for yourself and your dependents if you didn't when you first became eligible to do so, or to re-elect coverage if you waived coverage. You must submit the required enrollment material and your employer must withhold the appropriate payroll deductions.

Employee Special Enrollment Periods

If you waived all health care coverage under the Plan because of other health care coverage existing when you first became eligible under the Plan, you may be able to enroll for coverage in the Plan when that other coverage is involuntarily lost. You do not need to wait for an Open Enrollment Period.

Dependent Special Enrollment Periods

In a few special circumstances, you do not need to wait for the Open Enrollment Period to enroll your dependents. You can enroll them for coverage within 60 days after any of the following events:

- Termination of other group health coverage, including COBRA continuation coverage, existing when you first became eligible for Dependent Coverage under the Plan, unless that coverage ended because required premium payments were stopped;
- Your marriage;
- The birth of your child;
- The adoption or placement for adoption of a child under age 26;
- A dependent previously residing in a foreign country comes to the United States and takes up residence with you;
- The loss of your or a dependent's eligibility for Medicaid or Child Health Insurance Program benefits; or
- When you or a dependent becomes eligible for state financial assistance under a Medicaid or Child Health Insurance Program with the cost of UNITE HERE HEALTH's Dependent Coverage.

If you submit the required enrollment material as specified above and arrange to make the required payments, coverage for your dependents will begin as follows:

- If you get married or the other coverage terminates, Dependent Coverage begins on the first day of the month following that date.
- If your child is born, or you adopt a child, a child is placed with you for adoption, or a dependent comes to the United States to take up residence with you, Dependent Coverage begins on that date.

If you do not take advantage of a Special Enrollment Period, you may have to wait until the next Open Enrollment Period to provide coverage for your dependents.

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Medical Management Review

Medical Management Review is a **mandatory program requiring precertification** as well as on-going and retroactive review of certain treatments and procedures. Medical Management Review evaluates whether health care services are medically necessary and are the most appropriate for your diagnosis or condition.

✓ Certification or authorization under Medical Management Review does not guarantee eligibility for benefits or that benefits will be payable for treatment or services provided.

Medical Management Review is not intended as and does not constitute medical advice. UNITE HERE HEALTH is not responsible for any consequences resulting from decisions you or your doctor make based on the Plan's certification or determination of benefits the Plan will pay.

Who to Call
Tufts manages the Medical Management Review for medical and surgical benefits, and for prescription drug benefits.
Medical/Surgical Benefits and Prescription Drug Benefits Tufts Health Plan: **(800) 462-0224**
Modern Assistance Programs, Inc. (MAP) manages the Medical Management Review for mental health and substance abuse treatment, as well as the Alternative Care Benefits.
Mental Health, Substance Abuse, and Alternative Care Benefits MAP: **(617) 774-0331**

Medical and Surgical Treatment and Prescription Drug Benefits

Tufts Health Plan (Tufts) administers the Medical Management Review program for medical and surgical benefits and for prescription drug benefits, and provides utilization review services before the care is provided, while care is being provided, and after care has been provided.

To certify medical and surgical treatment, call
Tufts Health Plan
(800) 462-0224

✓ If you use a network provider, it is your provider's responsibility to follow the Medical Management Review program.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or a newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending

provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you are using a non-Tufts provider due to an urgent care or emergency situation, have your provider contact Tufts to ensure your care is reviewed. In case of emergency admission, someone should contact Tufts within 48 hours of that admission.

If the Medical Management Review program is not followed, no benefits will be payable.

Medical/Surgical Care Requiring Precertification or Review by Tufts

If the Medical Management Review program is not followed, no benefits will be payable.

The following are categories of services and care that may need to be reviewed by Tufts. If your PCP recommends any of the following types of care, he or she will follow the Medical Management Review program on your behalf. The following are the types of services and supplies that may need to be reviewed by Tufts:

- Ambulance services (except in emergencies);
- Day surgery;
- Diagnostic screening and imaging;
- Durable medical equipment;
- Extended care;
- Foot orthotics;
- Home health care;
- Hospice care;
- Hospital stays and services;
- Injectable, infusion, or inhaled medications;
- Laboratory tests;
- Non-prescription enteral formulas, and special medical formulas;
- Oral medications for cancer;
- Physical and occupational therapy;
- Prosthetic devices;
- Reconstructive surgery and procedures;
- Transplants, including bone marrow.

The services and supplies requiring precertification or review may change from time to time.

Specialty Case Management

Tufts may recommend use of specialty case management if you or a dependent have a severe injury or illness. Specialty case management encourages the use of the most appropriate and cost-effective treatment as well as supporting your treatment and progress. You may be considered for specialty case management if you have a high-risk pregnancy, a serious heart or lung condition, cancer, certain neurological disease, serious immune system disease, severe traumatic injury, or other serious condition or injury as determined by Tufts. If Tufts determines you may benefit from specialty case management, Tufts will reach out to you.

Individual Case Management

In certain cases, Tufts may recommend use of individual case management for you or a dependent. Individual case management is designed to arrange for the most appropriate type, level, and setting of health care services and supplies for the patient. Tufts may also authorize coverage for alternative serves and supplies that are not otherwise considered a covered expense. However, the benefits payable for alternative services and supplies will be limited to the services and supplies that would typically be covered. Tufts will monitor the appropriateness of alternative services and supplies. If the alternative services or supplies cease to be the most appropriate, Tufts will modify or terminate the alternative services. If Tufts determines you may benefit from individual case management, Tufts will reach out to you.

Mental Health/Substance Abuse Treatment and Alternative Care Benefits

Modern Assistance Programs, Inc. (MAP) administers the Medical Management Review program for mental health/substance abuse treatment and alternative care, and provides utilization review services before the care is provided, while care is being provided, and after care has been provided.

Modern Assistance Programs, Inc. (MAP)
(617) 774-0331 inside Massachusetts
(800) 878-2004 outside Massachusetts

✓ MAP must coordinate and approve care for these types of services and supplies. The Plan will not pay benefits unless MAP coordinates and approves the care. If you receive emergency care, or urgent care outside the service area, contact MAP to arrange for follow-up care.

Processing Requests for Precertification of Benefits

In general, precertification of benefits must be processed no later than 15 days from the date the request is received.

If More Time Is Needed

However, this period may be extended by 15 days if necessitated by matters beyond Tuft's or MAP's control, including the failure to submit information sufficient to certify benefits. If an extension is required, you will be notified before the end of the 15-day period of the reasons for the extension and when a decision can be expected.

If Additional Information Is Needed

Requested information must be submitted no later than 45 days after the request is received. The 15-day period for processing will be suspended from the date the notification of extension is sent until the date Tufts or MAP receives a response. Failure to provide any required information within 45 days will result in the denial of the requested certification of services.

Special Rules for Decisions Involving Urgent Care

Decisions on urgent care claims will be made as soon as possible, taking into account medical circumstances, but not later than 72 hours after receipt of the claim. If Tufts or MAP does not have enough information to make a determination on an urgent care claim, Tufts or MAP will request the specific information necessary to complete the claim as soon as possible, but not later than 24 hours after receiving information insufficient to make a determination.

You will have a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. You will be notified of the benefit determination as soon as possible, but not later than 48 hours after the earlier of the receipt of the requested information, or the end of the period of time you were given to provide the specified additional information.

Special Rules for Decisions Involving Concurrent Care

Concurrent care decisions refer to decisions regarding precertified courses of treatment or treatment authorized for a definite or indefinite duration.

If an extension of the prescribed period is requested and qualifies as a request involving emergency treatment/urgent care, a determination must be made as soon as possible, taking into account the medical circumstances, but not later than 24 hours after receipt of the request, provided that the request is received at least 24 hours before the end of the precertified or authorized period of time.

If the request is not made more than 24 hours in advance, the determination must be made not later than 72 hours after receipt. If the request for an extension of the prescribed period is not a

request involving urgent care, the request will be treated as a new request to certify benefits and be decided according to the general requirements described above.

If a Request for Precertification Is Denied

See pages G-9 to G-14 for more information about appealing benefit denials.

If all or any part of a request for precertification of benefits is denied, you will receive a written denial, containing:

- The name of the health care provider;
- The date of service;
- A statement that the diagnosis codes and treatment codes and their corresponding meanings are available upon request;
- The denial code and its corresponding meaning;
- The specific reason or reasons why your claim was denied;
- Reference to the specific SPD provisions on which the denial is based;
- Description of any material necessary to process the claim properly and why the materials are needed;
- A description of the review procedures and any time limits applicable to such procedures;
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial of your claim on appeal;
- If an internal rule, guideline, protocol or other similar criterion was relied upon;
- in denying your claim, a statement that a copy of such rule, guideline, protocol or criterion will be provided to you free of charge upon request;
- If your claim was denied based upon a medical necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your medical circumstances will be provided to you free of charge upon request;
- The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman under Section 2793 of the Public Health Service Act; and
- If your claim concerned benefits that qualify as a request for emergency treatment/urgent care, a description of the expedited review process applicable to such claims.

The denial will also describe the rights to obtain a copy of any policy or other administrative criteria used to deny certification. If Tufts or MAP relied on medical judgment in reaching its decision, the denial will describe the rights to obtain free of charge an explanation of the scientific or clinical judgment used and its applicability to the request for certification. The denial will also describe the right to bring legal action if the denial is upheld after review.

Appealing the Denial of Benefit Certification for Medical/Surgical Treatment or Prescription Drug Benefits

All appeals for denied benefit certifications for medical or surgical treatment or prescription drugs, including extensions of treatment beyond limits previously approved, and prescription drug pre-authorizations, must be made within 180 days of the date certification of benefits was denied to:

Tufts Health Plan
Attn: Appeals and Grievances
705 Mount Auburn Street
P.O. Box 9193
Watertown, MA 02472-1508

Appeals may be filed verbally or in writing. Requests for appeal should include the claimant's name, Tuft's member ID, a detailed description of the appeals, and any other information required by Tufts. Documents or records that support certification of benefits should also be included.

Appealing the Denial of Benefit Certification for Mental Health or Substance Abuse Treatment, or Alternative Care Benefits

All appeals for denied benefit certifications for mental health or substance abuse treatment or alternative care benefits, including extensions of treatment beyond limits previously approved, must be made within 12 months of the date certification of benefits was denied to:

Modern Assistance Programs, Inc.
1400 Hancock Street
2nd Floor
Quincy, MA 02169

Appeals may be filed verbally or in writing. Requests for appeal should include the claimant's name, a detailed description of the appeals, and any other information required by MAP. Documents or records that support certification of benefits should also be included.

How Plan Benefits Are Determined

UNITE HERE HEALTH contracts with service providers (such as Tufts, Davis, Delta Dental, and MAP) to administer most of your benefits. These contracts govern how the contracted providers administer your benefits, including coverage terms, exclusions and limitations, claim filing and appeal provisions, and utilization management programs. If there is any discrepancy between any information provided by UNITE HERE HEALTH about how the contracted providers administer your benefits and these contracts, the contracts will govern.

This section summarizes how certain concepts will affect your benefits.

Injuries and Sicknesses

The Plan only provides medical benefits for the treatment of injuries or sicknesses not related to employment. The Plan also covers certain preventive health care services as listed on *pages D-8 to D-10*.

In addition to physical illness, sickness includes mental health conditions, alcohol or drug abuse, and pregnancy, including abortion. No benefits are available for or in connection with the treatment of infertility. *See pages D-29 to D-30 for a complete list of the Plan's General Exclusions and Limitations.*

Allowable Charges

An allowable charge is the amount upon which benefits are based for covered treatments, services, or supplies. The Board of Trustees has the sole authority to determine the level of allowable charges the Plan will use and in all cases, the Trustee's determination will be final and binding.

- Allowable charges for treatment by network providers reflect discounted fees. The contracts between the Plan and the applicable service provider determines both the discount and the allowable charge. This means lower out-of-pocket costs for you and your family. You only pay the difference between the provider's discounted charge and the Plan benefit.
- Treatment by a non-network provider means higher out-of-pocket costs because the charges for non-network providers are adjusted downward to about the level a network provider would have charged for the same services. Then, benefits are calculated using this reduced amount. You pay the difference between the provider's billed charge and the Plan benefit, including any amounts in excess of allowable charges.

The Plan will not cover any amount exceeding the allowable charge for a particular service or supply.

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Medically Necessary Care and Treatment

The applicable service provider will apply its definition of medical necessity to all claims it administers.

However, the Board of Trustees has the sole authority to determine what constitutes medically necessary care and treatment and experimental or investigational procedures. The Trustees may consult with the applicable service provider when making these determinations. In all cases, the Trustees' determination will be final and binding. However, those determinations are solely for the purpose of establishing what services or courses of treatment are covered by the Plan. All decisions regarding medical treatment are between you and your doctor and should be based on all appropriate factors, only one of which is the level of benefits available under the Plan.

Experimental, Investigational, or Unproven Procedures

The applicable service provider will apply its definition of experimental, investigational, or unproven procedures to all claims it administers.

However, the Board of Trustees has the sole authority to determine what constitutes medically necessary care and treatment and experimental or investigational procedures. The Trustees may consult with the applicable service provider when making these determinations. In all cases, the Trustees' determination will be final and binding. However, those determinations are solely for the purpose of establishing what services or courses of treatment are covered by the Plan. All decisions regarding medical treatment are between you and your doctor and should be based on all appropriate factors, only one of which is the level of benefits available under the Plan.

Routine patient costs associated with clinical trials are not considered experimental and investigative.

Emergency Medical Treatment

Emergency medical treatment means covered medical services used to treat a medical condition displaying acute symptoms of sufficient severity (including severe pain) that an individual with average knowledge of health and medicine could expect that not receiving immediate medical attention could place the health of a patient, including an unborn child, in serious jeopardy or result in serious impairment of bodily functions, bodily organs, or body parts.

Definition of Health Care Professional

Health Care Professional means a person who is licensed to practice any of the branches of medicine and surgery by the State in which such individual practices, provided he or she practicing within the scope of his or her license.

Safety Net Out-of-pocket Spending Limit (Network Charges Only)

The Plan's safety net out-of-pocket spending limit is $6,350 for allowable network charges incurred by a person during a calendar year. The out-of-pocket spending limit is $12,700 per family during a calendar year. Your out-of-pocket cost for covered network services each calendar year will not exceed the out-of-pocket limits. Once the applicable limit is reached, benefits for network services for that person or family will be paid at 100% for the rest of that calendar year.

The following amounts will not be used to satisfy the safety net out-of-pocket spending limits and are not eligible for the higher level of reimbursement:

- Charges for which the Plan pays 100%;
- Charges furnished by a non-network provider (other than emergency medical care received in an emergency room);
- Copays for prescription drugs purchased through the Prescription Drug Program;
- Charges for expenses not covered by the Plan or that exceed Plan limitations or maximums; or
- Any amounts imposed as a penalty for failure to satisfy the Plan's precertification requirements.

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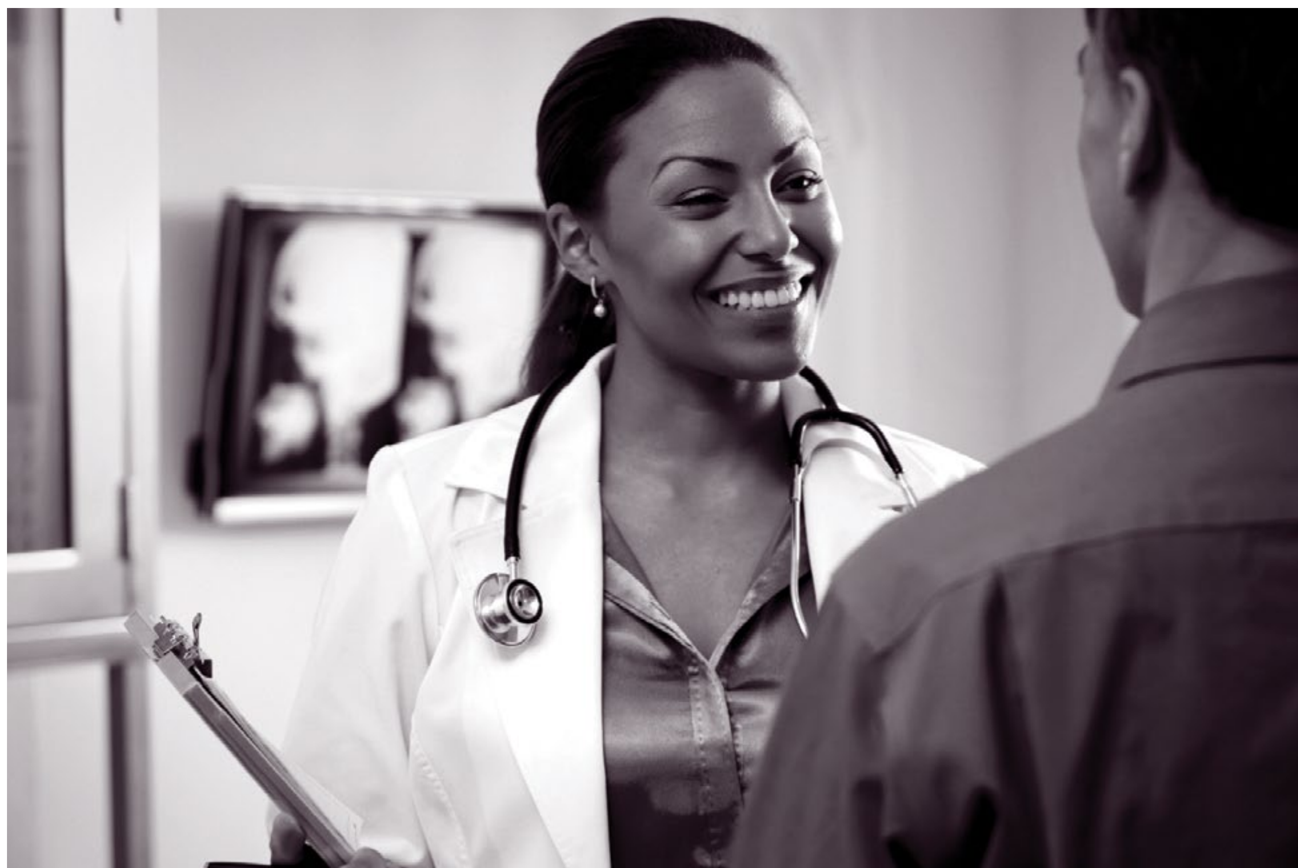

To help get the most for your health care dollar, UNITE HERE HEALTH has contracted with Tufts so you and your covered dependents can receive medical and surgical services from area hospitals and doctors participating in the Tufts EPO/HMO Select Network. (*See pages D-27 to D-28* for information about your benefits for mental health and substance abuse treatment.)

