



Plan 176 B

Platinum



Summary Plan Description
Your Health and Welfare Benefits

UNITE HERE HEALTH

Summary Plan Description

Food Service Plan—Platinum (176 B)

Effective January 2016

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

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Using this book

Learn:

- What UNITE HERE HEALTH is.
- What this book is and how to use it.
- How your benefit options affect you.

Please take some time to review this book.

If you have dependents, share this information with them, and let them know where you put this book so you and your family can use it for future reference.

What is UNITE HERE HEALTH?

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 made up of an equal number of union and employer trustees. Each employer contributes to the Fund based on the terms of specific Collective Bargaining Agreements (CBAs) between the employer and the union.

Your Plan, the Food Service Plan, is part of UNITE HERE HEALTH. Plan 176 has been adopted by the Trustees to pay for medical and other health and welfare benefits through the Fund. The Food Service Plan has several benefit packages available to employers. Your benefit package is the Food Service Plan—Platinum (Plan 176 B). Other Summary Plan Descriptions describe the other benefit packages under Plan 176.

What is this book and why is it important?

This book is your Summary Plan Description (SPD). Your SPD helps you understand what your benefits are and how to use your benefits. It is a summary of the Plan's rules and regulations and describes:

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

If information contained in this SPD is inconsistent with the Plan Document, the Plan Document will govern.

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

How do I use my SPD?

This SPD is broken into sections. You can get more information about different topics by carefully reading each section. A summary of the topics is shown at the start of each section. When you have questions, you should always contact your Care Coordinators at **(866) 686-0003**. Your Care Coordinators can help you understand your benefits.

Read your SPD for important information about how your benefits are paid and what rules you may need to follow. A summary of your benefits, called a Summary of Benefits, begins *on page B-2*. You can find more information about a specific benefit in the applicable section. For example, you can get more information about your medical benefits in the section titled “Medical Benefits.” If you want to know more about your life or AD&D benefits, read the section titled “Life and AD&D Benefits.”

Remember, this SPD may describe benefits that do not apply to you. Your CBA determines which benefit options you have (see below).

Some terms are defined for you in the section titled “Definitions” starting *on page I-2*. The SPD will also explain what some commonly used terms mean. When you have questions about what certain words or terms mean, contact your Care Coordinators.

What are my benefit options?

The benefits described in this SPD describe the terms of all of the benefit options available under the Food Service Plan. However, your CBA and your enrollment elections determine which benefit options you have. For example, if dental benefits are available to you, but you don’t want dental benefits, the part of the SPD that explains dental benefits does not apply to you. If your CBA does not include short-term disability benefits, the part of the SPD that explains short-term disability benefits does not apply to you.

The benefits you elect apply to both you and your enrolled dependents. You cannot elect coverage for your dependents only. You must elect coverage for yourself in order to elect coverage for your dependents. Dependents are not eligible for life/AD&D benefits or short-term disability benefits, even if you are.

You can change your coverage choices at certain times during the year, called “enrollment periods.” *See page G-9* for more information about enrollment periods.

When you have questions about your benefit options, contact your Care Coordinators at **(866) 686-0003**.

How can I get help?

Care Coordinators (866) 686-0003

Call your Care Coordinators:

- To get specialist referrals.
- To choose a primary care provider (PCP).
- When you have questions about your benefits.
- When you have questions about your eligibility.
- When you have questions about your claim—including whether the claim has been received or paid.
- To update your address.
- To request new ID cards.
- To get forms or a new SPD.
- To find a network provider.
- To find out if your provider got prior authorization for your care.

You can also visit UNITE HERE HEALTH's website to get forms, get another copy of your SPD, or ask for other information: www.uhh.org.

This booklet contains a summary in English of your plan rights and benefits under UNITE HERE HEALTH. If you have difficulty understanding any part of this booklet, you can visit or contact any of the regional offices shown below. Office hours are from 9:00 a.m. to 4:30 p.m. Monday through Friday. You may also call UNITE HERE HEALTH at (855) 405-FUND for assistance. Phones are answered from 9:00 a.m. to 5:00 p.m. local time.

Este folleto contiene un resumen en inglés de sus derechos y beneficios bajo el Plan Hospitality de UNITE HERE HEALTH. Si tiene dificultad para entender cualquier parte de este folleto, puede ponerse en contacto o visitar cualquiera de las oficinas regionales que se muestran a continuación. Los horarios de oficina son de 9:00 a.m. a 4:30 p.m. de lunes a viernes. También puede ponerse en contacto con UNITE HERE HEALTH al (855) 405-FUND para asistencia. Las llamadas son contestadas de 9:00 a.m. a 5:00 p.m. hora local.

Regional offices (Llame para consulta médica)

- 218 S. Wabash Ave., Suite 800, Chicago, IL 60605.
- 1801 Atlantic Ave, Suite 200 Atlantic City, NJ 08401.
- 33 Harrison Ave, Suite 500, Boston, MA 02111.
- 13252 Garden Grove Boulevard Suite 200, Garden Grove, CA 92843.
- 130 S. Alvarado St, 2nd Floor, Los Angeles, CA 90057.
- 702 Forest Ave, Suite B, Pacific Grove, CA 93950.
- 275 Seventh Avenue, Suite 1504, New York, NY 10001.



How do I get the most from my benefits?

Learn:

- Why you should get a primary care provider.
- Why you should get preventive care.
- How to reduce your costs for urgent care.
- Why you should call your Care Coordinators.
- How to use network providers to save time and money.
- How to join the Better Living program to manage your chronic condition.

How do I get the most from my benefits?

Get a primary care provider

You and each of your dependents should have a primary care provider (also called a “PCP”). You should get to know your PCP so he or she can help you get, and stay, healthier. Your PCP can help you find potential problems as early as possible and coordinate your specialist care.

Make sure you or your PCP calls your Care Coordinators before your first visit to a specialist. **You pay \$15 more if you go to a specialist before your Care Coordinators are contacted.**

Your PCP also helps you keep track of when you need preventive care.

- ✓ Call your Care Coordinators at **(866) 686-0003** to get help finding a PCP.

Get preventive care

Your Plan pays 100% for most types of preventive care. Getting preventive care helps you stay healthy by looking for signs of serious medical conditions. If preventive care or tests show there is a problem, the sooner you get diagnosed, the sooner you can start treatment.

Re-think emergency room care

Is it really an emergency? If not, you pay less when you go to an urgent care center. You pay much less when you go to a network urgent care center than when you go to the emergency room.

If you use a network hospital emergency room for routine care your PCP could provide, you pay 50% of the allowable charges. If you use a non-network hospital emergency room for routine care your PCP could provide, you pay the entire cost of the visit. *See page I-4* for a definition of “emergency.”

- ✓ If you need emergency care, call 911 or go to the emergency room.

Call your Care Coordinators

Your Care Coordinators are here to help you. They can help you find a provider, answer your questions about your benefits, help you understand your medical treatment plan, get you in touch with a nurse, help coordinate your care, and answer other questions for you. *See page C-2* for more information.

- ✓ Call your Care Coordinators at **(866) 686-0003**.