Tufts administers your Medical Benefits according to the contract between Tufts and UNITE HERE HEALTH. If there is a conflict between any information UNITE HERE HEALTH provides and the terms of the contract, the contract governs. You can obtain a copy of the contract by contacting UNITE HERE HEALTH.

To find medical or surgical network providers,
call **Tufts** toll free
(800) 462-0224

or visit them online at www.tuftshealthplan.com/local26

Make sure you look for a provider in the Tufts EPO/HMO Select Network.

You must have a Primary Care Provider (PCP) before non-emergency benefits are payable.

To select a PCP,
contact **Tufts** at: **(800) 462-0224**

The Tufts service area includes the following Massachusetts counties: Barnstable, Bristol, Essex, Franklin, Hampshire, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, Worcester. The Tufts service area may also include counties in other states. Contact Tufts with any questions about the Tufts service area.

Your Primary Care Provider (PCP)

Plan benefits are generally only payable when your PCP coordinates your care or refers you to a specialist.

Plan benefits are generally only provided when your PCP coordinates your care or refers you to a specialist. You have the right to designate any primary care provider who participates in the Tufts network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You need a referral from your PCP to see a specialist. Your PCP must also approve any visits to another provider your specialist refers you to. However, no PCP referral is necessary for any of the following:

- Emergency care in a hospital emergency room or in a provider's office. However, you must contact your PCP within 48 hours to get any follow-up care.
- Urgent care received outside the Tufts service area. However, you must contact your PCP for any follow-up care.

- Obstetrical or gynecological care from a network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

If you are newly eligible, or if your PCP leaves the Tufts network, you may be able to continue seeing your PCP for a limited time under certain circumstances. Contact Tufts for more information.

Unless you are an inpatient or a patient in a partial hospitalization program, you may change your PCP at any time. Make sure you ask the PCP if he or she is taking new patients. However, the change in your PCP will not take effect until you report your choice to a Tufts Member Specialist, and Tufts approves the change.

What the Plan Pays

For benefit purposes, the Plan distinguishes between network and non-network services. Except in emergencies or for certain urgent care, **the Plan only pays benefits for services and supplies provided by a provider participating in the Tufts EPO/HMO Select network**. Non-network care is not covered, except for emergencies or certain urgent care. However, non-network care will generally not be covered once you can safely be transferred to a network provider.

The Plan typically pays 100% of covered expenses. However, the Plan will not pay the first $100 of covered expenses received in an emergency room (your $100 emergency room copay). The copay will be waived if you are admitted to the hospital or undergo day surgery.

What You Pay

You are responsible for paying any amounts the Plan does not pay, including but not limited to:

- $100 emergency room copays;
- Any portion of allowable charges the Plan doesn't pay, including any amounts not paid for failing to satisfy any part of the Medical Management Program;
- Any amount over the maximum benefits; and
- Any expenses that are not covered by the Plan, including expenses in excess of any allowable amount.

You may also be responsible for the $100 emergency room copay if you register in an emergency room but leave the facility without receiving care.

You must identify yourself as a Tufts EPO/HMO Select member when you see a network provider. If you don't identify yourself as a Tufts member, you may have to pay the full cost of your care.

What's Covered

The Plan covers the allowable charges for the following services and supplies:

- Hospital charges for:
    - Room and board, up to the semi-private room rate unless a private room is medically necessary, and other inpatient services actually administered by the hospital;
    - Outpatient services actually administered by the hospital;
- Professional medical and surgical services of a health care professional, including office visits and outpatient surgery performed in an office;
- Spinal manipulation for individuals older than 12 years of age, up to 20 visits per person per year;
- Short-term rehabilitation services for physical and occupational therapy, provided the services are to restore function lost or impaired as the result of an accident or injury as long as your condition shows significant improvement within 60 days from the start of services;
- Respiratory therapy and pulmonary rehabilitation services;
- Diagnosis and treatment of speech, hearing and language disorders;
- Outpatient cardiac rehabilitation services for treatment of cardiovascular disease that begins within 26 weeks after diagnosis. Cardiac rehabilitation services only include the phases following release from the hospital and addressing multiple risk reduction, adjustment to illness, and therapeutic exercise. The maintenance of cardiac health is not covered;
- Medically necessary early intervention services provided to a dependent child from birth to the child's third birthday;
- Allergy testing and treatment, including antigens, and allergy injections;
- Smoking cessation counseling services;
- Home health care services, including:
    - Home health visits;
    - Skilled nursing care and physical therapy;
    - Medical or psychiatric social work, nutritional consultation, services of a home health aide, or durable medical equipment (provided separately from the durable medical equipment as specified *on page D-5*);
    - Physical therapy, speech therapy, or occupational therapy following an injury or illness, to the extent that such services are provided to restore function lost or impaired due to such injury or illness; and
    - Durable medical equipment and physical, occupational, or speech therapy provided through home health care are not subject to the rules and limits for durable medical equipment described on *page D-5*, or the rules and limits for physical, speech, or occupational therapy described earlier;

- Home health care services are provided only if you are homebound, as determined by Tufts;
- Outpatient hemodialysis, including home hemodialysis and home peritoneal dialysis;
- Chemotherapy and radiation therapy;
- Human leukocyte antigen testing or histocompatibility locus antigen testing for use in bone marrow transplantation, including costs of antigen testing;
- Injectable, infused or inhaled medications, including but limited to total parenteral nutrition therapy, chemotherapy, and antibiotics, that are:
    - Required for and an essential part of an office visit to diagnose or treat an illness or injury; or
    - Received at home with drug administration services by a home infusion provider;
- Day surgery and related charges for anesthesia, provided you are expected to be discharged the same day;
- Medical supplies, including ostomy, tracheostomy, catheter, and oxygen supplies, diabetic monitoring strips, insulin pumps and related supplies;
- Scalp hair prostheses or wigs for hair loss resulting from the treatment of cancer or leukemia, up to $350 per person per calendar year;
- Special medical formulas, nonprescription enteral formulas, and low protein foods, when prescribed by a doctor, but only for the following:
    - Low protein foods when given to treat inherited disease of amino acids and organic acids;
    - Nonprescription enteral formula for home use for treatment of certain medical conditions;
    - Medically necessary infant formula for milk or soy protein intolerance, formula for premature infants, and supplemental formulas for growth failure; and
    - Other special medical formulas for the treatment of certain diseases;
- Outpatient diagnostic imaging, x-rays and laboratory services. Laboratory services must be performed at a licensed laboratory;
- Transportation by a professional ambulance service, including ground, sea, or air ambulance transportation for emergency care, and non-emergency ambulance transportation when your medical condition prevents safe transportation by any other means, or for transfer between facilities. If you are treated by EMTs or other ambulance staff, but you refuse to go to the hospital or other medical facility, you will be responsible for the cost the treatment provided by the EMTs or other ambulance staff;
- Blood processing and devices;
- Maternity charges, other than for dependent children, including prenatal and postnatal care provided in a health care professional's office;
- Extended care services, including skilled nursing, rehabilitation or chronic disease hospital services;

- Patient care services provided as part of a qualified trial for the treatment of cancer or other life-threatening condition, to the same extent that such services would be covered if the care were not received as part of a clinical trial;
- Medical services for transplants, human leukocyte antigen testing, and up to 10 searches for donors not related by blood (unless more searches are authorized by the Medical Management Review organization), as follows:
    - Bone marrow transplants; and
    - Hematopoietic stem cell transplants and human solid organ transplants which are generally accepted in the medical community for patients who are the stem cell or solid organ recipients, including services related to the procurement of the stem cells or sold human organ from the donor to the extent that such services are not covered by any other plan or health benefits or health care coverage;
- Hospice services and supplies for a person whose life expectancy is six (6) months or less. Bereavement counseling services for family of the terminally ill person will be covered for up to one year following such person's death;
- The preventive health care services shown on *pages D-8 to D-10*;
- Surgical services for mastectomy (the excision of all or a portion of the breast, including removal of chest muscle and lymph nodes if required) including:
    - Reconstruction of the breast upon which the mastectomy is performed;
    - Surgical treatment of the other breast to produce a symmetrical appearance;
    - Breast implants; and
    - Treatment of physical complications resulting from a mastectomy, including lymphedema;
- Breast, arm, and leg prosthetic devices;
- Medically necessary charges for treatment of cleft lip and cleft palate, and associated services for management and follow-up care;
- Outpatient diabetes self-management training and educational services, provided by a certified diabetes health care professional;
- Nutrition counseling, up to a maximum benefit of 12 visits per person per year;
- Durable medical equipment for all non-disposable devices or items for which you have a prescription, including but not limited to wheelchairs, breast pumps, cataract lenses or eyeglass lenses following cataract surgery (one pair of either contacts or lenses per prescription change), cranial helmets, blood glucose monitors, gradient stockings (up to 3 pairs per year), hearing aids (up to one per ear per prescription change), oral appliances for the treatment of sleep apnea, oxygen concentrators, prosthetic devices other than limb or breast prostheses, scalp hair prostheses for hair loss due to certain medical conditions or injury, and other similar medical equipment or devices that are:
    - reasonable and necessary to sustain a minimum threshold of independent daily living;

- made primarily to serve a medical purpose;
- not useful in the absence of an illness or injury;
- can withstand repeated use; and
- can be used in the home.

In order to be considered a covered expense, the equipment must be purchased from a contracted provider. Tufts must determine that the durable medical equipment is the most appropriate available amount, supply or level of service, and whether to rent or purchase durable medical equipment.

What's Not Covered

In addition to the Plan's General Exclusions and Limitations (*See pages D-29 to D-30*), no medical benefits will be provided for:

- Treatment, services, or supplies received by a provider not part of the Tufts EPO/HMO Select Network or received outside the Tufts service area, except for covered emergency or urgent care;
- Treatment, services, or supplies not approved, referred, or managed by your PCP, except for covered emergency or urgent care;
- Prescription drugs, other than those consumed or administered at the place where they are dispensed;
- With respect to organ transplants:
  - Donor costs covered by any other plan or health benefit coverage;
  - Donor charges when the covered person is the donor of stem cells or solid organs to individuals who are not covered under the plan; and
  - Donor search expenses for more than 10 searches for donors not related by blood, unless approved by Tufts;
- Cosmetic, plastic, or reconstructive surgery, unless that surgery is for:
  - the relief of pain, or to restore bodily function impaired as a result of a congenital defect, accidental injury, or a covered surgical procedure;
  - breast reconstruction following a mastectomy; or
  - removal of a breast implant, but only if the implant was due to a mastectomy, if a silicone implant has ruptured, or if the patient has an auto-immune disease;
- To the extent of any penalty assessed for any treatment or services requiring the use of any medical management program, when this mandatory program is not used as required;
- Any elective procedure, except as specifically stated as covered, that is not for the correction or cure of bodily injury or sickness. If there is a question as to the elective nature of the procedure, the decision of the Trustees will be final;
- Procedures for the reversal of voluntary sterilization;

- Treatment for or in connection with infertility;
- Alternative, holistic, naturopathic, and/or functional health medicine services, supplies or procedures;
- Services, programs, supplies or procedures performed in a non-conventional setting, including but not limited to Outward Bound, wilderness, camp, or ranch programs, spas or resorts, vocational or recreational settings, even if provided by a health care professional;
- Devices and procedures intended to reduce snoring;
- Private duty nursing;
- Methadone treatment or methadone maintenance;
- Routine foot care, other than for patients diagnosed with diabetes, or treatment of flat feet or partial dislocation of feet;
- Examinations, evaluations, or services for educational purposes, or developmental purposes, other than as specifically covered as an early intervention service;
- Vocational rehabilitation or retraining services;
- Services to treat learning disabilities, behavioral problems, and developmental delays;
- Sex transformation;
- Equipment that is non-medical in nature or used primarily for non-medical purposes, even if such equipment has limited use as medical equipment;
- Hospital charges for personal comfort items, including but not limited to telephone;
- Television, cosmetics, guest trays, magazines, and bed or cots for family members or other guests;
- Supplies or equipment for personal hygiene, comfort, or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, home traction unit, tanning bed, or water bed;
- Treatment provided by an EMT or other ambulance staff if you refuse to be transported to the hospital or other medical facility;
- Care for conditions that state or local law requires to be treated in a public facility;
- A service, supply, or medication if there is a less intensive level of service, supply or medication, or a more cost-effective alternative which can be safely and effectively provided, or if the service, supply or medication can be safely and effectively provided in a less intensive setting;
- Laboratory tests ordered by you or a dependent, even if provided by a licensed laboratory;
- Fees charged by a health care professional as a condition of access, or any amenities that fee is represented to cover;
- Costs associated with home births, or cost associated with a doula;
- Preventive dental care or orthodontia, even when part of other surgical or medical procedures;

- Routine eye exams or eyeglasses, lenses, or frames. Eyeglass frames for lenses required following cataract surgery will be covered up to a $69 maximum benefit per person per calendar year;
- Circumcisions performed in any setting other than a hospital, as day surgery, or in a health care professional's office;
- Purchase of an electric hospital-grade breast pump or donor breast milk;
- Acupuncture, hypnotherapy, psychoanalysis, neuromusculature stimulators, cognitive rehabilitation or retraining programs;
- Oral contraceptives or over-the-counter contraceptives;
- Weight loss clinics or programs;
- Services related to excluded treatment, care, or medications;
- Treatment, care, or services related to teeth or dental care, including TMJ and surgical removal of teeth, unless specifically covered under the contract with Tufts;
- Biofeedback training except for urinary incontinence; or
- Any treatment, services, or supplies that Tufts deems to be excluded from benefits, based on the contract between UNITE HERE HEALTH and Tufts Health Plan.

Preventive Health Care Services Covered at 100% When Network Providers Are Used
This Plan covers certain preventive health care with no cost sharing when a network provider is used, as required under federal law. The following lists are summaries of the types of preventive care that will be covered at 100% when a network provider is used. Certain age or frequency requirements, or other reasonable cost containment methods, may apply. Contact Tufts for more information about the circumstances under which the preventive care listed below will be provided at no cost to you.
Covered Preventive Services for Adults
Screening for men aged 65-75 for abdominal aortic aneurysm
Alcohol misuse screening and behavior counseling
Aspirin counseling for men age 45-79 and for women age 55-78
Blood pressure screening
Colorectal cancer screening for adults ages 50 to 75
Depression screening
Type 2 diabetes screening for adults with blood pressure greater than 135/80
Diet counseling for adults at higher risk for cardiovascular and diet-related chronic disease
HIV screening
Immunization vaccines as recommended by the Advisory Committee on Immunization Practices (ACIP)
Lipid disorders screening
Lung cancer screening
Obesity screening and counseling
Sexually Transmitted Infection (STI) prevention counseling and screening

Preventive Health Care Services Covered at 100% When Network Providers Are Used
Tobacco use screening and counseling
Syphilis screening
Exercise or physical therapy and vitamin D supplementation for certain adults at increased risk for falls
Other recommended age and developmentally appropriate preventive care as determined by Tufts
Covered Preventive Services for Women, Including Pregnant Women
Anemia screening for pregnant women
Bacteriuria urinary tract or other infection screening for pregnant women
BRCA counseling about genetic testing for women at increased risk
Breast cancer mammography screenings beginning at age 40
Preventive medications for risk reduction of breast cancer
Breast feeding support, supplies, and counseling
Cervical cancer screening
Chlamydia infection screening
Coverage for all FDA-approved contraception and counseling
Domestic violence screening and counseling
Screening for gestational diabetes for pregnant women
Gonorrhea screening
Hepatitis B screening for pregnant women
Human papilloma virus (HPV) DNA testing for all women ages 30 and older
Osteoporosis screening
Rh incompatibility screening for all pregnant women
Syphilis screening for all pregnant women or other women at increased risk
Well woman exams for recommended age and developmentally appropriate preventive services, including routine prenatal care
Other recommended age and developmentally appropriate preventive care as determined by Tufts
Covered Preventive Services for Children
Alcohol and drug use assessments for adolescents
Developmental screening and behavioral assessments
Congenital hypothyroidism screening for newborns
Depression screening for adolescents
Dyslipidemia screening
Height, weight, and body mass index measurements
Hematocrit or hemoglobin screening
HIV screening for adolescents at higher risk
Immunization vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)
Lead screening

Preventive Health Care Services Covered at 100% When Network Providers Are Used
Medical history
Obesity screening and counseling (age 6 and older)
Phenylketonuria (PKU) screening for newborns
Sexually Transmitted Infection (STI) prevention counseling and screening for sexually active adolescents at increased risk
Counseling for children and young adults who have fair skin about minimizing reduce risk for skin cancer
Tobacco use screening and counseling
Tuberculin testing
Vision screening for acuity and impairment
Other recommended age and developmentally appropriate preventive care as determined by Tufts

Prescription Drug Benefits

Prescription drug benefits are provided by Caremark through the contract between UNITE HERE HEALTH and Tufts. Benefits are only available for prescription drugs purchased at a Caremark network pharmacy. If there is any discrepancy between the Tufts contract and information UNITE HERE HEALTH provides regarding the Prescription Drug Benefits, the terms of the contract will govern.

To find a participating pharmacy,
call **Tufts** toll free
(800) 462-0224
www.tuftshealthplan.com

What You Pay

Retail

When you have a covered prescription filled at a network pharmacy, the Plan pays 100% of allowable charges for prescription drugs after you pay the following copayments:

- $0 for the following drugs when filled at a network pharmacy with a prescription (certain age or frequency requirements, or other reasonable cost containment methods, may apply):
    - Aspirin use to reduce the threat of stroke;
    - Folic acid supplements for women who may become pregnant;
    - Iron supplements for asymptomatic children ages 6 months to 12 months at risk for iron deficiency anemia;
    - Fluoride supplementation for pre-school children whose primary water source is deficient in fluoride;
    - Certain tobacco cessation products;
    - Prescription oral contraceptives, diaphragms, and self-administered hormonal contraceptives such as patches and rings, and all FDA-approved contraception for women, including over-the-counter drugs, devices or supplies; and
    - Vitamin D for adults age 65 and older.

You will have a copay for other covered drugs. The copay is based on the drug tier, as determined by Tufts. Tufts may change a drug's tier from time to time. Contact Tufts with questions about drug tiers. Your copays for up to a 90-day supply of a drug are:

- $4 for tier 1 drugs;
- $8 for tier 2 drugs; or
- $12 for tier 3 drugs.

Contact **Tufts** with questions about which tier a drug falls into.
(866) 884-4176
www.tuftshealthplan.com/local26

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If you request a brand name drug when your prescription allows for the use of a generic drug, you will pay the difference in cost between the brand name drug and the generic drug, in addition to the applicable copay.

Mail Order

When you have a covered prescription filled at the mail order pharmacy, the Plan pays 100% of allowable charges for prescription drugs after you pay the following copayments for up to a 90-day supply of the drug:

- $4 for tier 1 drugs;
- $8 for tier 2 drugs; or
- $12 for tier 3 drugs.

Certain drugs may not be available through the mail order pharmacy. For example, medications for short term medical conditions, certain controlled substances, and drugs that are subject to the Quantity Limit Program or the Special Designated pharmacy program (*See pages D-13 to D-14*) are not available through the mail order pharmacy.

What's Covered

Prescription Drug Benefits are only available for the covered expenses listed below:

- Drugs and medications which may only be lawfully obtained upon the written prescription of a doctor, including oral and injectable contraceptives, vitamins, and medications mixed to order by a pharmacist, if they contain at least one medicinal substance and one prescription drug;
- Insulin, insulin pens, and blood, urine, and ketone monitoring strips;
- Disposable syringes and needles, and lancets;
- Oral diabetes medications that influence blood sugar levels;
- Acne medications for individuals through the age of 25;
- Injectables and biological serum as designated by Tufts, as well as the medically necessary syringes or hypodermic needles necessary to administer these medications;
- Prefilled sodium chloride for inhalation (both over-the-counter and prescription);
- Off-label use of FDA-approved prescription drugs used in the treatment of cancer or HIV/AIDS which have not been approved by the FDA for that individual, provided, however, that such a drug is recognized for such treatment in one of the standard reference compendia, in medical literature, or by the Massachusetts Commissioner of Insurance;
- Over-the-counter drugs as designated by Tufts; and
- Items used for preventive care as described in the $0 copay section on *pages D-8 to D-10*.

Pharmacy Management Programs

In order to provide safe, clinically appropriate, and cost-effective medications, Tufts has implemented several Pharmacy Management Programs. If your health care professional prescribes a drug in one or more of the Pharmacy Management Programs, the pharmacist will let you know when you have the prescription filled. The pharmacist will help you understand how your prescription will be affected, and help you arrange for any alternate prescriptions that you may need.

Contact **Tufts** for more information about the
Pharmacy Management Programs
(800) 462-0224
www.tuftshealthplan.com/local26

Provider Overrides

If your drug is subject to any of the programs described below, your healthcare provider may submit a request for coverage. Tufts will review the request for coverage and may approve the drug even if it would not normally be covered. Have your provider contact Tufts with any questions about requesting coverage for a drug that is not otherwise covered.

Quantity Limit Program

The quantity of certain selected medications is limited for cost, safety, and/or clinical reasons.

Prior Authorization Program

Coverage may be restricted for certain drug products that have a narrow indication for usage, may have safety concerns, and/or are extremely expensive. The prescribing healthcare professional may need to obtain prior approval from Tufts for drugs in the prior authorization program. *See pages C-1 to C-6* for more information.

Step Therapy

Step therapy is a clinical program that only applies to certain types of prescription medications. This program helps manage the rising cost of prescription drugs, and the overall cost of health care. A "step" approach encourages the safe, cost-effective use of medication by first trying lower-cost medications whenever appropriate.

If a drug is subject to step therapy, members will be required to first try medications which have been determined to be safe, effective and less costly. In cases where alternative drugs are not appropriate for you to use, your health care professional can request an exception to the step therapy program.

Special Pharmacies

Tufts has designated certain special pharmacies to supply certain medications through mail order. These pharmacies specialize in providing medications and support for certain conditions. You can access clinical staff at these pharmacies to help you manage your care. Special pharmacies dispense up to a 30-day supply of medication at one time.

Drugs available through the special pharmacies include but are not limited to drugs to treat:

- Multiple sclerosis;
- Hemophilia;
- Hepatitis C;
- Growth hormone deficiency;
- Rheumatoid arthritis; and
- Cancers treated with oral medications.

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Non-Covered Drugs with Suggested Alternatives

Certain drugs with effective and affordable alternatives may not be covered. Instead, alternative drugs will be covered. The alternative drugs are approved by the U.S. Food and Drug Authority (FDA) and are widely accepted in the medical community to treat the same conditions as the drugs that are not covered.

New-To-Market Drug Evaluation Process

New-to-market drugs will not be covered until Tufts has reviewed the product for safety, clinical effectiveness and cost, and has been approved for coverage.

What's Not Covered

In addition to the Plan's General Exclusions and Limitations (*See pages D-29 to D-30*), no prescription drug benefits are provided for:

- Drugs, other than specifically stated as covered, that are available over-the counter;
- Homeopathic medications;
- Experimental or investigational drugs;
- Vitamins and dietary supplements, other than those specifically listed as covered;
- Drugs that are purchased without following a required pharmacy management program;
- Fluoride for adults;
- Depo-Provera, cervical caps, IUDs, or other implantable contraceptives;
- Immunization agents;

- Fertility drugs;
- Acne drugs for individuals age 26 or older unless such medications are medically necessary;
- Prescriptions or refills exceeding the applicable dispensing limitations;
- Medications for the treatment of idiopathic short stature;
- Prescriptions written by a health care professional who does not participate in the Tufts network, except in cases of authorized referral or emergency care;
- Non-drug products such as therapeutic or other prosthetic devices, appliances, supports, or other non-medical products;
- Drugs for asymptomatic onchomycosis, except to treat diabetes, vascular compromise, or immune deficiency status;
- Oral non-sedating antihistamines;
- Prescription medications when packaged with non-prescription products;
- Compounded medications, if no active ingredients require a prescription by law;
- Prescriptions filled through a non-network pharmacy, except in cases of emergency;
- Weight loss drugs;
- Drugs for the treatment of infertility;
- Prescriptions filled through an internet pharmacy that is not a verified internet pharmacy practice site as certified by the National Association of Boards of Pharmacy;
- Methadone treatment or methadone maintenance;
- Drugs related to excluded treatment, care, or medications;
- Any drug of medication if a mandatory pharmacy management program is not used as required;
- Alternative, holistic, naturopathic, and/or functional health medicine;
- Prescription medications once the same or similar active ingredient becomes available over-the-counter, including either a specific medication or a class of medications, except as specifically stated as covered;
- With respect to the mail order pharmacy only, medications for short term medical conditions, certain controlled substances, and drugs that are subject to the Quantity Limit Program or the Special Designated pharmacy program (*See pages D-13 to D-14*); or
- Any treatment, services, or supplies that Tufts deems to be excluded from benefits, based on the contract between UNITE HERE HEALTH and Tufts.

Dental Benefits

Regular dental care is an important part of good health. That's why the Plan provides dental benefits, so you can obtain needed dental care before little problems become big ones.

A dentist is a person who is duly licensed to practice dentistry or perform oral surgery in the state in which he or she is practicing, and who is acting within the scope of that license. For the purpose of this definition, a health care professional will be considered to be a dentist when performing a covered dental service as long as he or she is operating within the scope of his or her license.

Network and Non-Network Providers

Benefits are paid differently depending on whether you use a network or a non-network provider. The difference between network and non-network benefits can be significant.

Network Dentists—Delta Dental PPO Dentist

If you go to a Delta Dental PPO Dentist, you are using a network dentist. Allowable charges reflect discounted fees provided by Delta Dental. This means lower out-of-pocket costs for you and your family. You only pay the difference between the provider's discounted charge and the Plan benefit.

Non-Network Dentists—Delta Dental Premier Dentists and Non-Participating Dentists

If you go to a Delta Dental Premier Dentist or a Non-Participating Dentist, Plan benefits will be paid at non-network benefit level.

If you choose to use dentists in the Delta Dental Premier network, benefits will be paid as non-network benefits; however, these dentists accept Delta Dental's discounted fees, so your out-of-pocket costs will typically not include balance billed amounts.

Non-Participating Dentists do not accept Delta Dental's discounted fees. This means your out-of-pocket costs will be higher than if you use a Delta Dental PPO Dentist or a Delta Dental Premier Dentist. You will be responsible for paying the difference between the applicable Plan benefit based on Delta Dental's approved amount and the provider's billed charge. In some instances, this can be a substantial amount.

To find a network dentist,
call **Delta Dental of Illinois** toll free
(800) 323-1743
www.deltadental.com

What the Plan Pays

In general, the plan provides higher benefits for network provider services than it does for non-network provider services.

The Plan pays the benefits highlighted below for covered services for non-orthodontic treatment furnished by a dentist up to a $2,000 maximum per person each calendar year for network services and non-network services combined. However, dental exams provided to children under age 19 do not apply to the maximum benefits. Delta Dental may allow you to carry over all or part of the unused portion of your $2,000 annual maximum for non-orthodontic treatment. You must have been eligible for Dental Benefits for the entire calendar year, and have submitted at least one claim during the year that would have applied to your annual maximum benefit. Contact Delta Dental for more information about carrying over all or part of your maximum benefit.

The Plan pays up to a lifetime maximum benefit of $3,000 per person for orthodontic treatment for network and non-network services combined.

The table below shows the levels of payment the Plan provides for allowable charges incurred for covered services furnished by network and non-network providers.

What You Pay

You are responsible for paying any portion of allowable charges the Plan doesn't pay, any amount over the maximum allowable benefit, and any expenses that are not covered by the Plan.

Your out-of-pocket costs for covered dental services are based on the Plan's benefit percent and the treating dentist's participating status with Delta Dental.

	You Pay	
Description of Services	Delta Dental PPO Dentists	Delta Dental Premier Dentists and Non-Participating Dentists
Diagnostic & Preventive Services	No charge	20%
Minor Restorative Services	No charge	20%
Periodontics & Endodontics	No charge	20%
Oral Surgery	No charge	20%
Prosthetic Maintenance	No charge	20%
Prosthodontics and Major Restorative	40%	60%
Orthodontia	50%	50%

What's Covered

Covered expenses mean all allowable charges made by a dentist for the following services and supplies, if based on a valid dental need and performed according to accepted standards of dental practice:

- Diagnostic & Preventive Care;
  - Comprehensive dental examinations, limited to once every 60 months per dentist;
  - Periodic oral exams, limited to once every six months;
  - Full mouth x-rays limited to once every 60 months;
  - Bitewing x-rays, limited to once every six months;
  - Single tooth x-rays as needed;
  - Prophylaxis (tooth cleanings), limited to once every six months;
  - Fluoride treatment for children under age 19, limited to once every six months;
  - Sealants for unrestored permanent molars of dependent children under age 16, limited to one treatment per tooth every four years (sealants will be covered for children from age 16 up to age 19 for a tooth with a recent cavity if the child is at risk for tooth decay);
  - Space maintainers required due to the premature loss of teeth for children under age 14, once per tooth per lifetime;
  - Recementation of space maintainers once per calendar year;
  - Pulp vitality tests once per visit;
  - Chlorhexidine mouth rinse only when administered and dispensed in the dentist's office following scaling and root planing;
  - Fluoride toothpaste when administered and dispensed in the dentist's office following periodontal surgery; and
  - Emergency dental care, including:
    - Minor treatment for pain relief, limited to three occurrences every 12 months; and
    - General anesthesia provided in conjunction with a covered surgical service;

  Additional cleanings, including periodontal cleanings, may be available for individuals with diabetes, high-risk cardiovascular conditions, kidney failure, suppressed immune systems, periodontal disease. Additional cleanings may also be available for individuals who are pregnant, or are undergoing dialysis, or chemotherapy/radiation therapy. Contact Delta Dental for more information.

- Minor Restorative Care:
  - Silver or white fillings, limited to once every 24 months per surface per tooth;
  - Sedative fillings, limited to once per tooth;

- Temporary fillings, limited to once every 60 months per tooth;
- Recementation of crowns, inlays or onlays, cast or prefabricated posts, and cores limited to once per tooth evey 12 months;
- Prefabricated stainless steel crowns, on deciduous teeth only, limited to once every 24 months per tooth; and
- Amalgam & resin based fillings, limited to once per surface each 12-month period;

- Periodontics & Endodontics:
  - Osseous surgery, limited to once per quadrant every 36 months;
  - Full mouth debridement once per lifetime to enable comprehensive evaluation and diagnosis;
  - Scaling and root planing, limited to once per quadrant every 24 months;
  - Periodontal cleaning, limited to once every three months following active periodontal treatment;
  - Bone replacement or soft tissue grafts;
  - Root canal therapy, limited to once per tooth;
  - Pulpal therapy;
  - Clinical crown lengthening;
  - Guided tissue regeneration, when performed in association with natural teeth;
  - Apicoectomy once per tooth every 24 months;
  - Retrograde filling once per filling per root;
  - Gingivectomy or gingivoplasty, and gingival flap procedures; and
  - Vital pulpotomy, limited to deciduous teeth;
- Oral Surgery:
  - Simple extractions or surgical extractions, including removal of impacted teeth, limited to once per tooth;
  - Tooth reimplantation of an accidentaly displaced tooth or alveoulus;
  - Surgical access of an unerupted tooth;
  - Alveoloplasty;
  - Biopsy of oral tissue; and
  - Surgical excision of lesions;
- Prosthetic Maintenance:
  - Repairs to complete or partial dentures, including replacement of missing or broken teeth;
  - Fixed partial denture (bridge) repair, limited to once every 12 months; and
  - Rebase or reline of dentures, limited to once every 36 months;

- Prosthodontics:
    - Complete and partial dentures, limited to once every 60 months;
    - Fixed bridges or crowns when part of a bridge, limited to once within 60 months;
    - Adjustments to complete and partial dentures, limited to twice per denture in a 12-month period;
    - Pontics;
    - Recementation of fixed partial dentures; and
    - Fixed partial denture retainers, including inlays, onlays, and crowns;
- Major Restorative:
    - Onlays for permanent teeth;
    - Crowns and ceramic restorations for permanent teeth;
    - Pin retention, limited to once per tooth;
    - Endosteal implants, when the implant replaces one missing tooth in lieu of a three-unit bridge, and when all adjacent teeth do not require crowns, limited to once every 60 months per implant; and
    - Cast or prefabricated posts and cores, and core buildup;
- Orthodontics.