Get prior authorization for your care

You or your provider must call your Care Coordinators before you get certain types of care. [See page C-2](#) for information about your Care Coordinators. If you don't call first, you may pay more for your healthcare—you may even have to pay all of the cost.

Care Coordinators
(866) 686-0003

Use network providers

Reduce your costs with a network provider

The Plan generally pays higher benefits if you choose a network provider than if you choose non-network care. You only have to pay the difference between the network provider's discounted rate (the Plan's allowable charge) and what the Plan pays for covered services. The network provider cannot charge you for the difference between the allowable charge and his or her actual charges (sometimes called balance billing). This means that you will usually pay less out-of-pocket if you choose a network provider.

Here is a sample medical claim to show you how using a network provider usually saves you money. You can see how staying in the network means less money out of your pocket.

Outpatient surgery in an ambulatory surgical facility		
	Network Provider	Non-Network Provider
A. Total charge	\$10,000	\$20,000
B. Network discount	- \$5,000	n/a
C. Plan's allowable charge (See page I-2)	\$5,000	\$5,000
What you pay		
D. Amount over allowable charge	\$0 (A minus B minus C)	\$15,000 (A minus C)
E. Your copay	\$100	\$2,500 (50% of C)
Your total payment	\$100 (D plus E)	\$17,500 (D plus E)

The Plan will apply network benefits to treatment provided by non-network healthcare providers who specialize in emergency medicine, radiology, anesthesiology, or pathology, as well as for in-hospital consultations with non-network providers. However, the allowable charge will be determined based on the provider's non-network status. **You must still pay the difference between the Plan's allowable charge and what the non-network provider charges.**

This rule also applies if there is no network provider in that specialty.

How do I get the most from my benefits?

Easier claims filing with a network provider

The other advantage to using a network provider is that the network provider will usually file a claim for you. You generally don't have to fill out a claim form or submit your receipts.

If you choose a non-network provider, you may have to pay the entire cost of your care. The non-network provider may or may not file a claim for you. If you choose a non-network provider, you can file a claim to get paid back for the Plan's share of your covered care. *See page H-3* for more information about filing claims.

How do I stay in the network?

- Blue Cross Blue Shield of Illinois provides access to a national network of doctors, hospitals, and other healthcare providers. Your network is the Participating Provider Organization (PPO) network.
- True Choice provides access to a select national network of participating pharmacies that you must use in order to get benefits for prescription drugs. Not all pharmacies are in the network. For example, **Walgreens is in your network** while **CVS and Wal-Mart are not**. Contact your Care Coordinators at **(866) 686-0003** to find a network pharmacy.
- If you are enrolled in the Davis Vision benefit, Davis Vision provides access to a national network of vision care providers. You can stay in the network by using any participating Davis Vision provider.
- If you are eligible for dental benefits, Cigna provides access to a national network of dental care providers. Your network is the DPPO Advantage network.

If you have questions about your benefits, or if you need help finding a network provider, call your Care Coordinators at **(866) 686-0003**.

Join Better Living!

Is your chronic health condition taking over your life? Change your daily routine with the Better Living Program.

The Better Living program is a free program that meets once a week for 6 weeks. Each meeting lasts just 2½ hours.

Join the program, and you will learn how to:

- Eat well.
- Manage your prescription drug.
- Deal with isolation and depression.
- Control your pain.
- Meet your goals.
- Fight fatigue and frustration.
- Start an exercise program.
- Manage stress and relax.

- Solve problems.
- Communicate better.
- Use your healthcare plan.
- Explore new treatments.

Workshop leaders

The workshop leaders are people just like you who have been trained to lead the group. They understand the challenges of living with ongoing health conditions. The workshop leaders manage their own chronic conditions using the skills you will learn.

Support along the way

You will receive a lot of support from your classmates, but help outside the program is important too. You may be able to bring a family member to each session.

Contact your Care Coordinators at **(866) 686-0003** for more information about the Better Living Program!

Summary of benefits



Summary of benefits

Please call your Care Coordinators with questions about your benefits: **(866) 686-0003**.

B

Medical Benefits

In general, what you pay for medical care is based on what kind of care you get, where you get your care, and whether you go to a network or a non-network provider. For example, you pay less using an urgent care center instead of going to the emergency room.

Unless shown otherwise, this section shows what you pay for your care (called your “cost-sharing”). You pay any copays, deductibles, your coinsurance share, any amounts over a maximum benefit, and any expenses that are not covered, including any charges that are more than the allowable charge.

Annual Deductibles —

applies to both network and non-network services combined.

None

Medical Plan Payments	BCBS PPO Network	Non-Network
Office Visits		
Preventive Healthcare (<i>See page I-7</i>)	\$0	Not covered
Primary Care Provider (PCP) Office Visit	\$10 copay/visit	50%
Specialist Visit — when a PCP refers you to the specialist visit according to the specialist referral rules (<i>See page C-3</i>)	\$15 copay/visit	50%
Specialist Visit — when a PCP does not refer you according to the specialist referral rules (<i>See page C-3</i>)	\$30 copay/visit	50%
Mental Health/Substance Abuse Office Visit	\$10 copay/visit	50%
Chiropractic Services — up to 12 total visits per person each year	\$15 copay/visit	Not covered
Acupuncture Treatment — up to 12 total visits per person each year	\$15 copay/visit	Not covered
Routine Podiatric Services — up to 4 total visits per person each year	\$15 copay/visit	Not covered
Emergency and Urgent Care		
Urgent Care Facility	\$30 copay/visit	50%
Hospital Emergency Room		
Emergency care provided in an ER	\$100 copay/visit <i>waived if admitted</i>	\$100 copay/visit <i>waived if admitted</i>
Routine care provided in an ER	50%	Not covered
Professional Ambulance Services	\$100 copay/trip <i>waived if admitted</i>	\$100 copay/trip <i>waived if admitted</i>
Outpatient Services		
Laboratory Services		
Provider’s Office or Non-Hospital Facility	\$15 copay/visit	50%
Hospital Outpatient Department	\$75 copay/visit	50%

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Summary of benefits

B

Medical Plan Payments	BCBS PPO Network	Non-Network
Radiology — x-ray, ultrasound, fetal monitoring		
Provider's Office or Non-Hospital Facility	\$15 copay/visit	50%
Hospital Outpatient Department	\$75 copay/visit	50%
Diagnostic Imaging (CT, MRI, PET) and Cardiac Testing		
Provider's Office or Non-Hospital Facility	\$100 copay/visit	50%
Hospital Outpatient Department	\$200 copay/visit	50%
Outpatient Surgery		
Ambulatory Surgical Center	\$100 copay/visit	50%
Hospital Outpatient Department	\$200 copay/visit	50%
Physical, Speech, Occupational Therapy — up to 60 total visits per person each year for physical and occupational therapies combined, and up to 30 total visits per person each year for speech therapy		
Provider's Office or Non-Hospital Facility	\$15 copay/visit	50%
Hospital Outpatient Department	\$35 copay/visit	50%
Radiation Therapy	20%	50%
Dialysis		
Home, Provider's Office or Non-Hospital Dialysis Center	\$0	50%
Hospital Outpatient Department	20%, maximum of \$200 copay/visit	50%
Chemotherapy or Infusion Medication		
Home	\$0	50%
Provider's Office or Non-Hospital Infusion Center	\$10 copay/visit	50%
Hospital Outpatient Department	20%, maximum of \$200 copay/visit	50%
Inpatient Treatment		
Inpatient Hospitalization	\$200 copay/day, maximum of \$400 copay per admission	50%
Inpatient Hospitalization for Mental Health/ Substance Abuse Treatment	\$200 copay/day, maximum of \$400 copay per admission	50%