Alternate Course of Treatment

If Delta Dental determines that an alternate method of treatment would be, or would have been, at least as effective but less costly, Dental Benefits may be paid based on the alternate method provided the alternate treatment is:

- Commonly used in the treatment of the existing condition, as determined by Delta Dental; and
- Recognized by the dental profession to be appropriate in accordance with accepted nation-wide standards of dental practice.

Predetermination of Dental Benefits

Predetermining the benefits available for covered expenses is a voluntary program, recommended when treatment involves dentures, crowns, periodontic services or bridgework, and in all other non-emergency situations in which the proposed treatment is expected to cost more than $250.

A predetermination of dental benefits will be issued by Delta Dental upon receipt of the treating dentist's examination and treatment records, describing each procedure necessary to fully complete the recommended dental treatment, and an itemized cost estimate of the recommended treatment.

Predetermination of benefits does not guarantee dental coverage under the plan, nor does it guarantee that a benefit will be payable for dental treatment or services provided.

What's Not Covered

In addition to the Plan's General Exclusions and Limitations (*See pages D-29 to D-30*), no Dental Benefits are provided for:

- Services or supplies which are cosmetic (except for covered orthodontic treatment);
- Periodontal cleanings provided in combination with preventative cleanings;
- Instruction or programs for plaque control or oral hygiene;
- Replacement of any existing cast restoration (crowns, onlays, ceramic restorations) with any type of cast restoration within 60 months following initial placement of existing restoration;
- Recementation of inlays, onlays, partial coverage restorations, casts, and prefabricated posts and cortes and crowns by the same office within six months of the initial placement;
- Recementation of a space maintaner within six months of the initial placement;
- Space maintainers for the replacement of primary or permanent anterior teeth;
- Pulp vitality tests in conjunction with any service, other than emergency exams or palliative treatment;
- Additional procedures to construct a new crown under the existing partial denture framework within six months following initial placement;
- Replacement at any time of a bridge or denture which is or can be made usable according to accepted dental standards;
- Services or supplies with respect to any disturbance of the temporomandibular joint disorder;
- Fillings in crowns have been allowed for the same tooth;
- Services for anesthetists or anesthesiologists;
- Services for temporary procedures;
- Cast restoration if there is no radiographic evidence of decay or a missing tooth;
- Crowns for periodontal splinting, or if the tooth is restorable by other means;
- Services or supplies that will not restore function;
- Missed or broken appointments;
- Drugs or medications other than general anesthesia or IV sedation;
- Services which are payable under any other part of the Plan;
- Retreatment of a tooth which has had an endodontic procedure performed within two years;
- Any service or procedure performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone;
- Services performed on non-functional teeth (second or third molar without an opposing tooth);

- Services or supplies to correct harmful habits;
- Endodontic procedures performed in conjunction with complete removable prosthodontic appliances;
- Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation;
- Bone replacement grafts performed in conjunction with extractions or implants;
- Periodontal splinting to restore occlusion;
- Fixed or removable prosthodontics for a patient under age 16;
- Pontics when the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth;
- Servcies to correct developmental malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and congenitally missing teeth, except for newborn infants;
- Procedures deemed experimental or investigative by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature;
- Services, supplies or procedures that Delta Dental considers to be included in the fees for other procedures;
- Infection control procedures and fees associated with compliance with requirements of the Occupational Safety and Health Administration (OSHA);
- Charges for inpatient or outpatient hospitalization; and
- Services rendered more frequently than permitted under the Plan, more frequently than commonly accepted according to the dental standards determined by Delta Dental, or more frequently than specified in the contract with Delta Dental.

Dental Benefits After Eligibility Ends

If coverage ends because of the loss of eligibility for reasons other than termination of the Plan, benefits will only be determined for allowable charges incurred for covered expenses before coverage ends.

If coverage ends because the Plan terminates, in whole or in part, no benefits will be available for claims submitted after coverage ends.

Davis administers the vision care benefits based on the contract with UNITE HERE HEALTH. If there are any discrepancies between the contract and any information UNITE HERE HEALTH provides, the contract will govern. A copy of the contract may be obtained by calling UNITE HERE HEALTH.

The highest coverage and lowest out-of-pocket costs are available for services provided by network providers.

To locate a network provider near you,
contact **Davis Vision** toll free
(800) 999-5431
www.davisvision.com

What's Covered

Frames and lenses must be acquired on the same day as the eye exam.

The following services and supplies are available to you or a covered dependent once every 24 months:

- A routine eye examination, including dilation when professionally indicated;
- Frames;
- Spectacle lenses, single vision, bifocal, or trifocal, including:
    - Plastic or glass;
    - Polycarbonate lenses for dependent children, monocular patients and patients with prescriptions +/- 6.0 diopters or greater;
    - Glass grey # 3 prescription lenses;
    - Oversize lenses;
    - Post-cataract lenses;
    - Fashion-tinted plastic lenses; and
    - Gradient tints;
- Standard contact lenses (soft, daily-wear, disposable, or planned replacement) in place of eyeglasses. Non-standard contact lenses, including gas permeable, toric, or tinted lenses, are also available up to Davis' maximum benefit.

However, both contact lenses and eyeglasses are allowed for the treatment of the eye condition known as Keratoconus, a progressively worsening eye condition that distorts vision.

Disposable and planned replacement contacts will be supplied in quantities determined by Davis Vision.

You may use Lens 123, a mail order contact lens replacement service to purchase replacement lenses at a lower cost. Call **(800) 536-7123** or visit www.lens123.com for more information.

D

What the Plan Pays

Network Provider

The Plan pays 100% for exams, covered spectacle lenses and specified standard or designer level frames. Frames other than Davis' specified selections are allowed up to a maximum benefit of $14. The Plan pays 100% toward the cost of standard contact lenses and up to $25 for non-standard contact lenses and the associated eye examination.

Non-Network Provider

The Plan pays 100% up to the maximum allowance for covered services and supplies if a non-network provider is used. You are responsible for any amounts in excess of these allowances.

- Exam: $16
- Frames: $14
- Lenses:
    - Single vision: $14
    - Bifocals: $23
    - Trifocals: $29
- Contact lenses: $40

However, for children under age 5, the $16 maximum benefit for exams does not apply.

What You Pay

You pay the difference between the amount the Plan pays and the amount billed by the provider.

Options and Upgrades

You can also purchase vision options and upgrades from a network provider at a discounted price. The options and upgrades provided under the Plan and what you will have to pay for each are shown on the following chart:

Option or Upgrade	What You Pay
“Premier“frames	$25
Progressive multifocal lenses	
Standard brands	$50
Premium brands	$90
Photochromic lenses	$20
Single vision	$20

Option or Upgrade	What You Pay
Multifocal	$20
Intermediate-vision lenses	$30
Scratch protectant plan	
Single vision	$20
Multifocal	$40
Anti-reflective coating	
Standard	$35
Premium	$48
Ultra	$60
High index lenses	$55
Polarized lenses	$75
Polycarbonate lenses for persons:	
With a prescription of +/-6.0	$0
Age 17 and older	$30
Plastic photosensitive lenses	$65
Blended segment lenses	$20
Ultraviolet coating	$12

Conventional bifocals will be supplied if you or a covered dependent cannot adapt to progressive addition lenses. However, the applicable copayment will not be refunded.

Low Vision Benefit

If a Davis Vision network provider believes you require additional treatment for visual impairment even after correction by regular lenses (low vision), low vision services will be available either from a Davis Vision network provider or through a non-network provider. All low vision treatments, services, or supplies must receive prior approval from Davis Vision.

The Plan pays 100% for most low vision services and supplies. Maximum benefits and frequency limits apply, as determined in accordance with the agreement between UNITE HERE HEALTH and Davis Vision. Contact Davis Vision for more information about low vision services and supplies.

What's Not Covered

In addition to the Plan's General Exclusions and Limitations (*See pages D-29 to D-30*), no Vision Care Benefits will be provided for:

- Services and supplies not specifically listed as covered;
- Medical treatment of eye disease or injury;

- Vision therapy;
- Special lens designs or coatings, other than specifically listed as covered;
- Lenses or frames not obtained on the same day as the exam;
- Non-prescription lenses;
- Contact lenses in addition to frames/lenses;
- Two pairs of spectacle lenses instead of bifocals; or
- Replacement of lost lenses or frames, or scratched lenses.

Mental Health/Substance Abuse Treatment/Alternative Care Benefits

UNITE HERE HEALTH contracts with Modern Assistance Programs, Inc. (MAP) to administer your benefits for:

- Mental health and substance abuse treatment
- Smoking cessation
- Alternative care

✓ MAP must coordinate and approve care for mental health, substance abuse, and Alternative Care Benefits. The Plan will not pay benefits unless MAP coordinates and approves the care. If you receive emergency care, or urgent care outside the service area, contact MAP to arrange for follow-up care.

Modern Assistance Programs, Inc. (MAP)
(617) 774-0331 inside Massachusetts
(800) 878-2004 outside Massachusetts

MAP is here to help, and will help you develop a treatment plan that works for you. **If you or a dependent is having a difficult time, please call MAP.**

MAP
1400 Hancock Street, 2nd Floor
Quincy, MA 02169
MAP is located by the MBTA Quincy Center Train Station on the Red Line.

Office hours
Monday – Thursday, 9AM – 5PM
Friday, 9AM – 1PM

Get Help

MAP provides you and your dependents with help and certain services at no cost to you. MAP is here to assist you and your family members in times of need. You can get help for many problems, including:

- Substance abuse counseling and treatment
- Mental health counseling and treatment
- Marital difficulties

MAP is committed to overcoming all physical, language, cultural, or other barriers which may be perceived as an impediment to counseling.

D

What the Plan Pays

The Plan pays 100% of covered care provided by MAP or managed by MAP, if the practitioner has accepted MAP's guidelines and fee schedules.

What You Pay

You pay nothing out-of-pocket for covered care provided by or managed by MAP.

What's Covered

MAP counselors will work with you to assesss your situation. MAP will work with you to develop a treatment plan that best suits your needs. Treatment may include individual or group services, or referral to outside agencies or practitioners for inpatient or outpatient treatment. Services and supplies are only considered covered if they are provided by MAP, offered at MAP, or MAP manages the care through a practitioner that has accepted MAP's guidelines and fee schedules.

The following are examples of alternative care services and supplies that will be covered:

- Acupuncture, up to 20 visits per person per year;
- Traditional Chinese medicine, up to 12 visits per person per year;
- Naturopathy, up to 12 visits per person per year;
- Massage therapy, up to 12 visits per person per year;
- Nutrition counseling; and
- Smoking cessation counseling.

What's Not Covered

In addition to the Plan's General Exclusions and Limitations (*See pages D-29 to D-30*), no benefits will be provided for:

- Services or supplies that are not coordinated or approved by MAP; or
- Services or supplies provided by a health care professional not contracted with MAP.

General Exclusions and Limitations

In addition to individual benefit exclusions, a covered expense will not include, and no benefit will be paid, under the Plan for charges incurred for or resulting from the following:

- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a health care professional;
- Any injury, sickness, or dental or vision treatment which arises out of or in the course of any occupation or employment, or for which a person has received or is entitled to receive benefits under a workers' compensation or occupational disease law, whether or not application has been made or approved for such benefits;
- Any treatment, services, or supplies:
    - For which no charge is made;
    - For which a person is not required to pay; or
    - Which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish, or municipal hospital when there is no legal requirement to pay for such treatment, services, or supplies;
- Any charge which is in excess of the Plan's allowable charge;
- Treatment, services, or supplies not medically necessary in treating the injury or sickness as defined by UNITE HERE HEALTH or by the contracted provider designated by UNITE HERE HEALTH to make such decision;
- Experimental treatment, or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH or by the contracted provider designated by UNITE HERE HEALTH to make such decision;
- Any expense or charge for failure to appear for an appointment as scheduled, or charge for completion of claim forms, or finance charges;
- Any treatment, services, or supplies provided by an individual who is related by blood or marriage to the employee or dependent, or who normally lives in the employee's home;
- Services, supplies or medicines primarily for your or your provider's, or other person's convenience;
- Any treatment, services, or supplies purchased or provided outside the 50 United States of America, unless for the treatment of a medical emergency. The decision of the Trustees in determining the emergency will be final;
- Any charges incurred for treatment, services, or supplies as a result of a declared or undeclared war or any act thereof; or any loss, expense or charge incurred while a person is on active duty or in training in the Armed Forces, National Guard, or Reserves of any state or any country;
- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault;

- Any expense greater than the Plan's maximum benefits, or any expense incurred before eligibility for coverage begins or after eligibility terminates, unless specifically provided for under the Plan; or
- With respect to the benefits administered by each contracted provider, any service or supply not covered under the terms of the contract.

Adoption Assistance Benefits

UNITE HERE HEALTH provides an Adoption Assistance Benefit to help you pay some or all of the costs of adopting a child. Modern Assistance Programs, Inc. (MAP) administers this benefit. Contact MAP to file a claim for Adoption Assistance Benefits.

MAP
1400 Hancock Street, 2nd Floor
Quincy, MA 02169

(617) 774-0331 inside Massachusetts
(800) 878-2004 outside Massachusetts

Eligibility

You are eligible for Adoption Assistance Benefits if you are eligible for benefits as an active employee under UNITE HERE HEALTH Plan Unit 108. The Adoption Assistance Benefit is not available to you if you are maintaining your coverage through COBRA self-payments.

What the Plan Pays

The Plan will reimburse you for adoption expenses you incur for eligible adopted children. You must submit an application to MAP before you incur any expenses. This application must be submitted at the time the adoption has been finalized. MAP will determine if your application is accepted and whether the expenses you incur are eligible for reimbursement.

The maximum amount you will be reimbursed under this Plan is $2,000 of eligible expenses incurred per eligible adopted child per Plan Year. The Plan Year runs from each April 1 through the following March 31.

What's Covered

All reasonable and necessary expenses related to an adoption that are reimbursable under this Plan include:

- Adoption fees;
- Court costs;
- Attorney fees; and
- Other expenses directly related to and for the primary purpose of a legal adoption.

What's Not Covered

The following expenses are not covered under the Adoption Assistance Benefit:

- Expenses you incur while you are not covered under this Plan;
- Expenses incurred in violation of state or federal law;
- Expenses incurred in carrying out any surrogate parenting program;

- Expenses in connection with the adoption of a child who is a child of your spouse;
- Expenses that you take a federal income tax credit for under Section 23 of the Internal Revenue Service (IRS) Code; and
- Expenses that are covered by any other means including expenses for legal services provided under the Greater Boston Hotel Employees Local 26 Group Legal Services Plan and for legal work performed by another attorney when the work could have been performed by the Greater Boston Hotel Employees Local 26 Group Legal Services Plan.

Eligible Adopted Child

In order to receive reimbursement under this Plan, the child you adopt must be:

- Under 18 years of age;
- Physically or mentally incapable of caring for himself or herself; or
- A child with special needs as defined by the Internal Revenue Code.

Adoptions from Another State or Country

If you adopt an eligible child from another state or country, reimbursement will be made the same as for a Massachusetts adoption if the adoption is not in violation of the laws of the state or country the child is adopted from. You may be required to apply to the Probate and Family Court in the county where you live for a determination of whether or not the adoption will be accepted in Massachusetts. This court determination will be used to consider whether your adoption expenses are eligible for reimbursement under this benefit.

These benefits are not available to dependents, except for a dependent spouse who is paying for two-way coverage (*See pages F-3 to F-4*).

Short Term Disability Benefits are provided under a group insurance policy issued to UNITE HERE HEALTH by The Guardian Life Insurance Company (Guardian). The terms and conditions of your Short Term Disability Benefits are contained in a certificate of insurance made available by Guardian. The certificate describes, among other things:

- How much Short Term Disability Benefits is available;
- How to file a claim.

The terms of the certificate are summarized below. If there is a conflict between this summary and the certificate of insurance, the certificate governs. You may obtain a copy of the certificate of coverage by contacting UNITE HERE HEALTH.

The Guardian Life Insurance Company of America
7 Hanover Square
New York, NY 10004
(212) 598-8000

Short Term Disability Benefits are designed to provide benefits as the result of a disability caused by a non-occupational injury or sickness. You are considered disabled if you are prevented by injury or sickness from engaging in the normal activities of your job. To be entitled to benefits, you must be eligible when disability begins. No benefits are available for any period of continuous disability beginning:

- Before initial eligibility is established; or
- After employment terminates.

Eligibility for Short Term Disability Benefits

Basic Short Term Disability Benefits

You must be working at least 20 hours per week in order to be eligible for basic Short Term Disability Benefits.

Extended Short Term Disability Benefits

You must be working full time (an minimum average of 32 hours per week) and have been covered by UNITE HERE HEALTH or the Greater Boston Hotel Employees Local 26 Health and Welfare Fund for 3 or more years in order to be eligible for extended Short Term Disability Benefits.

What the Plan Pays

If a non-work related injury or sickness prevents you from doing your job, the Plan pays **two-thirds (2/3) of your average weekly pay per week. Under the basic Short Term Disability Benefits, the Plan pays benefits for up to 13 weeks for any one period of disability.** Under the extended Short Term Disability Benefits, the Plan pays benefits for up to 26 weeks for any one period of disability. For periods of disability less than 7 days, the Plan pays one-seventh (1/7) of your benefits weekly benefit for each day of disability.

Benefits begin on:

- The 1st day of disability caused by injury; and
- The 8th day of disability caused by sickness or pregnancy.

Benefits will be paid directly to you. However, if you are not legally competent, benefits may be paid to the legal representative of your estate.

E

Your employer may be eligible for reimbursement of up to $2,500 in workplace modifications done in order to accommodate your disability. The reimbursement may be made if it allows you to return to, and remain at, work.

Calculation of Your Weekly Benefits

Your benefits are calculated based on the average hours you worked in the 3 months immediately preceding your disability. Your average hours are multiplied by your hourly pay rate. The minimum hourly pay rate is two-thirds (2/3) of the Room Attendant hourly pay rate. Gratuities are not included in the calculation of your hourly pay rate.

Your weekly benefit may be reduced certain disability, retirement, or other income you receive. Your weekly benefit may be reduced based on other income or benefits to which you are entitled, even if you do not apply for or receive such benefits. You can get more information about how your weekly benefits are calculated by contact Guardian.

Benefits are governed based on the rules in effect on the date the disability occurs.

Multiple Periods of Disability

A subsequent disability will be treated as a recurring disability as long as all of the following conditions have been met:

- You return to active work after receiving Short Term Disability Benefits;
- The disability recurs less than two weeks following the date you were last entitled to Short Term Disability Benefits;
- The subsequent disability is due to the same or related cause as the earlier disability;
- You do not become covered under any other similar group income replacement plan during the time you return to active work; and

- You continue to meet the Plan's eligibility rules, including the requirement that employer contributions be made on your behalf, following your return to active work.

If a later period of disability is considered a recurring disability, benefits will begin immediately upon the recurring disability, and the rules and benefits in effect as of the original disability will remain in effect.

What's Not Covered

No short Term Disability Benefits are provided for or in connection with:

- War or act of war;
- Service in the military;
- Participation in a riot or in civil disorder;
- Commission of, or attempted commission of, a felony for which you have been convicted;
- Involvement of an incident, including but not limited to, a motor vehicle accident, in which the person is intoxicated at the time of the incident. "Intoxication" means blood alcohol concentration that meets or exceeds the level that would be required in order to charge the person with driving while intoxicated under the laws of the jurisdiction in which the incident occurred, regardless of whether or not the person is ever charged;
- The voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: a) it was prescribed to you by a doctor, and b) it was used as prescribed. In the case of non-prescription drugs, no payments are made for any loss resulting from or contributed to by the use of the drug in a manner inconsistent with package instructions;
- Intentional self-inflicted injuries; or
- Job-related or on-the-job injuries.

In addition, no benefits are payable for any period of disability:

- During which the person is confined to a facility due to the conviction of a crime;
- During which the person is receiving medical treatment or care outside the United States or Canada, unless expressly authorized as payable by Guardian;
- Which begins before the individual is covered under UNITE HERE HEALTH or predecessor plans; or
- During which the loss of earnings is not solely due to the disability.

When Coverage Ends

Benefits end on the earliest of the following:

- The end of the maximum number of weeks benefits are payable (13 weeks for basic Short Term Disability Benefits, plus, if you are eligible for the extended Short Term Disability Benefits, an additional 26 weeks);

- The date on which the Plan determines you are no longer approved to continue to receive Short Term Disability Benefits;
- The date on which you are eligible to receive SSI or SSDI benefits;
- The day on which you are no longer considered Totally Disabled;
- The day you perform any work for wage or profit;
- The date you fail to provide proof of loss as required by this plan;
- The date you have been outside the United States for more than 2 months in a 12 month period;
- The date you die;
- The date you are no longer receiving regular and appropriate care from a doctor; or
- The date you are able to perform the major duties of your own job on a full-time basis with reasonable accommodation.

Filing A Claim

The required claim forms are available from UNITE HERE HEALTH.

You must submit a completed application for benefits and a doctor's statement establishing total disability before benefits can begin.

Notice of a claim for benefits must be provided within 20 days of the day the injury occurs or the sickness begins. Once notice of the claim has been submitted, you must submit written proof of the loss within 90 days of the loss.

If you cannot submit a claim within the required time frame, your claim may still be considered if notice and proof of loss is submitted as soon as reasonably possible.

Proof will include information about the disability, information about your medical care, and information about your loss of income. Contact Guardian for information on what proof documentation is required. Failure to provide this information may delay, suspend, reduce or terminate your benefits.

You must provide Guardian any authorization required to obtain medical, financial, vocational, occupational, and governmental records required by Guardian. Failure to provide such authorizations may delay, suspend or terminate your benefits.

Guardian may require examination or assessment of your condition, at Guardian's expense. If you do not take part in or cooperate with the required examination or assessment, your payments may stop or be suspended.

Ongoing Proof of Loss

To continue to receive payments from this plan, you must provide current proof of loss as often as Guardian may reasonably require. Ongoing proof of loss must be provided within 30 days of the date requested.

Overpayment Recovery

If Guardian overpays you, you must repay Guardian in full. Guardian has the right to reduce your payment or apply any benefits payable toward recovery of overpayment.

Benefit Determination

Guardian will provide a benefit determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies you before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies you, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If you fail to provide all information needed to make a benefit determination, Guardian will notify you of the specific information that is needed as soon as possible but no later than 45 days after receipt of the claim.

If Guardian extends the time period for making a benefit determination due to your failure to submit information necessary to decide the claim, you will be given at least 45 days to provide the requested information. The extension period will begin on the date on which you respond to the request for additional information.

Life and Accidental Death & Dismemberment Insurance Benefit

These benefits are not available to dependents, except for a dependent spouse who is paying for two-way coverage (*See pages F-3 to F-4*).

Life insurance and AD&D insurance benefits are provided under a group insurance policy issued to UNITE HERE HEALTH by The Guardian Life Insurance Company of America (Guardian). The terms and conditions of your life and AD&D insurance coverage are contained in a certificate of insurance made available by Guardian. The Certificate describes, among other things:

- How much life and AD&D insurance coverage is available;
- How to name or change beneficiaries;
- How benefits are paid if you do not name a beneficiary or if a beneficiary dies before you do; and
- How to file a claim.

The terms of the Certificate are summarized below. If there is a conflict between this summary and the Certificate of Insurance, the certificate governs. You may obtain a copy of the certificate by contacting UNITE HERE HEALTH.

The Guardian Life Insurance Company of America
7 Hanover Square
New York, NY 10004

Life Insurance Benefit

Your Life Insurance Benefit will be paid to your beneficiary if you die while you are eligible for coverage.

In order to be eligible for life and AD&D insurance benefits, you must: 1) be eligible under UNITE HERE HEALTH at the time of loss; 2) be legally working in the U.S., and 3) be fully capable of performing the major duties of your regular occupation for your employer on a full-time basis as of the date your benefits become effective. If you are not fully capable of performing the major duties of your job, your life and AD&D benefits will not become effective until you become so capable.

Guardian has certain rules about covering individuals outside the U.S. Contact Guardian for more information.

Termination of Eligibility

This termination of eligibility applies only to benefits administered by Guardian. It does NOT apply to your termination of eligibility rules for UNITE HERE HEALTH (*See page F-5*).

If your eligibility under UNITE HERE HEALTH terminates, your eligibility for life and AD&D benefits will end on the earlier of:

- The end of a 31-day period which starts on the date your group benefits would otherwise end;
- The date you become eligible for similar benefits;
- The date you have been outside the U.S. for six months in any 12-month period; or
- The date your full-time service ends for any reason, including disability, retirement, layoff, leave of absence (other than a leave of absence under FMLA), or layoff.

Continuing Your Insurance

If your eligibility for life insurance benefits terminates, you may be able to continue all or part of your life insurance coverage. If your coverage under UNITE HERE HEALTH ends, contact Guardian for information about your options.

For more information about how to continue your life insurance benefits if your eligibility ends, contact Guardian: **(800) 433-5982 (option 1) extension 5696.**

Accidental Death & Dismemberment Insurance Benefit

If you die or suffer a covered loss within 365 days of an accident occurring while you're eligible for coverage, Accidental Death & Dismemberment Insurance Benefits will be paid as shown on the following chart:

Your AD&D Benefit for a loss (death or dismemberment) within 365 days of an accident			
Event	Benefit if You Worked Less than 4 Years	Benefit if You Worked 4-10 Years	Benefit if You Worked More Than 10 Years
Death	$5,000	$10,000	$35,000
Quadriplegia	$5,000	$10,000	$35,000
Loss of speech and hearing in both ears	$5,000	$10,000	$35,000
Loss of cognitive function	$5,000	$10,000	$35,000
Comatose state lasting more than one month	$5,000	$10,000	$35,000
Hemiplegia or paraplegia	$2,500	$5,000	$17,500

Your AD&D Benefit for a loss (death or dismemberment) within 365 days of an accident			
Loss of one hand or one foot	$2,500	$5,000	$17,500
Loss of the sight in one eye	$2,500	$5,000	$17,500
Loss of thumb and index finger of same hand	$1,250	$2,500	$8,750

"Loss of cognitive function" means a significant delcine or loss in intellectual aptitude resulting from accidental injury. Contact Guardian for more information.

"Loss of a hand or foot" means that it is completely cut off at or above the wrist or ankle.

"Loss of sight" means the total and permanent loss of sight.

AD&D Exclusions

Accidental Death & Dismemberment Benefit does not cover losses caused by:

- Any infection, except an infection of an accidental injury;
- Sickness, disease, mental infirmity, medical or surgical treatment;
- Taking part in a riot or other civil disorder, or the commission of or the attempt to commit a felony;
- By travel on any type of aircraft if you are an instructor or crew member, or have any duties at all on that aircraft;
- By war or act of war, except loss of life which occurs while you are not actively serving in the military;
- While you are in the military, including active, Reserve, and Guard duty;
- While you are a driver in a motor vehicle accident, if you do not hold a current and valid driver's license;
- By your legal intoxication, including but not limited to, your operation of a motor vehicle; and
- Your voluntary use of a controlled substance unless it was prescribed for you by a doctor and it was used as prescribed.

In addition, benefits are generally unavailable for losses caused while under the influence of narcotics or other controlled substances, gas or fumes, losses caused while intoxicated, by active participation in a riot, or war or an act of war while serving in the military.

See your certificate for complete details.

Additional Insurance Benefits and Services

The additional insurance benefits described below have been added to existing life and accidental death & dismemberment (AD&D) coverages available through the Plan. The full terms and conditions of these additional insurance benefits are contained in a certificate made available by Guardian. If there is a conflict between these highlights and the certificate, the certificate governs.

Contact Guardian for more information about these benefits, including information about continued eligibility for the benefit, and when the benefit will cease to be paid.

Accidental Death & Dismemberment Insurance Benefits

- **Dependent Child Education Benefit** – If you have children in college at the time of your death, the amount of the benefit will be the lesser of the amount of the child's net tuition expenses for the term, or 5% of the AD&D benefit payable, up to a lifetime maximum of $20,000.
- **Spousal Education and Retraining Benefit** – If you have a spouse and you suffer a specified loss due to an accidental bodily injury, a spousal education and retraining benefit will be available if all of the following conditions are met: (1) the AD&D benefit is payable for your loss; (2) you and your spouse share the same place of residence on the date the accidental injury occurs; and (3) the spouse provides proof of enrollment in an Institute of higher learning within 12 months of the date of the accidental injury. The amount of the benefit will be the lesser of the amount of the spouse's net tuition expenses for the term, or 5% of the AD&D benefit payable, up to a lifetime maximum of $20,000.
- **Day Care Expense Benefit** – If you have children and you suffer a specified loss due to an accidental bodily injury, Guardian will pay the lesser of $10,000 annually or the actual annual day care expenses.
- **Seat Belt Benefit** – If you are wearing a seat belt at the time of an accident resulting in your death, your AD&D coverage will pay an additional benefit of $10,000.
- **Air Bag Benefit** – If you are wearing a seat belt at the time of an accident resulting in your death and an air bag deployed, your AD&D coverage will pay an additional benefit of $5,000.

Accelerated Life Benefit

✓ Only available for employees who have worked more than 10 years and are eligible for the highest life insurance benefit.

If you have a terminal illness (an illness so severe that you have a life expectancy of 24 months or less), your Life Insurance will pay a cash lump sum equal to the lesser of $10,000 or 50% of the death benefit in force on the day proof of terminal illness. The remaining portion of your death benefit will be paid to your named beneficiaries upon your death. Contact Guardian for informa-

tion about requesting the Accelerated Life Benefit, and for information about any restrictions on when the benefit will be paid.

Naming a Beneficiary

Your beneficiary is the person or persons you want Guardian to pay if you die. You can name anyone you want, and you can change beneficiaries at any time. Beneficiary designations will become effective on the date signed by the employee. If a beneficiary is a minor or not legally competent to receive payment, Guardian may make payment to that person's legal guardian.

If you don't name a beneficiary, death benefits will be paid to one of the following classifications: your estate, your spouse; your parents; your child(ren); or your brothers or sisters. Guardian will review each case and make the determination of which class to pay benefits to on a case by case basis.

Guardian may pay up to $250 to anyone who pays expenses for your funeral or last illness.

You may also choose a permanent beneficiary. However, if you choose to make a irrevocable beneficiary designation, you will not be able to change your beneficiary later. Contact Guardian for more information.

Filing a Claim

See pages G-9 to G-14 for more information about appealing a denial of benefits.

You will be notified within 90 days of the date the claim is received. However, Guardian may request up to a 90-day extension.

Life Insurance Claims

All claims must be submitted to Guardian along with proof of death. Proof of death must be provided to Guardian as soon as possible.

Accidental Death & Dismemberment Claims

Notice of a claim for benefits must be provided within 20 days of the day the injury occurs or the sickness begins. Once notice of the claim has been submitted, you must submit written proof of the loss within 90 days of the loss.

If you cannot submit a claim within the required time frame, your claim may still be considered if notice and proof of loss is submitted as soon as reasonably possible.

Eligibility for Coverage

You establish and maintain eligibility by working for an employer required by a Collective Bargaining Agreement to make contributions to UNITE HERE HEALTH on your behalf. There may be a waiting period before your employer is required to begin making those contributions. Any hours worked during a waiting period will not be used to satisfy eligibility requirements.

You should look at your CBA – it will tell you when your employer will begin making contributions for your coverage. The eligibility rules discussed in this section will not apply to you until your employer is required to begin making contributions on your behalf.

Coverage is not free. You must arrange to make payroll deductions to pay for your share of the monthly cost of benefits. At the time this SPD was published, the monthly employee contribution rates were:

- $8 Two-Way Coverage
- $16 Single Coverage
- $32 Single Plus One Coverage
- $48 Family Coverage

However, the Trustees have the right to change these employee contribution rates at any time.

When Your Coverage Begins

If you work for the Boston Convention and Exhibition Center (Hynes Convention Center), please *see page F-2* for special eligibility rules.

Your coverage begins at 12:01 a.m. on the first day of the Coverage Period corresponding to the Work Period during which you are credited with at least 240 hours, for which contributions are required on your behalf, and for which the appropriate payroll deduction is made.

For purposes of establishing initial eligibility:

- Work Period means the two-month or three-month period during which you are credited with at least 240 hours, for which your employer must make contributions to UNITE HERE HEALTH on your behalf, and for which the appropriate payroll deduction is made.
- Lag Period means the calendar month between the end of a Work Period and the beginning of the corresponding Coverage Period.
- Coverage Period means the calendar-month for which coverage is in force as determined by the corresponding Work Period.

Example 1 – Establishing Initial Eligibility		
Work Period	**Lag Period**	**Coverage Period**
July - Aug - Sep	Oct	Nov

Suppose you start working in July, and work 90 hours during July, 75 hours during August, and 80 hours during September. Your coverage will begin on November 1 because you worked at least 240 hours during the three-month period running from July through September.