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Summary of benefits

B

Medical Plan Payments	BCBS PPO Network	Non-Network
Skilled Nursing Facility — up to 60 total days per person each year	\$50 copay/day, maximum of \$400 copay per admission	50%
Other Services and Supplies		
Diabetes Education	\$0	Not covered
Nutrition Education — up to 4 total visits per person each year	\$0	Not covered
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment	\$30 copay/day, up to \$400 per episode of care	50%
Home Healthcare Services — up to 60 total visits per person each year	\$10 copay/visit	50%
Hospice Care	\$0	50%
Durable Medical Equipment	20%	Not covered
Podiatric Orthotics — up to \$500 total per person every 24 months	\$0	Not covered
Habilitative Therapy for Children with Autism Spectrum Disorder — benefits available only for treatment that starts before June 1, 2018; certain other limits apply (<i>see page D-6</i>)	\$15 copay/day	50%
Medical Foods for Inborn Metabolic Errors	The Plan will reimburse you 100%, up to \$2,500 per person each year	
Transportation and Lodging for Certain Serious Medical Conditions	The Plan pays 100% up to \$250 per day, and up to \$10,000 per episode of care	
All Other Covered Expenses	20%	50%
Out-of-Pocket Limits – \$5,000 per person/\$10,000 per family The most you pay out-of-pocket for copays and coinsurance for certain covered medical expenses in a calendar year (<i>applies to In-Network only</i>)		

Commencement of Legal Action

Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted. This requirement does not apply to your rights to an external review by an independent review organization (IRO) under the Affordable Care Act.

If you finish all internal appeals and decide to file a lawsuit against the Plan, that lawsuit must be commenced no more than 12 months after the date of the appeal denial letter. If you fail to commence your lawsuit within this 12-month time frame, you will permanently and irrevocably lose your right to challenge the denial in court or in any other manner or forum. This 12-month rule applies to you and to your beneficiaries and any other person or entity making a claim on your behalf.

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Summary of benefits

B

Prescription Drug Benefit <i>Benefits only available at a True Choice network pharmacy</i>	Copay for retail 34-day supply or mail-order 60-day supply
Certain Preventive Drugs and Supplements – <i>see page I-7</i>	\$0
Generic Drugs	\$3
Preferred Brand-Name Prescription Drugs on the Formulary	\$20
Non-Preferred Brand-Name Prescription Drugs not on the Formulary	\$50
Specialty and Biosimilar Prescription Drugs	25% of the cost, maximum of \$50
Pharmacy Out-of-Pocket Limits - The most you pay out-of-pocket for prescription drug copays in a calendar year	\$1,600 per person/\$3,200 per family

Life and Accidental Death & Dismemberment Benefit (<i>Employees Only</i>)	
Life Insurance	\$10,000
Accidental Death & Dismemberment Insurance (<i>full amount</i>)	\$5,000

B-5

Care Coordinators

Learn when and why you should call your Care Coordinators:

- To lower your specialist office visit copay by using the specialist referral program.
- To get prior authorization for your care.
- To sign up for the case management program.
- To sign up for the chronic condition management program.

Care Coordinators

C

The Care Coordinator program is designed to help make sure you and your dependents get the right care in the right setting. It helps make sure you don't get unnecessary medical care and helps you manage complex or long-term medical conditions. The Care Coordinator program includes mandatory prior authorization of certain types of care to help you make decisions about your healthcare. It also includes specialist care referral, voluntary case management, and chronic condition programs.

A team of Care Coordinators works with you to help you find a provider, answer questions about your benefits and eligibility, understand your treatment plan, and coordinate your healthcare and the information flow between your providers.

To reach your Care Coordinators, call toll free:
(866) 686-0003

The Care Coordinator program is not intended as and is not medical advice. You are still responsible for making any decisions about medical matters, including whether or not to follow your healthcare provider's suggestions or treatment plan. UNITE HERE HEALTH is not responsible for any consequences resulting from decisions you or your provider make based on the Care Coordinator program or the Plan's determination of the benefits it will pay.

Choosing a PCP

You should choose a primary care provider (PCP) for yourself and for each of your dependents. You can all have the same PCP, or you can each choose different PCPs. For children, you may designate a pediatrician as your child's PCP. Remember, you save money if you use a network PCP.

Contact your Care Coordinators to choose a PCP. You can change your PCP any time. If you don't have a PCP, your Care Coordinators can help you find one. Remember, you will usually pay less if you choose a network provider as your PCP.

A PCP is a provider who specializes in:

- Family medicine
- General practice
- Internal medicine
- Pediatrics (for children)
- Obstetrics/gynecology (while you are pregnant)

The Fund encourages you to pick a PCP. You have the right to designate any PCP, whether the provider participates in the network or not, who is available to accept you or your family members. For information on how to select a PCP, and for help finding participating PCPs, contact your Care Coordinators at **(866) 686-0003**.

Specialist referral program

- ✓ You or your PCP should call your Care Coordinators if you need to see a specialist. However, it is up to you to make sure your Care Coordinators are contacted before you go to a specialist. You can always contact your Care Coordinators to see if your PCP has provided the referral.
- ✓ You do not need a referral for: acupuncture, chiropractic care, routine podiatry, physical, occupational, or speech therapy, or to see a non-network provider.

If you need to see a specialist, ask your PCP to contact your Care Coordinators with the referral. Care Coordinators may send your PCP information about your healthcare services so your PCP can coordinate your care.

Your Care Coordinators will send you a letter telling you when your referral to the specialist is approved, and how many visits are approved or how long the approval lasts. You do not need another referral for that type of specialist until you use all the pre-approved visits, or until after the approved period of time. If you still need specialist care, ask your PCP to contact your Care Coordinators again.

- If your PCP contacts your Care Coordinators about the network specialist visit, your copay will be \$15. Any PCP can make this referral, including a non-network PCP.
- If your PCP does not contact your Care Coordinators before you see a network specialist, your copay will be \$30. Your copay will not be reduced to \$15 if your PCP calls after the specialist visit. However, you should still have your PCP contact your Care Coordinators before your next specialist visit so your copay will only be \$15.
- If you choose a non-network specialist, you pay 50% of the allowable charges for the visit. You should still ask your PCP to contact your Care Coordinators to refer you to a non-network specialist.

Although an OB/GYN (or other provider specializing in obstetrics or gynecology) is not considered a PCP unless you are pregnant, the \$10 PCP copay applies to each network office visit to an OB/GYN. However, you should still ask your PCP to contact your Care Coordinators if you are not pregnant and need to see an OB/GYN. Your Care Coordinators can help coordinate your care between the OB/GYN and your PCP.