Example 2 – Establishing Initial Eligibility		
Work Period	**Lag Period**	**Coverage Period**
July – Aug	Sep	Oct

Suppose you start working in July, and work 130 hours during July and 120 hours during August. Your coverage will begin on October 1 because you worked at least 240 hours during the two month period running from July through August.

Special Rules for Employees of the Boston Convention and Exhibition Center

The Collective Bargaining Agreement (CBA) between the Boston Convention and Exhibition Center (BCEC) and the Local Union determines how many employees will become eligible for benefits each year. Eligibility will be determined based on the terms of the CBA, and not the rules described elsewhere in this Summary Plan Description.

Under the terms of the CBA, eligibility will be offered only to a set number of the employees based on both seniority and hours worked. A review will be conducted each January to determine those employees to whom eligibility will be offered. An employee being offered coverage must enroll in the Plan during the open enrollment period according to the enrollment process described *on page B-7*. Benefits will become effective July 1 of each year, provided the employee makes the required contributions for his or her share of coverage.

When Dependent Coverage Begins

See page B-7 for information about adding a newly acquired dependent.

You become eligible for Dependent Coverage on the date you become eligible for coverage under the Plan or on the date you acquire your first dependent, whichever happens last.

Once you have enrolled your existing dependents, coverage for additional dependents becomes effective on the date the dependent is acquired. However, you must enroll your dependents within 60 days of a special enrollment event (*see pages B-8 to B-9*). Otherwise, you will have to wait until the next open enrollment period or special enrollment period to enroll the dependent.

Continuing Eligibility

Once you establish eligibility, you maintain eligibility when you continue to meet work requirements described below during the corresponding Work Periods, and the appropriate payroll deduction is made.

For purposes of continuing eligibility:

- Work Period means the three-month period during which you are credited with at least 240 hours, for which your employer must make contributions to UNITE HERE HEALTH on your behalf, and for which the appropriate payroll deduction is made.
- Lag Period means the calendar month between the end of a Work Period and the beginning of the corresponding Coverage Period.
- Coverage Period means the calendar month during which coverage is in force as determined by the corresponding Work Periods.

Example – ContinuingEligibility		
Work Period	**Lag Period**	**Coverage Period**
Aug - Sep - Oct	Nov	Dec

Suppose you work 75 hours during August, 80 hours during September, and 90 hours in October. Your coverage will continue during December because you worked at least 240 hours during the three-month period running from August through October.

Special Rules for Employees of the Boston Convention and Exhibition Center

Continuing eligibility will be determined based on the terms of the CBA, and not the rules described elsewhere in this Summary Plan Description.

Under the terms of the CBA, eligibility will is continued based on both seniority and hours worked. Once a BCEC employee has enrolled in coverage, such employee will remain covered through the last day of the following June, as long as payroll deductions continue to be made for the employee. Thereafter, the BCEC employee will only continue coverage if he or she is offered coverage for the next year, due to the terms of the CBA.

Two-Way Coverage

Coverage Option if the Spouse is Also a Employee

If you and your spouse both work for contributing employers, your spouse can waive coverage as an employee and be covered as your dependent for purposes of the medical benefits, prescription drug benefits, mental health and substance abuse benefits, Alternative Care Benefits, Adoption Assistance Benefits, dental benefits, and vision benefits. You must enroll your spouse as a dependent.

Your spouse may continue his or her benefits as an employee under the Short Term Disability Benefits and life and AD&D benefits by applying for two-way coverage, as long as your spouse meets the eligibility rules. Your spouse must have the appropriate payroll deductions deducted from his or her paycheck.

✓ Contact the Boston regional office for information about two-way coverage.

Self-payments

Self-payments During a Work Place Closing

If your work place closes because of remodeling or restoration, you may self-pay until your work place is reopened, but not for more than 18 months from the date of initial closing.

Self-payments During a Strike

Eligible employees may make self-payments if:

- Your Collective Bargaining Agreement has expired;
- Your Employer is involved in collective bargaining with the Union and impasse has been reached; and
- The Union certifies that affirmative actions are being taken to continue the collective bargaining relationship with the Employer.

✓ You may self-pay for a maximum of 12 months as long as you do not engage in conduct inconsistent with the actions being taken by the union.

Survivor Eligibility

If you die while eligible for benefits, your dependents will continue to be eligible for the same benefits as other dependents, including medical benefits, prescription drug benefits, MAP benefits, dental benefits, and vision benefits. for three full months following your death. Eligibility for your surviving dependents' coverage will terminate on the last day of the third full month following the date of your death.

✓ For example, if you die on May 15, eligibility for your surviving dependents will terminate August 31.

Your surviving dependents may then be eligible for COBRA coverage.

A Participant who is absent from covered employment because of uniformed service may elect to continue health care coverage under the Plan for himself and his Eligible Dependents up to a maximum of 24 months from the date on which the his or her absence begins. For more information, including the effect of this election on COBRA rights, contact the Services & Operations Department at **(866) 711-4373**.

Coverage for you and your dependents will continue as long as eligibility is maintained and your employer makes the appropriate payroll deductions. Situations that can cause termination of coverage are listed below. In some cases, you and your dependents can temporarily continue coverage beyond the date it would otherwise cease by enrolling for COBRA continuation coverage.

When Employee Coverage Ends

Employee coverage ends on the earliest date any of the following occurs:

- The Plan is terminated;
- If you are terminated, the last day of the month following your termination date;
- For all employees other than BCEC employees, the last day of the Coverage Period for which you were last credited with the minimum work requirements necessitating a contribution in the corresponding Work Period to maintain eligibility;
- With respect to two-way coverage, if the spouse who declined coverage as an employee does not have the appropriate payroll deduction is made;
- If you are laid off, the last day of the Coverage Period for which you have satisfied the continuing eligibility rules;
- The last day of the Coverage Period during which you waive coverage;
- The last day of the month for which you pay your share of the cost of coverage; or
- The last day of the Coverage Period for which you last made a timely self-payment, if allowed to do so (*See page F-4* for information about self-payments during layoff or renovations).

See page F-7 for special rules that apply if your employer's Collective Bargaining Agreement expires.

When Dependent Coverage Ends

Dependent Coverage ends on the earliest date any of the following occurs:

- The Plan is terminated;
- Your coverage ends;
- The dependent enters any branch of the uniformed services;
- The last day of the month during which a disenrollment form for the dependent is received; or
- The last day of the month in which the dependent no longer meets the Plan's definition of dependent.

Coverage for children diagnosed with a physical or mental handicap, who cannot support themselves and who continue to depend on you for support, may be continued after their 26th birthday as long as:

- You remain eligible;
- The handicap began before age 19; and
- The children were covered by the Plan on the day prior to their 19th birthday.

To continue coverage, you must provide proof of the mental or physical handicap within 30 days after the date coverage would end because the dependent child reaches any age limits. The Trustees may also request that you provide proof of the handicap periodically while the handicapped dependent continues to be covered. Contact UNITE HERE HEALTH for more information on how to continue coverage for your handicapped children.

Definition of Totally Disabled or Total Disability

A dependent is considered to be totally disabled if he or she is completely unable, because of injury or sickness, to perform the normal activities of a well individual of like age or sex.

Determination of total disability requires written certification by the attending doctor and approval of UNITE HERE HEALTH.

F

Certificate of Creditable Coverage

Any time a person loses coverage, UNITE HERE HEALTH will automatically send a certificate documenting up to 18 months of coverage under the Plan. The certificate is required by the Health Insurance Portability and Accountability Act (HIPAA), and if you or a dependent become covered under another group health plan, the length of coverage under this Plan can be used to reduce any pre-existing condition time limits imposed by the new plan.

UNITE HERE HEALTH also automatically sends a certificate when a person's COBRA continuation coverage ends. A copy of the last certificate issued, updated to show any additional coverage, can also be requested within the 24 months immediately following the date Plan coverage ends.

Among other things, each certificate shows the persons covered by the Plan and the length of coverage applicable to each.

For details on COBRA, *see pages F-11 to F-16*. If you have questions about the right to receive a certificate of creditable coverage or the information it contains, contact UNITE HERE HEALTH at **(866) 711-4373**.

When Your Employer's Collective Bargaining Agreement Expires

If your employer is in negotiations, you should stay informed of the status of the negotiations and how they may affect your eligibility for benefits.

Your coverage under the Plan will end if any of the following happens:

If
Your employer is no longer required to contribute because of decertification, disclaimer of interest by the Union, or a change in your collective bargaining representative,

Then: Your coverage ends on the last day of the last month in which the decertification is determined to have occurred. In the case of a change in your collective bargaining unit, your coverage ends on the last day of the month for which your employer is required to contribute.

If
Your employer's Collective Bargaining Agreement expires and during the post-expiration 12-month period a new Collective Bargaining Agreement is not established and your employer does not make the required contributions to UNITE HERE HEALTH,

Then: Your coverage ends no later than the last day of the month following the month in which your employer's contribution was due but was not made.

If
Your employer's Collective Bargaining Agreement expires, a new Collective Bargaining Agreement is not established, and your employer continues making the required contributions to UNITE HERE HEALTH,

Then: Your coverage ends on the last day of the 12th month after the Collective Bargaining Agreement expires.

If
Your employer withdraws in whole or in part from UNITE HERE HEALTH,

Then: Your coverage ends on the last day of the month for which your employer is required to contribute to UNITE HERE HEALTH.

The Effect of Severely Delinquent Employer Contributions

The Trustees may terminate eligibility for employees of an employer whose contributions to the Fund are severely delinquent. Coverage for those employees will terminate as of the last day of the Coverage Period corresponding to the last Work Period for which the Fund grants eligibility by processing the employer's work report. The work report reflects an employee's work history, which allows the Fund to determine his or her eligibility.

The Trustees have the sole authority to determine when an employer's contributions are severely delinquent. However, because participants generally have no knowledge about the status of their employer's contributions to the Fund, participants will be given advanced notice of the planned termination of coverage.

Limited Retroactive Terminations of Coverage Allowed

Your coverage under the Plan may not be terminated retroactively (this is called a rescission of coverage) except in the case of fraud or an intentional misrepresentation of material fact. In this case, the Plan will provide at least 30 days advance notice before retroactively terminating coverage, and you will have the right to file an appeal.

If the Plan terminates coverage on a prospective basis, the prospective termination of coverage is not a rescission. Additionally, the Plan may retroactively terminate coverage in the following circumstances, and the termination is not considered a rescission of coverage:

- Failure to make contributions or payments towards the cost of coverage, including COBRA continuation coverage, when those payments are due;
- Untimely notice of death or divorce; or
- As otherwise permitted by law.

Remedies for Fraud

If a person submits information that he or she knows is false or purposely does not submit or conceals important information in order to obtain any Plan benefit, the Trustees may take actions to remedy the fraud, including: asking for the repayment of any benefits paid, denying payments of any benefits, deducting amounts paid from future benefit payments, and suspending and revoking coverage.

Re-establishing Eligibility

If you lose eligibility due to leave of absence governed by and conforming to the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA), your eligibility will be re-established as shown *on pages F-10*.

If you lose eligibility because you are terminated or not laid off, you will become covered under the Fund as of the first day of the month following your rehire or reinstatement date if:

- You are rehired or reinstated within 12 months of losing eligibility; and
- You elect to continue your coverage within 30 days of rehire.

Under this rule, your hours requirement will be deemed to have been met during the first two months of your rehire or reinstatement. In order to continue your coverage during the third month, you must have at least 80 credited hours during the first month following your rehire or reinstatement. In order to continue your coverage during the fourth month, you must have at least 160 credited hours during the first two months following your rehire or reinstatement. Thereafter, the continuing eligibility rules will apply (*See page F-3*).

If you lose eligibility because you do not have enough hours to continue your eligibility, you must again satisfy the Plan's continuing eligibility rules in order to re-establish your eligibility.

Portability

If you are covered by one Plan Unit when employment ends and go to work within 90 days for an employer participating in another Plan Unit, immediate coverage will be extended to you under UNITE HERE HEALTH's portability rule beginning with the first month for which your employer is required to contribute to UNITE HERE HEALTH on your behalf.

- Within 60 days after employment begins with your new employer, written notice from you, the union local, or the new employer should be sent to UNITE HERE HEALTH stating that a transferring employee's eligibility should be provided under UNITE HERE HEALTH's portability rules. The transferring employee's eligibility under the new plan will be established according to that plan's rules used to determine eligibility for the employees of new contributing employers.
- If the required notification is not received within the required 60-day period, your eligibility under the new plan will be established according to that plan's rules used to determine eligibility for the employees of current contributing employers.

Family and Medical Leave Act

✓ Eligibility will be continued for employees during any leave of absence governed by and conforming to the requirements of the Family and Medical Leave Act (FMLA).

Your coverage will be continued while you are on FMLA leave. Once you return from leave, your payroll deductions will be doubled until you have paid your share of the cost of benefits for the time you were on leave.

The Effect of Uniformed Service

Coverage for employees honorably discharged and returning from military service (active duty, inactive duty training, or full-time National Guard service), or from absences for the purposes of determining fitness to serve in the military, will be reinstated immediately upon return to covered employment if:

- The employer receives advance notice of the employee's absence, whenever possible;
- The cumulative length of absence for "eligible service" does not exceed 5 years; and
- The former employee reports or submits an application for re-employment within the prescribed time limits.

Former employees must notify the employer of their intent to return to work as follows:

- For service of less than 31 days or for an absence of any length to determine a person's fitness for uniformed service, the person must report by the first regularly scheduled work period after the completion of service PLUS a reasonable allowance for time and travel (8 hours);
- For service of more than 30 days but less than 181 days, the person must submit an application not later than 14 days following the completion of service; or
- For service of more than 180 days, the person must return to work or submit an application to return to work not later than 90 days following the completion of service.

However, if service ends and you are hospitalized or convalescing from an injury or sickness sustained during uniformed service, you must report or submit an application, whichever is required, at the end of the period necessary for recovery. Generally the period of recovery may not exceed 2 years.

No waiting periods may be imposed on reinstated coverage, and upon reinstatement, coverage shall be deemed to have been continuous for all Plan purposes.

✓ Your rights to reinstate coverage are governed by The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you have any questions, or if you need more information, contact UNITE HERE HEALTH.

COBRA Continuation Coverage

If you or your dependents lose coverage under the Plan, you have the right in certain situations to temporarily continue coverage beyond the date it would otherwise end. This right is guaranteed under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

COBRA continuation coverage is not automatic. It must be elected, and the required premiums must be paid when due. A premium will be charged under COBRA as allowed by federal law.

Who Can Elect COBRA Coverage?

Only qualified beneficiaries are entitled to COBRA continuation coverage, and each qualified beneficiary has the right to make an election.

An employee or dependent is a qualified beneficiary if he or she loses coverage due to a qualifying event and is covered by the Plan on the day before the earliest qualifying event occurs. However, a child born to, or placed for adoption with, an employee while he or she has COBRA coverage is also a qualified beneficiary.

Adding Dependents

If you want to continue dependent coverage or add a new dependent after you elect COBRA continuation coverage, you may do so in the same way as active employees do under the Plan.

What Is a Qualifying Event?

A qualifying event is any of the following events if it would result in a loss of a person's coverage:

- Your death;
- Your loss of eligibility due to:
    - Termination of your employment (except for gross misconduct); or
    - A reduction in your hours of work below the minimum required to maintain eligibility;
- The last day of a leave of absence governed by and conforming to the requirements of the Family and Medical Leave Act of 1993, as amended, if you don't return to work at the end of that leave;
- Divorce or legal separation from your spouse;
- A child no longer meeting the Plan's definition of dependent;
- Your coverage under Medicare (Medicare coverage means you are eligible to receive coverage under Medicare; you have applied or enrolled for that coverage, if an application is necessary; and your Medicare coverage is effective); or
- Your employer withdraws from UNITE HERE HEALTH.

What Coverage Can Be Continued?

By electing COBRA coverage, you have the same coverage options and can continue the same health care coverage available to participants who have not experienced a qualifying event.

In addition to medical benefits, prescription drug benefits, and mental health and substance abuse benefits, and the Alternative Care Benefits, health care coverage includes dental and vision care benefits. Life and AD&D Insurance, Short Term Disability Benefits, and the Adoption Assistance Benefit cannot be continued. However, you may be able to convert your Plan life insurance to an individual policy. Contact Guardian for more information.

How Long Can Coverage Be Continued?

The maximum period for which COBRA continuation coverage can be continued depends upon the type of qualifying event and when it occurs:

- Coverage can be continued for up to 18 months from the date coverage would have otherwise ended, when:
  - You terminate employment;
  - Your hours of work are reduced below the minimum required to maintain eligibility;
  - You fail to make voluntary self-payments;
  - Your ability to make self-payments ends;
  - You fail to return to employment from a leave of absence governed by and conforming to the requirements of the Family and Medical Leave Act of 1993, as amended; or
  - Your employer withdraws from UNITE HERE HEALTH.