You do not need prior authorization from your Care Coordinators in order to access obstetrical or gynecological care from a network healthcare provider who specializes in obstetrics or gynecology. The healthcare provider, 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. For help finding participating healthcare providers who specialize in obstetrics or gynecology, contact your Care Coordinators at **(866) 686-0003**.

Get prior authorization for medical and surgical treatment

You or your healthcare provider must call your Care Coordinators before you get any of the types of care listed below. If your healthcare provider does not get prior authorization before you receive these types of care, your claim may be denied. Your Care Coordinators will ask your healthcare provider for more information to decide whether the claim should be re-processed and paid. Making sure your Care Coordinators is called first helps you avoid surprise medical bills. **If you get treatment, services, or supplies that are not covered or are not medically necessary, you pay 100% of your care.**

Care Coordinators
toll free: (866) 686-0003

- ✓ Prior authorization or provider referrals under the Care Coordinators program does not guarantee eligibility for benefits. The payment of Plan benefits are subject to all Plan rules, including but not limited to eligibility, cost sharing, and exclusions.

When to call your Care Coordinators

You or your healthcare provider should call your Care Coordinators any time you plan to get care other than in your PCP's office.

You should also make sure you or your healthcare provider contacts your Care Coordinators before any of the following:

- Any inpatient admission, including to a skilled nursing facility.
- Outpatient surgery (other than surgery performed in a provider's office).
- Durable medical equipment rentals or purchases of \$500 or more. (This includes breast pumps costing \$500 or more.)
- Home healthcare.
- Hospice care.
- Oncology services, including but not limited to radiation therapy and chemotherapy.
- Dialysis.
- Genetic testing.
- The following diagnostic imaging procedures:
 - MRA or MRI (magnetic resonance imaging or magnetic resonance angiography).
 - PET scan or PET-CT scan (positron emission tomography scintiscan or integrated positron emission tomography and computed tomography scan).

- Transplants.
- Habilitative therapy for children with autism spectrum disorder.
- Medical foods for inborn errors of metabolism.
- Travel and lodging.
- Treatment of TMJ.

You should contact your Care Coordinators at least three business days before receiving any of the above types of services and supplies. If you need emergency care, you should contact your Care Coordinators as soon as possible. If you are hospitalized because you are having a baby, you must call your Care Coordinators if your stay will be longer than 48 hours for normal childbirth, or 96 hours for a Cesarean section. However, you should contact your Care Coordinators before a maternity admission, preferably at least 30 days prior to your expected delivery date.

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 Cesarean 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).

See page H-7 for information about when your Care Coordinators must respond to your request for prior authorization and for information about how to appeal a prior authorization denial.

Case management program

You and your dependents may be eligible for the case management program if you have a catastrophic or chronic medical condition, or if your condition has a high expected cost. For example, case management may apply to cancer, chronic obstructive pulmonary disease (COPD), spinal injury, multiple trauma, stroke, head injury, AIDs, multiple sclerosis (MS), severe burns, severe psychiatric disorders, high-risk pregnancy, or premature birth.

If you are selected for the case management program, a case manager will work with you and your healthcare providers to create a treatment plan and help you manage your care. The goal of case management is to make sure that your healthcare needs are met while helping you work toward the best possible health outcome, and managing the cost of your care.

You or your healthcare provider can ask to join the case management program. In most cases, Care Coordinators will look for patients who may benefit from case management services. Care Coordinators may ask you to join the case management program.

The case manager may recommend treatments, services, or supplies that are medically appropri-

Care Coordinators

ate but are more cost-effective than the treatment proposed by your healthcare provider. UNITE HERE HEALTH, at its discretion and in its sole authority, may approve coverage for those alternatives, even if the treatment, service, or supply would not normally be covered.

However, in all cases, you and your healthcare provider make all treatment decisions.

You may be required to use the case management program in order to get benefits for transplants or travel and lodging costs. Otherwise, it is your choice whether or not to join the case management program, and whether or not to follow the program's recommendations.

Chronic condition management program

The Care Coordinator program also includes a chronic condition management program. If you have a long-term, chronic medical condition (such as coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease (COPD), diabetes or asthma), you may be asked to join the chronic condition program. This program is designed to help you learn the best ways to manage your chronic conditions. Care Coordinators will help you coordinate your healthcare, answer questions about your condition, and help you follow your treatment plan.

Care Coordinators may also reach out to you if you are at high risk for developing a chronic condition.

It is always your choice whether or not to join the chronic condition management program, and whether or not to follow the program's recommendations.



Medical benefits

Learn:

- What you pay for healthcare.
- How the network out-of-pocket limits protect you from large out-of-pocket expenses.
- What types of medical healthcare the Plan covers.
- What types of medical healthcare are not covered.

Medical benefits

See the Summary of Benefits *on page B-2* for a summary of what you pay for your medical healthcare.

Network providers

The Plan pays benefits based on whether treatment is rendered by a network provider or a non-network provider. To find network providers, contact:

Blue Cross and Blue Shield of Illinois (BCBS)—PPO Network
toll free: **(800) 810-BLUE (2583)**
www.bcbsil.com

(Go to the Provider finder, and select the “Participating
Provider Organization (PPO)” network)

See page A-7 for more information about how staying in the network can help you save time and money.

What you pay

You must pay your cost share (such as copays and coinsurance) for your share of covered expenses. You must also pay any expenses that are not considered covered expenses (*see page D-8* for information about excluded expenses), including any amounts over the allowable charge, or charges once a maximum benefit or limitation has been met.

See page B-2 for a summary of your cost sharing.

Copays

The copay covers all healthcare you receive at the time of the service. For example, you only pay one office visit copay for all healthcare you receive during the office visit. You only pay one emergency room copay for all emergency care received during the emergency room visit.

If you have multiple types of care during one visit, you only have to pay the highest cost sharing amount. You do not have to pay a separate copay for each procedure. For example, if you get an x-ray, a CT scan, and lab services all at the same time at the same network non-hospital facility, you pay only the \$100 CT scan copay.

See page I-2 for more information about what a copay is.

Out-of-Pocket limit for network services and supplies

Your out-of-pocket cost sharing for most network medical covered expenses is limited to \$5,000 per person (\$10,000 per family) each year. Once your out-of-pocket costs for covered expenses meet these limits, the Plan will usually pay 100% for your (or your family’s) network medical covered expenses during the rest of that year.

Only your out-of-pocket cost sharing for medical healthcare applies to your \$5,000 out-of-pocket

limit (\$10,000 limit for your family). Amounts you pay out of pocket for prescription drugs, vision care, or dental care will not apply to the \$5,000 or \$10,000 out-of-pocket limits. The only exception is that amounts you pay out-of-pocket for pediatric vision exams will count towards your out-of-pocket limit. A separate out-of-pocket limit applies to prescription drug benefits (*see page D-13*).

See page I-6 for more information about what an out-of-pocket limit is.

What's covered

The Plan will only pay benefits for injuries or sicknesses that are not related to your job. Benefits are determined based on allowable charges for covered services resulting from medically necessary care and treatment prescribed or furnished by a healthcare provider.

- **Preventive healthcare services** (*see page I-7*) when a network provider is used. The following limits apply to specific types of preventive care (other limits may apply to other types of preventive care based on your gender, age, and health status):
 - Cervical cancer screening (pap smears) once every 36 months for just the pap smear, or once every 60 months if both a pap smear and human papillomavirus screening are done together.
 - Routine mammograms for women are covered every 1-2 years if you are age 40 through age 74. Routine mammograms for women under 40, or older than 75, may be covered if you are at high-risk for breast cancer.
 - PSA tests for men are covered every year if you are between ages 40 and 69.
- **Professional medical and surgical services of a healthcare provider.** The following rules apply:
 - If more than one surgery or procedure is done through the same incision or natural body cavity during the same operation, covered expenses are limited to the allowable charge for the major surgery or procedure.
 - Covered expenses do not include incidental procedures performed through the same incision during one surgery.
- Treatment of **mental health conditions and substance abuse**, including inpatient and residential care, outpatient care, partial hospitalization, intensive outpatient care, and ambulatory detoxification.
- **Chiropractic care** provided by a network provider, excluding x-rays, up to a total of 12 visits per person each year. Non-network chiropractic care is not covered.
- **Acupuncture services** provided by a network provider, up to a total of 12 visits per person each year. Non-network acupuncture is not covered.

Medical benefits

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- **Podiatric care**, excluding x-rays.
 - Routine podiatric care provided by a network provider is limited to a total of 4 visits per person each year. Non-network routine podiatry is not covered. “Routine podiatry” includes but is not limited to treatment of callouses or nail trimming.
 - Podiatric orthotics provided by a network provider, limited to a total of \$500 per person every 24 months. Non-network podiatric orthotics are not covered.
 - Non-routine podiatric office visits are considered a specialist visit.
 - Non-routine surgical podiatric services. If more than one surgery is done during the same operation, covered expenses are limited to the allowable charge for the major procedure.
- **Outpatient services** in a clinic or urgent care center.
- Transportation by a **professional ambulance service** to an area medical facility that is able to provide the required treatment. If you have no control over the ambulance getting called, for example when the ambulance is called by a healthcare professional, employer, law enforcement, school, etc., the ambulance will be considered medically necessary. Contact your Care Coordinators if you had no control over an ambulance being called.
- **X-rays and laboratory** work, including x-rays and laboratory work for chiropractic and non-routine podiatric care.
- **Ambulatory surgical facility services**, including general supplies, anesthesia, drugs, and operating and recovery rooms. If you have multiple surgeries, covered expenses are limited to charges for the primary surgery. However, professional services for surgical procedures that would normally be performed in a provider’s office are not covered.
- Outpatient rehabilitation services for **physical and occupational therapy**, limited to a total of 60 combined visits per person each year for network and non-network treatment combined.
- Outpatient **speech therapy services**, limited to a total of 30 visits per person each year for network and non-network treatment combined.
 - For adults, only speech therapy to restore speech lost as the result of injury or sickness is covered.
 - For dependent children, speech therapy is only covered to:
 - Screen, detect, and treat pervasive developmental disorders, such as autism and Asperger’s.
 - Restore or improve speech for speech-language and developmental delay disorders caused by a non-chronic sickness, intra-uterine trauma, hearing loss, difficulty swallowing or acute sickness or injury.

- Treat a speech delay associated with a specific disease, injury, or congenital defect, such as cleft lip and palate.

- **Radiation therapy.**
- **Chemotherapy and infusion** services.
- **Kidney dialysis** services.
- **Hospital charges** for room and board, and other inpatient or outpatient services.
 - Professional services provided during your inpatient stay, including professional consultations, will generally be paid at 100% of allowable charges (you pay only amounts over the allowable charge).
- For employees and spouses only, **pregnancy** and pregnancy-related conditions, including childbirth, miscarriage, or abortion. However, preventive healthcare (*see page I-7*) for a dependent child's pregnancy will also be considered a covered expense. Non-preventive care for a dependent child's pregnancy, including but not limited to ultrasounds, charges associated with a high-risk pregnancy, abortions, and maternity and delivery charges will not be covered.
- **Mastectomies**, 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 swollen lymph glands.
- **Medical services for organ transplants** if the following rules are all met:
 - The transplant must be covered by Medicare, including meeting Medicare's clinical, facility, and provider requirements.
 - You must use any case management program recommended by the Fund or its representative.
 - The Fund or its representative must get prior authorization for the transplant.
 - Donor expenses for your transplant are only covered if the donor has no other coverage.
 - Transplant coverage does not include your expenses if you are giving an organ instead of getting an organ.
- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- **Skilled nursing facility care**, limited to a total of 60 days per person each year for network and non-network care combined. All of the following rules must be met:
 - The person must be under the care of a healthcare provider during the confinement.

Medical benefits

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- The person must be confined as a regular bed patient.
- Network professional services for **diabetes education** and training for the care, monitoring, or treatment of diabetes. Non-network expenses are not covered.
- Network professional services for **nutrition counseling**, limited to a total of 4 visits per person each year. Non-network expenses are not covered.
- **Home healthcare services**, limited to a total of 60 visits per person each year for network and non-network services combined. General housekeeping services or custodial care is not covered.
- **Hospice** services and supplies for a person who is terminally ill. The services must be authorized by a healthcare provider.
- **Durable medical equipment, and supplies**, for all non-disposable devices or items prescribed by a healthcare provider, such as wheelchairs, hospital-type beds, respirators and associated support systems, infusion pumps, home dialysis equipment, monitoring devices, home traction units, and other similar medical equipment or devices. Non-network DME is not covered.
 - Rental fees are covered if the DME can only be rented, and the purchase price is covered if the DME can only be bought.
 - However, if DME can be either rented or bought, and if the rental fees for the course of treatment are likely to be more than the equipment's purchase price, benefits may be limited to the equipment's purchase price.
 - If DME is bought, costs for repair or maintenance are also covered.
- **Habilitative therapy** for children with autism spectrum disorder (only for treatment that begins between June 1, 2015 and May 31, 2018). *You must get prior authorization for habilitative therapy before the Plan pays benefits.* Plan benefits are limited to 30 hours per person each week, and to a total of 36 months, for network and non-network services combined. "Habilitative therapy" includes applied behavioral analysis (ABA) therapy and similar types of treatment. It does not include physical, speech, or occupational therapy.
 - Your child must be at least 2 years old, but no more than 8 years old.
 - Your child must have a diagnosis of autism spectrum disorder, and have a prorated mental age of at least 11 months.
 - The provider supervising the habilitative therapy must be certified by the Behavioral Analyst Certification Board (BACB) as a Board Certified Behavior Analyst or Board Certified Behavior Analyst Doctorate (or is otherwise licensed to supervise this type of supervision).
 - The person providing the habilitative therapy must be certified by the BACB as a Board Certified Assistant Behavioral Analyst or Registered Behavioral Technician (or is

otherwise licensed to provide this type of treatment).