  However, coverage for you and your covered dependents can be continued up to an additional 11 months, for a total of 29 months if the Social Security Administration determines that you or a covered dependent are disabled according to the terms of the Social Security Act of 1965 (as amended) any time during the first 60 days of continuation coverage.

- Up to 36 months from the date coverage would have originally ended for all other qualifying events, provided that those qualifying events would have resulted in a loss of coverage despite the occurrence of any previous qualifying event.

However, the following special rules are used to determine maximum periods of coverage when multiple qualifying events occur:

- Qualifying events shall be considered in the order in which they occur.
- If additional qualifying events, other than your coverage by Medicare, occur during an 18 or 29-month continuation period, affected qualified beneficiaries may continue their coverage up to 36 months from the date coverage would have originally ended.

- If you are covered by Medicare and subsequently experience a qualifying event, continuation coverage for your dependents can only be continued for up to 36 months from the date you were covered by Medicare.
- If continuation coverage ends because you subsequently become covered by Medicare, continuation coverage for your dependents can only be continued for up to 36 months from the date coverage would have originally ended.

These rules only apply to persons who were qualified beneficiaries as the result of the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event.

Termination of COBRA Coverage

A person's COBRA continuation coverage will end when the maximum period for which the person's coverage can be continued is reached.

However, on the occurrence of any of the following, continuation coverage may end earlier:

- The end of the month for which a premium was last paid, if there is a failure to pay any required premium when due;
- Termination of the Plan;
- Medicare coverage after electing COBRA (Medicare coverage means you are entitled to coverage under Medicare; you have applied or enrolled for that coverage, if application is necessary; and your Medicare coverage is effective);
- Re-satisfying the Plan's eligibility requirements;
- The end of the month occurring 30 days after the date disability under the Social Security Act ends, if that date occurs after the first 18 months of continuation coverage have expired; or
- Coverage under any other group health plan:
    - That does not contain limitations or exclusions for pre-existing conditions; or
    - To the extent that any pre-existing condition limitations or exclusions no longer apply because of the terms of the Health Insurance Portability and Accountability Act of 1996, as amended.

If termination of continuation coverage ends for any of the reasons listed above, the person will be mailed an Early Termination Notice shortly after coverage terminates. The notice will specify the date coverage ended and the reason why.

Notifying UNITE HERE HEALTH When Qualifying Events Occur

Your employer is required to notify UNITE HERE HEALTH within 30 days of your death, termination of employment, reduction in hours, or failure to return to work at the end of a leave of absence governed by the Family and Medical Leave Act of 1993, as amended. UNITE HERE HEALTH uses its own records to determine when participants' coverage under the Plan ends.

Your employer is required to notify the Services & Operations Department of your death, termination of employment, reduction in hours, or failure to return to work at the end of a leave of absence governed by the Family and Medical Leave Act of 1993, as amended. The Services & Operations Department uses its own records to determine when a participant's coverage under the Plan ends.

You or a dependent must inform the Services & Operations Department within 60 days of the following:

- Your divorce or legal separation;
- The date your child no longer qualifies as a dependent under the Plan; or
- The occurrence of a second qualifying event.

You must inform the Services & Operations Department before the initial 18 months of continuation coverage expires when a person is determined to be disabled according to the terms of the Social Security Act of 1965 (as amended).

You must also inform the Services & Operations Department within 30 days of the date a person is no longer determined to be disabled according to the terms of the Social Security Act of 1965 (as amended).

You can use UNITE HERE HEALTH's Qualifying Event Notification Form to provide notice of any qualifying event or the existence or termination of disability. You can get a form by calling the Services & Operations Department.

If you don't use the Qualifying Event Notification Form to provide the required notice, you must submit information describing the qualifying event, including your name, Social Security number, address, telephone number, date of birth, and your relationship to the qualified beneficiary, to the Services & Operations Department in writing. Be sure you sign and date your submission.

However, regardless of the method you use to notify the Services & Operations Department, you must also include the supplemental information described below, depending on the event that you are reporting:

- For divorce, legal separation, or termination of domestic partnership: spouse's/partner's name, Social Security number, address, telephone number, date of birth, and a copy of one

of the following: a divorce decree, legal separation agreement, or domestic partner benefit termination request.

- For a dependent child's loss of eligibility: the name, Social Security number, address, telephone number, date of birth of the child, date on which the child no longer qualified as a dependent under the plan; and the reason for the loss of eligibility (i.e., age, or ceasing to meet the definition of a dependent).
- For a participant's death: the date of death, the name, Social Security number, address, telephone number, and date of birth of the eligible dependent, and a copy of the death certificate.
- For a participant's or dependent's disability status: the disabled person's name, the date on which the disability began or ended, and a copy of the Social Security Administration's determination of disability status.

Failure to provide the notice and documentation as required will result in the loss of a person's right to elect COBRA coverage.

Election and Payment Deadlines

Continuation of coverage is not automatic. It must be elected, and the required payments must be paid when due.

When the Services & Operations Department receives the required notice of a qualifying event, it will determine if the persons are entitled to COBRA continuation coverage.

- Persons not entitled to continuation coverage will be mailed a Notice of Unavailability of Continuation Coverage within 14 days after the Services & Operations Department has been advised of the occurrence of a qualifying event. The notice will explain why continuation coverage is not available.
- Persons entitled to continuation coverage will be mailed a description of the Plan's COBRA continuation coverage rights, a member election form, and, if applicable, a dependent election form. The description of COBRA continuation rights and the applicable election forms will be mailed within 45 days after the Services & Operations Department has been advised of the occurrence of a qualifying event. These materials will be mailed to those entitled to continuation coverage at the last known address UNITE HERE HEALTH has on file.

If you or a covered dependent want COBRA continuation coverage, the completed COBRA election form must be mailed to the Services & Operations Department within 60 days from:

- The date coverage under the Plan would otherwise end; or
- The date the Services & Operations Department sends the election form and a description of the Plan's COBRA continuation coverage rights and procedures, whichever occurs later.

If it receives a person's election form within the 60-day election period, the Services & Operations Department will send that person a premium notice stating the amount owed for COBRA continuation coverage. The amount of premium charged for COBRA continuation coverage will not exceed the amount allowed by federal law.

- The Services & Operations Department must receive the first payment within 45 days after the date it receives the person's election form. The first payment must equal the premiums due from the date coverage ended until the end of the month in which payment is being made.
- After the first payment, additional payments are due on the first day of each month for which coverage is to be continued. To continue coverage, each monthly payment must be postmarked no later than 30 days after the payment is due.

Payments for COBRA continuation coverage must be made by check or money order, payable to UNITE HERE HEALTH, and mailed to:

UNITE HERE HEALTH
Attn: Services & Operations Department
P. O. Box 6557
Aurora, IL 60598-0557

If you have any questions about COBRA continuation coverage, your rights, or the Plan's notification procedures, please call the Services & Operations Department at **(866) 711-4373**.

For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Coordination of Benefits

The coordination of benefits provisions applicable to Tufts, although similar to those described in this section, are administered by Tufts. Call **(800) 462-0224** for more information about how Tufts' COB provisions work.

If you or your dependents are covered under this Plan and another group health plan, the two plans will coordinate benefit payments. Coordination of Benefits (COB) means that two or more plans may each pay a portion of your allowable expenses. However, the combined benefit payments from all plans will not exceed 100% of allowable expenses.

This Plan coordinates benefits with the following types of plans:

- Group, blanket, or franchise insurance coverage;
- Group Blue Cross or Blue Shield coverage;
- Any other group coverage, including labor-management trusteed plans, employee organization benefit plans, or employer organization benefit plans;
- Any coverage under governmental programs or provided by any statute, except Medicaid; and
- Any automobile insurance policies (including "no fault" coverage) containing personal injury protection provisions.

This Plan will not coordinate benefits with Health Maintenance Organizations (HMOs) or reimburse an HMO for services provided.

The Plan's COB provisions only apply to the coverage provided under: medical benefits, prescription drug benefits, mental health and substance abuse benefits, alternate medicine benefits, dental benefits, and vision care benefits.

Which Plan Pays First

The first step in coordinating benefits is to determine which plan pays first (the primary plan) and which plan pays second (the secondary plan). If this plan is primary, it will pay its full benefits. However, if this Plan is secondary, the benefits it would have paid will be used to supplement the benefits provided under the other plan, up to 100% of allowable expenses. Contact UNITE HERE HEALTH for more information about how the Plan determines allowable expenses when it is secondary.

Order of Payment

The general rules that determine which plan pays first are summarized below. Contact UNITE HERE HEALTH if you have any questions.

- Plans that do not contain COB provisions always pay before those that do.
- Plans that have COB and cover a person as an employee always pay before plans that cover the person as a dependent.

- Plans that have COB and cover a person as an active employee always pay before plans that cover the person as a retired or laid off employee.
- With respect to plans that have COB and cover dependent children of parents who are not separated, and on behalf of Dependent children age 18 or older (unless a custody order applies), plans that cover the parent whose birthday falls earlier in a year pay before plans covering the parent whose birthday falls later in that year. The birthday rule will also apply to adult children, unless a custody decree or court order governs the COB.
- With respect to plans that have COB and cover dependent children whose parents are separated or divorced:
  - Plans covering the parent whose financial responsibility for the child's health care expenses is established by court order pay first;
  - If there's no court order establishing financial responsibility, the plan covering the parent with custody pays first;
  - If the parent with custody has remarried and the child is covered as a dependent under the plan of the stepparent, the order of payment is as follows:
    1. The plan of the parent with custody;
    2. The plan of the spouse of the parent with custody;
    3. The plan of the parent without custody;
  - The birthday rule also applies to children age 18 and older if there is no court order or custody decree, regardless of whether the parents are together or separated;
  - With respect to plans that have COB and cover a person as a spouse, and cover the same person under his or her parents' plan(s), the plan which has covered the person for the longest time pays first. If both plans have covered the person since the same date, the birthday rule will apply.

If these rules do not determine the primary plan, the plan that has covered the person for the longest period of time pays first.

COB and Precertification

When this Plan is secondary (not required to pay its benefits first) and the primary plan's precertification or utilization management requirements are satisfied, you or a covered dependent will not be required to comply with this Plan's utilization review requirements. The Plan will accept the utilization management determinations made by the primary plan.

Special Rules for Medicare

If a person is entitled to Medicare while covered by the Plan, Medicare is secondary to the Plan except as shown below:

- The Plan is primary for the first 30 months a person is eligible for and entitled to Medicare because of end stage renal disease (ESRD).

- Medicare is primary with respect to any coverage under the Plan provided for a person after employment ends. If a person is entitled to Medicare benefits, but has not enrolled, Plan benefits will be determined as if the person has enrolled in both Medicare Part A (Hospital Benefits) and Part B (Doctor's Benefits).

Husband and Wife or Domestic Partner Employees Under This Plan

If both husband and wife or domestic partner couples are covered as employees under this Plan and either or both of them cover the other as a dependent, benefits will be coordinated but benefit maximums and copayment requirements will be administered as if only one employee had coverage under the Plan. This restriction also applies when coordinating benefits for children whose parents are both covered as employees under this Plan.

Subrogation

For benefit repayment purposes, subrogation means that UNITE HERE HEALTH takes over the same legal rights to collect money damages that a participant had.

The subrogation provisions applicable to Tufts, although similar to those described in this section, are administered by Tufts. Call **(800) 462-0224** for more information about how their subrogation provisions work.

The Plan's Right to Recover Payments

When Injury Is Caused by Someone Else

Sometimes, you or your dependent suffer injuries, including illnesses, and incur medical expenses as a result of an accident or act for which someone, other than UNITE HERE HEALTH, is financially responsible either in whole or in part. Typical examples include injuries sustained:

- In an automobile accident caused by someone else; or
- On someone else's property, if that person is also responsible for causing the injury.

In these cases, the other person's car insurance or property insurance may have to pay all or a part of the resulting medical bills, even though benefits for the same expenses may be paid by the Plan. By accepting benefits paid by the Plan, you agree to repay the Plan if you recover anything from a third party.

Statement of Facts and Repayment Agreement

In order to determine benefits for an injury caused by another party, UNITE HERE HEALTH will require a signed Statement of Facts. This form requests specific information about the injury and asks whether or not you intend to pursue legal action. If you receive a Statement of Facts, you must submit a completed and signed copy to UNITE HERE HEALTH before benefits are paid.

Along with the Statement of Facts, you will receive a Repayment Agreement. If you decide to pursue legal action or file a claim in connection with the accident, you and your attorney (if one is retained) must also sign a Repayment Agreement before UNITE HERE HEALTH pays benefits. The Repayment Agreement helps the Plan enforce its right to be repaid and gives UNITE HERE HEALTH first claim, with no offsets, to any money you or your dependents recover from a third party, such as:

- The person responsible for the injury;
- The insurance company of the person responsible for the injury; or
- Your own liability insurance company.

The Repayment Agreement also allows UNITE HERE HEALTH to intervene in, or initiate on your behalf, a lawsuit to recover benefits paid for or in connection with the injury.

If the Plan unknowingly pays benefits resulting from an injury caused by an individual who may

have financial responsibility for any medical expenses associated with that injury, your acceptance of those benefits is considered your agreement to abide by the Plan's subrogation rules, including the terms outlined in the Repayment Agreement.

Settling Your Claim

Before you settle your claim with a third party, you or your attorney should contact UNITE HERE HEALTH to obtain the total amount of medical bills paid. Upon settlement, UNITE HERE HEALTH is entitled to reimbursement for the amount of the benefits it has paid or the full amount of the settlement or other recovery you or a dependent receive, whatever is less.

If UNITE HERE HEALTH is not repaid, future benefits may be applied to the amounts due, even if those benefits are not related to the injury. If this happens, no benefits will be paid on behalf of you or your dependent (if applicable) until the amount owed UNITE HERE HEALTH is satisfied.

Although UNITE HERE HEALTH expects full reimbursement, there may be times when full recovery is not possible. The Trustees, in their sole and exclusive discretion, may reduce the amount you must repay if special circumstances exist, such as the need to replace lost wages, ongoing disability, or similar considerations. When your claim settles, if you believe the amount UNITE HERE HEALTH is entitled to should be reduced, send your written request to:

Subrogation Coordinator
UNITE HERE HEALTH
P.O. Box 6020
Aurora, IL 60598-0020

You must provide all information and documents required by UNITE HERE HEALTH.

General Claim Provisions

All benefit denial and appeals processes will be conducted in accordance with federal law.

Filing a Benefit Claim

The contracted providers each have their own benefit claim filing procedures and may have different requirements about what information is necessary in order to file a claim. Contact the applicable contracted provider for questions about filing a benefit claim.

If you use a network provider, in most cases the provider will file a claim on your behalf. However, if the provider does not file a claim for you, or in those cases in which non-network services and supplies are covered, you will need to file a claim.

See page E-12 for more information about the claims payment process for Life and AD&D Insurance Benefits and *see page E-6* for more information about the claims payment process for Short Term Disability Benefits.

Claim Filing and Time Limits

Medical and Prescription Drug Claims:
Claims for hospital, medical, or surgical treatment, or prescription drugs can be filed by mailing a completed claim form and all required information to:

Private Healthcare Systems, Inc.
P.O. Box 5397
DePere, WI 54115-5397

Medical and prescription drug claims must be filed within one year.

Dental Claims:
All claims for dental treatment must be mailed to:

Delta Dental of Illinois
P.O. Box 5402
Lisle, Illinois 60532

Dental claims must be filed with Delta Dental within 18 months.

Vision Claims:
Claims must be filed with Davis Vision:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Vision claims must be filed with Davis Vision within 18 months.

Life, Accidental Death and Dismemberment Insurance and Short Term Disability Benefit Claims:
Claims and required proof documentation must be filed with Guardian:

The Guardian Life Insurance Company of America
7 Hanover Square
New York, NY 10004

Life insurance claims must be filed with Guardian as soon as reasonably possible.

Notice of claim for accidental death and dismemberment insurance, and Short Term Disability Benefit insurance claims must filed with Guardian within 20 days of the accident or injury. Proof of claim must be submitted within 90 days.

Alternative Care Benefits, Adoption Assistance Benefits, and Mental Health/Substance Abuse Treatment Claims:
Claims must be filed with MAP:

MAP
1400 Hancock Street, 2nd Floor
Quincy, MA 02169

Alternative Care Benefits claims, Adoption Assistance Benefits claims, and mental health/substance abuse treatment claims must be filed within 18 months.

Individuals Who May File a Benefit Claim

You, a Health Care Professional (under certain circumstances), or an Authorized Representative acting on your behalf may file a claim for benefits under the Plan.

Who Is an Authorized Representative?

You may delegate authority to an individual to act on your behalf in regard to a claim for benefits or review of a denial of your claim. If you would like to designate an Authorized Representative, you and the person whom you wish to designate as an Authorized Representative must complete and sign the appropriate form designating your authorized representative, and submit the form to UNITE HERE HEALTH or the applicable contracted provider.