- The Plan will only pay benefits for services supplemental to any therapy for which your child is eligible through his or her school or school district. No benefits will be paid for therapy provided through the school or school district.
- The habilitative therapy and treatment plan must get prior authorization from the Fund before treatment begins. The treatment notes and treatment plan must be reviewed by the Fund at least twice a year, and must show that:
 - Your child is demonstrating improvement.
 - You are trained to, and do, participate in the habilitative therapy.
 - You follow the treatment plan.

- *No Plan benefits will be paid for a course of habilitative therapy that starts on or after June 1, 2018.*

- **Medical foods** if you have an inborn error of metabolism (IEM). *You must get prior authorization for your medical food costs before the Plan will reimburse you.* The Plan will reimburse 100% of your costs for medical foods, up to a total of \$2,500 per person each year. To be reimbursed, the medical food must be: (1) ordered by and used under the supervision of a healthcare provider; (2) the primary source of your nutrition; and (3) labeled and used for dietary management of your IEM.
- Reimbursement for **travel, lodging, and meal costs** for transportation to get certain treatment more than 50 miles away from your home (as long as you travel within the United States). *You must get prior authorization for these expenses before the Plan will reimburse you.* Covered expenses only include travel, lodging and meal costs related to: (1) transplants, (2) cancer-related treatments, and (3) congenital heart defect care. The following rules apply:
 - The travel, lodging, and meal costs of one other person will also be covered. (Two other people will be covered if the patient is a child.)
 - Reimbursement is limited to \$10,000 per episode of care for you and your traveling companion(s) combined. Up to \$250 each day will be reimbursed for lodging and meal costs.
 - You must provide the Plan with your original receipts.
 - You must participate in any case management programs required by the Fund.
 - You cannot get reimbursed for expenses related to your participation in a clinical trial, or for an organ transplant if you are donating an organ instead of getting an organ.
- **Anesthesia** and its administration.
- **Blood and blood plasma** and their administration.

Medical benefits

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- **Oxygen** and rental equipment for its administration.
- **Repair of sound natural teeth** and their supporting structures, if the covered expenses are the result of an injury. Treatment must be received while you are covered under the Plan and within six months of the injury. You may have additional dental coverage under your dental benefits, if applicable—see the dental benefits sections.
- **Sterilization procedures** for employees and spouses, and female dependent children.
- **Services of a surgical nurse** (a nurse who works under a surgeon to provide specialized nursing services before, during, and after surgery).
- **Surgical supplies and dressings**, including casts, splints, prostheses, braces, canes, crutches, and trusses.
- Treatment of **tumors, cysts and lesions** not considered a dental procedure.

What's not covered

See [page E-2](#) for a list of the Plan's general exclusions and limitations. In addition to that list, the Plan will not pay benefits for, or in connection with, the following treatments, services, and supplies:

- Ambulatory surgical facility fees for procedures normally performed in a provider's office.
- Prescription drugs and medications, other than those used where they are dispensed. Prescription drugs may be covered under the prescription drug benefit shown [on page D-12](#).
- Cosmetic, plastic, or reconstructive surgery, unless that surgery is either: (1) to treat an accidental injury, and the surgery is performed within 24 months after the accident, or (2) breast reconstruction following a mastectomy.
- Procedures to reverse a voluntary sterilization.
- Any services or supplies for or in connection with the treatment of teeth, natural or otherwise, and supporting structures. However, charges made by a hospital or other facility for dental procedures covered under the dental benefit provisions, if applicable (see the dental benefits sections), will be covered if the procedure requires the patient to be treated in an institutional setting to safely receive the care. For example, if you suffer from a medical or behavioral condition, such as autism or Alzheimer's, that severely limits your ability to cooperate with the dentist providing the care, charges made by a hospital or other facility will be considered a covered expense. Benefits for other types of dental care may be covered under the dental benefit as described in the dental sections, if applicable.
- Treatment of temporomandibular joint (TMJ) disorders, craniofacial disorders or orthognathic disorders, unless UNITE HERE HEALTH or its representative provides written prior approval.

- Surgery to modify jaw relationships including, but not limited to, osteoplasty and genioplasty procedures. However, Le Fort-type operations are covered when primarily to repair birth defects of the mouth, conditions of the mid-face (over or under development of facial features), or damage caused by accidental injury.
- Hospital charges for personal comfort items, including but not limited to telephones, televisions, cosmetics, guest trays, magazines, and bed or cots for family members or other guests.
- Private duty nursing care.
- Supplies or equipment for personal hygiene, comfort or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, tanning bed, or water bed.
- Home construction for any reason.
- Routine care that could be provided in an office or urgent care center if that care is provided in the emergency room of a non-network hospital.
- Any expense or charge by a rest home, old age home, or a nursing home.
- Any charges incurred while you are confined in a hospital, nursing home, or other facility or institution (or a part of such facility) which are primarily for education, training, or custodial care.
- Eye refractions, eyeglasses, or contact lenses. However, these expenses may be covered under the vision benefits, if applicable.
- Hearing aids.

Prescription drug benefits

Learn:

- What you pay for your covered prescription drugs.
- How the out-of-pocket limit protects you from high-cost prescription drugs.
- How you can save money by using generic prescription drugs.
- What types of prescription drugs the Plan covers.
- How the safety and cost containment programs help save you money and help protect your health.
- The limits on the quantity of a prescription drug you can get at one time.
- What the mail-order pharmacy is and how to use it.
- What the specialty order pharmacy is and when you must use it.
- What types of prescription drugs are not covered.

Prescription drug benefits

The Plan has contracted with HospitalityRx to administer your prescription drug benefits.

The Plan will only pay benefits if you buy your prescription drugs at a pharmacy that participates in the True Choice network. **Not all retail pharmacies are in your pharmacy network.** Retail pharmacies like CVS are in your network.

If you use a pharmacy not in your network, you will have to pay 100% of the cost of the prescription drug. **For example, Walgreens and Wal-Mart are not in your network.** The Plan will not reimburse you for the cost of any prescription drugs you buy at a non-network pharmacy.

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Important Phone Numbers		
If you want to:	Call:	At:
Find a True Choice network pharmacy	Care Coordinators	(866) 686-0003
Get prior authorization for prescription drugs	Care Coordinators	(866) 686-0003
Get a free glucometer	One Touch (LifeScan products) True Test (Nipro products)	(800) 227-8862 (866) 788-9618
Order from the specialty pharmacy	Walgreens Specialty Pharmacy	(877) 647-5807
Order from the mail-order pharmacy	WellDyneRx	(844) 813-3860

What you pay

You must pay the applicable copay shown below for each fill of a prescription drug. You must also pay any expenses that are not considered covered expenses ([see page D-17](#) for information about excluded expenses), including any amounts over the allowable charge.

Your Copay for Each Fill or Refill	
Preventive prescription drugs or supplies (see page I-7), including immunizations	\$0
Generic prescription drugs	\$3
Preferred brand name prescription drugs on the formulary, including insulin and formulary diabetic supplies (such as OneTouch and TrueTest)	\$20
Non-preferred brand name prescription drugs not on the formulary	\$50
Specialty and biosimilar prescription drugs	25% of the cost, maximum of \$50

Commencement of Legal Action

Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted. This requirement does not apply to your rights to an external review by an independent review organization (IRO) under the

Affordable Care Act.