- ✓ If UNITE HERE HEALTH determines that you are incompetent or incapable of naming an Authorized Representative to act on your behalf, UNITE HERE HEALTH may recognize your spouse or domestic partner, or an individual who has power of attorney or who is executor of your estate as your Authorized Representative without completion of an Authorized Representative Designation Form.

In the case of an Urgent Care/Emergency Treatment Claim, a Health Care Professional with knowledge of your medical condition shall be permitted to act as your Authorized Representative.

Your Authorized Representative will be entitled to act on your behalf until the earlier of the following dates:

- The date on which you inform the contracted provider, either verbally or in writing, that you have revoked the individual's authority to act on your behalf; or
- The date on which the contracted provider issues a final decision on your appeal.

Payment of Claims

The time frames during which each contracted provider will process and pay claims is determined by each contracting provider. However, claims will be processed and paid in accordance with federal law. Contact the contracted provider with questions about how your claims will be paid.

The following is a summary of the rules that will apply to each type of claims.

Concurrent Care Decisions

If Tufts or MAP approved an ongoing course of treatment to be provided to you over a period of time or a number of treatments, its reduction or termination of the course of treatment (other than by Plan termination or amendment) constitutes a denial of your claim.

In the event of such a denial of benefits, you shall be notified of such decision at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on appeal before the benefit is reduced or terminated. If you request that your course of treatment be extended beyond the period of time or number of treatments and such request is an Urgent Care/ Emergency Treatment Claim, a decision regarding your request will be made as soon as possible, taking into account the medical circumstances of the situation. You will be notified of the decision (whether adverse or not) not later than 24 hours after its receipt of your claim.

Health Care Claims Not Involving Concurrent Care Decisions

You will be notified of a decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after its receipt of the claim. In general, benefits for medical/surgical services will be paid to the provider of those services. The contracted provider has the right to extend this 30-day period for a single time for up to an additional 15 days if it determines that the extension is necessary due to matters beyond its control, and notifies you prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of the time and date by which it expects to render a decision.

If this extension is necessary because you failed to submit the information necessary to enable a decision to be made on the claim, you shall be afforded 60 days from the receipt of such notice

within which to provide the necessary information. The necessary information that you must submit to the contracted provider will be specified in the notice of extension.

If a Benefit Claim Is Denied

If your claim for benefits is denied, either in full or in part, you will receive a written notice from the applicable contracted provider explaining the reasons for the denial, including:

- The name of the health care provider;
- The date of service;
- A statement that the diagnosis codes and treatment codes and their corresponding meanings are available upon request;
- The denial code and its corresponding meaning;
- The specific reason or reasons why your claim was denied;
- Reference to the specific SPD provisions on which the denial is based;
- Description of any material necessary to process the claim properly and why the materials are needed;
- A description of the review procedures and any time limits applicable to such procedures;
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial of your claim on appeal;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in denying your claim, a statement that a copy of such rule, guideline, protocol or criterion will be provided to you free of charge upon request;
- If your claim was denied based upon a medical necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your medical circumstances will be provided to you free of charge upon request;
- The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman under Section 2793 of the Public Health Service Act; and
- If your claim concerned benefits that qualify as a request for emergency treatment/urgent care, a description of the expedited review process applicable to such claims.

Appealing the Denial of a Claim

You must exhaust the claim appeal procedures described in this section before you may file suit in court.

If your claim for benefits is denied, in whole or in part, you may file an appeal. As explained below, your claim may be subject to one or two levels of appeal.

All appeals are subject to the procedures and rules established by the applicable contracted provider.

You will be notified of the decision on your appeal within the time frames prescribed by federal law. The notice of the decision will include the information as required by federal law.

Appeals Subject to Two Levels of Appeals

Medical/Surgical and Prescription Drug Claims

You must submit your appeal to Tufts within 180 days of the denial:

Tufts Health Plan
Attn: Appeals and Grievances Department
705 Mount Auburn Street
P.O. Box 9193
Watertown, MA 02471-9193

Mental Health and Substance Abuse Treatment, Alternative Care Benefit Claims, and Adoption Assistance Benefit Claims

You must submit your appeal to MAP within 12 months of the denial:

Modern Assistance Programs, Inc.
1400 Hancock Street
2nd Floor
Quincy, MA 02169

Life and AD&D Insurance and Short-Term Disability Benefits Claims

You must submit your appeal to Guardian within 180 days of the denial:

The Guardian Life Insurance Company of America
Group Short Term Disability Claims Department
P.O. Box 26160
Lehigh Valley, PA 18002-6160

Final Level of Appeal

If your claim is still denied, you may appeal the denied claim to UNITE HERE HEALTH. You, or your Authorized Representative, must make application within 45 days of the date the denial was upheld to:

The Appeals Subcommittee
UNITE HERE HEALTH
711 N. Commons Dr.
Aurora, Illinois 60504

Vision and Dental Claims Subject to One Level of Appeal

If all or a portion of vision or dental claims are denied and you disagree with that decision, you must make application within 12 months of the date the claim was denied to:

The Appeals Subcommittee
UNITE HERE HEALTH
711 N. Commons Dr.
Aurora, Illinois 60504

The Appeals Subcommittee will not enforce the 12-month filing limit when:

- It was not reasonably possible to file the appeal within the 12-month filing limit due to:
  - Circumstances beyond the person's control if the appeal was filed as soon after the filing limit as was reasonably possible; or
  - Circumstances in which the claim was not processed according to the Plan's claim processing requirements; or
- The Appeals Subcommittee, consistent with its prior decisions, would have overturned the original benefit denial.

Appeals to UNITE HERE HEALTH Involving Urgent Care Claims

If you are appealing the denial of benefits to UNITE HERE HEALTH, and the appeal qualifies as a request for emergency treatment/urgent care, your request for an expedited appeal of the denial may be submitted orally by calling **(630) 699-4372**. All necessary information may be transmitted between you and UNITE HERE HEALTH by telephone, facsimile or any other available efficient method.

Appeals Under the Sole Authority of the Plan Administrator

The Trustees have given the Plan Administrator sole and final authority to decide all appeals resulting from the following circumstances:

- UNITE HERE HEALTH's refusal to accept self-payments or payroll deductions made after the due date;
- Late COBRA payments and applications to continue coverage under the COBRA provisions; and
- Late applications for enrollment, including for Dependent Coverage.

You must make your application, within 12 months of the date the late self-payment, late payroll deduction, or late application was refused, to:

The Plan Administrator
UNITE HERE HEALTH
711 N. Commons Dr.
Aurora, Illinois 60504-4197

Review of Appeals

Your appeals (whether first or second level) will be reviewed in accordance with the following provisions.

During review of your appeal, you or your Authorized Representative are entitled to:

- Examine and obtain copies, free of charge, of all Plan documents, records and other information that affect your claim;
- Submit written comments, documents, records, and other information relating to your claim;
- Information identifying the medical or vocational experts whose opinion was obtained in connection with the denial of your claim (You are entitled to this information even if the information was not relied on when denying your appeal);
- Designate someone to act as your authorized representative in the review procedure (*See pages G-7 to G-8*);
- UNITE HERE HEALTH or the applicable contracted provider may not afford deference to the initial denial of your claim;
- Review of your appeal must be conducted by a named fiduciary of UNITE HERE HEALTH or the applicable contracted provider who is neither the individual who initially denied your claim, nor a subordinate of such individual;
- If denial of your initial claim was based, in whole or in part, on a medical judgment (including decisions as to whether a drug, treatment, or other item is experimental, investigational, or not medically necessary or appropriate), a named fiduciary of UNITE HERE HEALTH or the applicable contracted provider must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional cannot be an individual who was consulted in connection with the initial determination on your claim, nor the subordinate of such individual.

Notice of the Decision on Your Appeal

You will be notified of the decision on your appeal. Such notice will be provided to you:

- As soon as possible, taking into account the medical circumstances, but not later than 72 hours (36 hours in the case of a second level appeal) after receipt of an appeal that qualifies as a request involving emergency treatment/ urgent care;

- Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days (15 days in the case of a second level appeal) after receipt of an appeal regarding precertification of services other than those pertaining to concurrent care decisions;
- Within a reasonable period of time, but not later than 60 days (30 days in the case of a second level appeal) after receipt of an appeal of health care claims for services not requiring precertification. An extension of up to an additional 60 days to process the claim may be requested;
- Within a reasonable period of time, but not later than 45 days after receipt of an appeal for disability claims. This period of time may be extended by an additional period of up to 45 days if special circumstances require an extension of the time period for processing, and you are so notified before the end of the initial 45-day period. Notice of the extension of time will include an explanation of the circumstances requiring an extension, as well as the date by which the final determination will be made.

If your appeal is denied, you will be provided with written notice of the denial which includes the following information:

- The name of the health care provider;
- The date of service;
- A statement that the diagnosis codes and treatment codes and their corresponding meanings are available upon request;
- The denial code and its corresponding meaning;
- The specific reason or reasons for the denial of your appeal;
- Reference to the specific Plan provisions on which the denial is based;
- A statement that you are entitled to receive, free of charge upon request, access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial of your claim on appeal;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim on appeal, a statement that a copy of such rule, guideline, protocol or criterion will be provided to you free of charge upon request;
- The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman under Section 2793 of the Public Health Service Act; and
- If your claim is denied on appeal based on a medical necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances will be provided free of charge upon request.

Independent External Review Procedures

Within four months after the date you receive a final notice from the applicable service provider, or from UNITE HERE HEALTH, that your appeal has been denied, you may request an external review by an independent external review organization. If you wish to have the external review organization review your claim, you should submit your request to the Plan.

The Plan will conduct a preliminary review of your eligibility for external review within five business days after receiving your request. To be eligible:

- You must have met the applicable eligibility criteria at the time you incurred the medical expense;
- Your claim must relate to an issue other than the Plan's eligibility criteria;
- You must have exhausted your internal appeal rights; and
- You must submit all the necessary information and forms.

After completing its preliminary review, the Plan has one day to notify you of its determination.

If you are eligible for external review, the Plan will forward your information to the review organization. If the request for external review is approved, the Independent Review Organization (IRO) will notify you and will explain your ability to submit additional information directly to the IRO within 10 business days after receipt of the approval. The external review will be truly independent and the review organization will afford no deference to the Plan's prior decisions. You may submit additional information to the review organization within ten business days after the review organization receives the request for review. This information may include:

- Your medical records;
- Recommendations from any attending health care professional;
- Reports and other documents;
- The Plan terms;
- Practice guidelines, including evidence-based standards; and
- Any clinical review criteria the Plan developed or used.

Within forty-five days of receiving the request for review, you will be informed of the external review decision. The notice from the review organization will explain the decision and include other important information. The external review organization's decision is binding on the Plan. If it approves your request, the Plan will provide immediate coverage. If it denies your request, you may file a suit in court.

Other Important Information

Interpretation of Plan Provisions

Medical Benefits

With respect to claims for medical or prescription drug benefits, the contracted provider has the sole authority to make decisions about whether a service or supply is covered under the contract.

Dental Benefits

With respect to claims for dental benefits, the contracted provider has the sole authority to make decisions about whether a service or supply is covered under the contract.

Vision Benefits

With respect to claims for vision benefits, the contracted provider has the sole authority to make decisions about whether a service or supply is covered under the contract.

Independent Review Organization

For claims qualifying for independent external review (*See page G-14*), the Independent Review Organization has sole authority to make decisions about claims submitted for independent external review.

All Other Authority Rests with the Board of Trustees

The Board of Trustees of UNITE HERE HEALTH has sole and exclusive authority to:

- Make the final decisions about applications for or entitlement to Plan benefits, including:
  - The exclusive discretion to increase, decrease, or otherwise change Plan provisions for the efficient administration of the Plan or to further the purposes of UNITE HERE HEALTH;
  - The right to obtain or provide information needed to coordinate benefit
  - Payments with other plans;
  - The right to obtain second medical or dental opinions or to have an autopsy performed when not forbidden by law;
- Interpret all Plan provisions and associated administrative rules and procedures not governed by a contract with a contracted service provider; and
- Authorize all payments under the Plan or recover any amounts in excess of the total amounts required by the Plan.

The Plan gives the Trustees full discretion and sole authority to make the final decision in all areas of Plan interpretation and administration, including eligibility for benefits, the level of benefits provided, and the meaning of all Plan language (including this Summary Plan Description).

In the event of a conflict between this Summary Plan Description and the rules and regulations governing the Plan, the rules and regulations will govern. The decision of the Trustees is final and binding on all those dealing with or claiming benefits under the Plan, and if challenged in court, the Plan intends for the Trustees' decision to be upheld unless it is determined to be arbitrary and capricious.

The Trustees' decisions are binding on all persons dealing with or claiming benefits from the Plan, unless determined to be arbitrary or capricious by a court of competent jurisdiction.

Benefits under this Plan will be paid only if the Board of Trustees of UNITE HERE HEALTH, in their sole and executive discretion, decide that the applicant is entitled to them.

Amendment or Termination of the Plan

The Trustees intend to continue the Plan within the limits of the funds available to them. However, they reserve the right, in their sole discretion, to amend or terminate the Plan, in its entirety or in part, without prior notice.

If the Plan is terminated, benefits for claims incurred before the termination date will be paid based on available assets. Full benefits may not be available if the Plan owes more than it has money to pay. If there is money left over, the Trustees may use it in a manner consistent with the purposes for which the Plan was created or they may transfer it to another fund providing similar benefits.

Providers

The decision to use the services of particular hospitals, clinics, doctors, dentists, or other health care providers is voluntary, and the Plan makes no recommendation as to what provider you should use, even when benefits may only be available for services furnished by providers designated by the Plan. You should select a provider or treatment based on all appropriate factors, only one of which is coverage under the Plan.

Providers are not agents or employees of UNITE HERE HEALTH, and the Plan makes no representation regarding the quality of service provided.

Workers' Compensation

The Plan does not replace or affect any requirements for coverage under any state Workers' Compensation or Occupational Disease Law. If you suffer a job-related sickness or injury, notify your employer immediately.

Type of Plan

The Plan is a welfare plan providing health care and other benefits, including life insurance , AD&D insurance, Adoption Assistance Benefits, and Short Term Disability Benefits protection. The Plan is maintained through Collective Bargaining Agreements between UNITE HERE and

certain employers. These agreements require contributions to UNITE HERE HEALTH on behalf of each eligible employee. For a reasonable charge, you can get copies of the Collective Bargaining Agreements by writing to the Plan Administrator. Copies are also available for examination at the Aurora, Illinois, Office and with 10 days of a request at the following locations: regional offices, the main offices of employers at which at least 50 participants are working, or the main offices or meeting halls of local unions.

Employer and Employee Organizations

You can get a complete list of employers and employee organizations participating in the Plan by writing to the Plan Administrator. Copies are also available for examination at the Aurora, Illinois, Office and within 10 days of a request at the following locations: regional offices, the main offices of employers at which at least 50 participants are working, or the main offices or meeting halls of local unions.

Plan Administrator

The Plan Administrator and the agent for service of legal process is the Chief Executive Officer (CEO) of UNITE HERE HEALTH. Service of legal process may also be made upon a Plan trustee. The CEO's address is:

UNITE HERE HEALTH
Chief Executive Officer
P. O. Box 6020
Aurora, IL 60598-0020

Employer Identification Number

The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is EIN# 23-7385560.

Plan Number

The Plan Number is 501.

Plan Year

The Plan year is the 12-month period established by the Board of Trustees for purposes of maintaining UNITE HERE HEALTH's financial records. Plan years begin each April 1 and end the following March 31.

Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Dept. of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

Receive Information About Your Plan and Benefits

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for copies not required by law to be furnished free-of-charge.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

ERISA also provides that all Plan participants shall be entitled to continue health care coverage for themselves, their spouses, or their dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Creditable Coverage

If you have creditable coverage from another health plan, it is used to reduce or eliminate periods of coverage that would be otherwise excluded because of a plan's preexisting condition limitation. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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Creditable Coverage

If you have creditable coverage from another health plan, it is used to reduce or eliminate periods of coverage that would be otherwise excluded because of a plan's preexisting condition limitation. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you make a written request for a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relation's order or a medical child support order, you may file suit in federal court.

If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Important Phone Numbers and Addresses

Davis Vision
P. O. Box 1525
Latham, MA 12110
(800) 999-5431

Delta Dental of Illinois
111 Shuman Boulevard
Naperville, Illinois 60563
(800) 323-1743

The Guardian Life Insurance Company of America
7 Hanover Square
New York, NY 10004
(212) 598-8000

Modern Assistance Programs, Inc.
1400 Hancock Street, 2nd Floor
Quincy, MA 02169
(800) 637-6453

Tufts Health Plan
705 Mount Auburn Street
Watertown, MA 02472-1508
(800) 462-0224

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