If you finish all internal appeals and decide to file a lawsuit against the Plan, that lawsuit must be commenced no more than 12 months after the date of the appeal denial letter. If you fail to commence your lawsuit within this 12-month time frame, you will permanently and irrevocably lose your right to challenge the denial in court or in any other manner or forum. This 12-month rule applies to you and to your beneficiaries and any other person or entity making a claim on your behalf.

Preferred brand name drugs and supplies are safe, effective, high-quality drugs and supplies that do not have generic equivalents. You pay less for these brand name drugs than you do for those brand name drugs that are not considered preferred. Prescription drugs and supplies may be added to or removed from the list of preferred drugs from time to time. Contact your Care Coordinators at **(866) 686-0003** if you or your healthcare provider have questions about which prescription drugs and supplies are on the list of preferred drugs.

You must use the specialty pharmacy to get specialty and biosimilar prescription drugs. *See page D-17* for more information about the specialty pharmacy.

Prescription drug out-of-pocket limit

Your copays for prescription drugs purchased through the prescription drug benefit are limited to \$1,600 per person each year (\$3,200 per family). Once your prescription drug copays total \$1,600 (\$3,200 for your family's prescription drugs copays), the Plan will pay 100% for your (or your family's) covered prescription drugs and supplies during the rest of that year.

Amounts you pay for prescription drugs or supplies that are not covered do not count toward your out-of-pocket limit. Only your copays for prescription drugs or supplies applies to your \$1,600 out-of-pocket limit (\$3,200 limit for your family). Amounts you pay for medical health-care, vision, or dental care will not apply to the \$1,600 or \$3,200 out-of-pocket limits for prescription drugs. A separate out-of-pocket limit applies to medical healthcare (*see page D-2*).

Generic prescription drug policy

If you or your provider chooses a brand name prescription drug when you could get a generic equivalent instead, you pay the difference in cost between the brand name prescription drug and the generic equivalent. For example, if the brand name prescription drug costs \$80, and the Fund's cost for the generic equivalent is \$30, you must pay the \$50 difference. You will also have to pay the \$3 generic prescription drug copay.

The generic prescription drug policy does not apply to certain prescription drugs that need to be closely monitored, or if very small changes in the dose could be extremely harmful. The policy will also not apply if the prior authorization program makes an exception. However, the prescription drugs that are not subject to the generic prescription drug policy change from time to time. You can get up-to-date information by calling the Fund. Your healthcare provider will need to get prior approval for this exception to apply to your prescription drugs.

Prescription drug benefits

If you have an exception to the generic prescription drug policy, you will still have to pay the applicable preferred or non-preferred copay.

What's covered

The Plan pays benefits only for the types of expenses listed below:

- FDA-approved prescription drugs which can legally be purchased only with a written prescription from a healthcare provider. This includes oral and injectable contraceptives, vitamins, and drugs mixed to order by a pharmacist, if it contains at least one medicinal substance and one prescription drug.
- Insulin and diabetic test strips.
- Disposable syringes and needles, and lancets.
- Thyrogen (a prescription drug used to help identify the existence of thyroid cancer).
- Prescription drugs and supplies that are preventive healthcare (*see page I-7*).
- Prescription and non-prescription (over-the-counter) preventive healthcare services and supplies, including immunizations (*see page I-7*).

Free glucometers

You can get a free glucometer every 12 months by calling either of the following phone numbers:

(800) 227-8862 for OneTouch (LifeScan) products

(866) 788-9618 for TrueTest (Nipro) products

You can only get a free glucometer through the Fund. If you don't want one of the Fund's free glucometers, you have to pay the full cost of the glucometer and then submit a claim to the Fund. The claim will be paid based on the rules for durable medical equipment under the medical benefits.

Safety and cost containment programs for prescription drugs

The Fund provides extra protection through several safety and cost containment programs. These programs may change from time to time, and the prescription drugs or types of prescription drugs that are part of these programs may also change from time to time. You and your health-care provider can always get the most current information by contacting your Care Coordinators at (866) 686-0003 or visiting www.uhh.org.

Safety and cost containment programs help make sure you and your family get the most effective

and appropriate care. These programs look at whether a prescription drug is safe for you to take. For example, some prescription drugs cannot be taken together. Safety programs help make sure you are not taking two prescription drugs in a combination that could harm you. The programs also can help make sure your money is not wasted on prescription drugs that will not work for you. For example, some prescription drugs cause serious side effects in some patients. By limiting your prescription to a limited number of pills, you can make sure the prescription drug is safe for you to take before you pay for a large supply of pills you will have to throw away if you get serious side effects.

See page H-8 for information about appealing a request for prior authorization, and see page H-9 for appealing a denial of prescription drug benefits.

Prior authorization

Call your Care Coordinators at **(866) 686-0003** for prior authorization.

If you have a prescription for certain drugs, your healthcare provider must be asked for your medical records to find out if the prescription drug is clinically appropriate for your medical situation. The list of prescription drugs that require prior authorization changes from time to time. Call **(877) 266-9991** for a list of drugs on the prior authorization list.

Prior authorization is also required for any prescription drug for which the U.S. Food and Drug Administration (FDA) is reviewing certain new or existing products based on known or potential serious risks under a risk evaluation and mitigation strategy.

Step therapy

In many cases, effective lower-cost alternatives are available for certain prescription drugs. A step therapy program will ask you to try over-the-counter, generic, or preferred formulary versions of prescription drugs first. If the first level of prescription drugs does not work for you, or causes serious side effects, you are “stepped up” to another level of prescription drugs.

For example, if you need an ARB (angiotensin receptor blocker)—used to treat high blood pressure—you may first be asked to try a generic version. If the generic version does not work or causes serious side effects, you may be asked to try a preferred formulary version. If this still does not work, you may be asked to try a non-preferred formulary version.

The list of prescription drugs that require step therapy changes from time to time. Contact your Care Coordinators with questions about which prescription drugs require prior authorization.

Case management

The pharmacy case managers may contact you if you take high-cost or specialty drugs or have a chronic long-term condition. This program will help you make sure you are taking your prescription drugs the way you are supposed to take them. The case managers can also help you manage and monitor your condition, and answer questions about your prescription drugs.

Prescription drug benefits

Be sure you talk with the case managers if they reach out to you!

Fill and refill limits

Quantity limits

Each prescription fill or refill is limited to the amount prescribed by your healthcare provider. However, a prescription filled at a retail pharmacy will not be filled for more than a 34-day supply at one time (you can get refills up to the total amount your doctor prescribes). However:

- Birth control drugs that are only available in 90-day quantities (such as Seasonale®) or that use a steady hormone release over time (such as NuvaRing®) will be filled based on one application or one unit, as applicable.
- If you use the mail-order pharmacy, you can get up to a 60-day supply at a time.

You generally cannot refill a prescription until you have used at least 75% of the prescription drugs. You may be able to refill a prescription sooner. For example, if you plan to be out of the country when you would run out of a prescription drug, the Plan may approve an early refill. However, if your eligibility will terminate, you will only be able to get enough days' supply to match the number of days of eligibility you have left. For example, if your eligibility terminates in 15 days, you can only get a 15-day supply of the prescription drug, even if UNITE HERE HEALTH allows for an early refill.

Exceptions to the standard quantity limits

There are certain prescription drugs that many providers prescribe at higher dosages (for example, more pills taken at one time or more often during the day) than approved by the FDA. Coverage for these prescription drugs will be limited to a 30-day supply. To help protect you and your family, in these situations you may get a smaller supply of a prescription drug than as described in the previous section.

You or your healthcare provider can call for information about these quantity limits. Your healthcare provider may also call to get an exception to these rules.

Mail-order pharmacy

You can save money by using the WellDyneRx mail-order pharmacy. If you need a prescription drug to treat a chronic, long-term condition, you can order these prescription drugs through the mail-order pharmacy. You can get up to a 60-day supply of your prescription drug (sometimes called a “maintenance” prescription drug) for the same copay you would pay for a 34-day supply at a retail pharmacy.

You can order from the mail-order pharmacy by mail, by phone, or on the internet.

WellDyneRx
(844) 813-3860
www.mywdrx.com

Specialty pharmacy

You must use the specialty pharmacy to purchase all specialty prescription drugs. (The only exception is for drugs prescribed to treat HIV/AIDs. You should go to the specialty pharmacy for these drugs, but you can get these drugs from any network pharmacy).

The specialty pharmacy provides prescription drugs for certain chronic or difficult health conditions, such as multiple sclerosis (MS) or Hepatitis C. Specialty prescription drugs often need to be handled differently than other prescription drugs, or they may need special administration or monitoring. Using the specialty pharmacy gives you access to pharmacists and other healthcare providers who specialize in helping people with your condition. The specialty pharmacy staff can help make sure your specialty prescription gets refilled on time, and can answer your questions about your prescription drugs and your condition.

Walgreens Specialty Pharmacy
(877) 647-5807

For regular prescription drugs, Walgreens retail pharmacies are still out of network!

You will not get pharmacy benefits if you use a Walgreens retail pharmacy for your regular prescription drugs.

What's not covered

See page E-2 for a list of the types of treatments, services and supplies that are not covered by the Plan. In addition to that list, the following types of treatments, services, and supplies are not covered under the prescription drug benefit:

- Prescription drugs that have not been approved by the FDA. However, the Fund may continue to cover prescription drugs not approved by the FDA in certain situations. You or your healthcare professional may ask for an exception through the Fund's prior authorization program.
- Any drugs to treat Hepatitis C, other than interferon, ribavirin, Harvoni, or Solvadi.
- Specialty prescription drugs, other than those used to treat HIV/AIDS, if you do not use the specialty pharmacy.
- Experimental or investigational drugs.
- Fertility drugs.

Prescription drug benefits

- Prescriptions or refills in amounts over the quantity limits (*see page D-16*).
- Non-sedating antihistamines.
- Over-the-counter proton pump inhibitors.
- New-to-market prescription drugs until the Fund or its representative has reviewed and approved the prescription drug.
- High-cost “me too” drugs, unless the Fund or its representative approves the drug for purchase. “Me-too” drugs usually have only very small differences in how they work, but are considered “new” drugs with no generic equivalent. Often, the manufacturer charges high prices for these drugs even though there are other drugs available that work just as well for a lower cost. You can find out if a “me too” drug is covered by contacting your Care Coordinators.
- Glucometers, other than those available to you at no charge through the Fund. You may be able to get a glucometer through the medical benefits if you do not want one of the free ones, but you will usually have cost sharing. (*See page D-6* for information about durable medical equipment under the medical benefit.)
- Rogaine and other drugs to prevent hair loss.
- Drugs or medications used, consumed or administered at the place where it is dispensed, other than immunizations. (These drugs may be covered under your medical benefits. *See page D-3.*)
- Diagnostics or biologicals, other than Thyrogen.
- Drugs used for cosmetic reasons.
- Human growth hormone, except to treat emaciation due to AIDS.
- Drugs or other supplies not purchased from a network pharmacy.

Dental Plan A

Learn:

- What you pay for your covered dental care.
- What the maximum benefits are.
- What types of dental care the Plan covers.
- How to find out what your dental care will cost you before you get treatment.
- What types of dental care are not covered.

*This section applies only if you can elect and have elected benefits under Dental Plan A. If you are not sure if you have elected Dental Plan A, please call your Care Coordinators at **(866) 686-0003** to find out.*

Dental Plan A

Contact your Care Coordinators for information about your benefit options or your benefits.

UNITE HERE HEALTH has contracted with Cigna to administer dental benefits for you and your dependents.

Dental Plan A		
Description of Services	Cigna DPPO Advantage Network	DPPO Network and Non-Network
Dental Services (Non-Orthodontic Services)		
Maximum Benefit	\$1,500 per person every calendar year for non-orthodontic services	
Calendar Year Deductible	\$50 per person and \$150 per family	
	What You Pay for Your Covered Dental Care	
Diagnostic and Preventive Services	\$0	30%
Emergency Palliative Services	\$0	30%
Diagnostic X-ray Services	\$0	30%
Minor Restorative Services	20%	40%
Periodontic Services	20%	40%
Endodontic Services	20%	40%
Oral Surgery	20%	40%
Major Restorative Services	50%	60%
Prosthodontic Services	50%	60%
Orthodontic Services		
Lifetime Maximum Benefit	\$2,500 per person	
	What You Pay for Your Covered Orthodontic Care	
Orthodontia Services	50%	50%

Commencement of Legal Action

Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted. This requirement does not apply to your rights to an external review by an independent review organization (IRO) under the Affordable Care Act.

If you finish all internal appeals and decide to file a lawsuit against the Plan, that lawsuit must be commenced no more than 12 months after the date of the appeal denial letter. If you fail to commence your lawsuit within this 12-month time frame, you will permanently and irrevocably lose your right to challenge the denial in court or in any other manner or forum. This 12-month rule applies to you and to your beneficiaries and any other person or entity making a claim on your behalf.

Network vs. non-network providers

The Plan pays benefits based on whether you get treatment from a network provider or a non-network provider.

- ✓ **Your network is the DPPO Advantage Network.** Be careful—dentists in the DPPO network are not in your network unless they are also **DPPO Advantage Network** providers.

To locate a network provider near you, contact:

Cigna Dental
toll free: **(800) 244-6224**
www.mycigna.com
(you will have to create an account)

See page A-7 for more information about how using network providers can save you time and money.

What you pay

You must pay your cost-sharing (deductibles and coinsurance) for your share of covered expenses. You must also pay any expenses that are not considered covered expenses (See page D-24 for information about excluded expenses), including any amounts over the allowable charge.

The deductibles do not apply to diagnostic and preventive services, emergency palliative services, diagnostic x-ray services, and orthodontic services.

Your \$50 and \$150 deductibles only apply to the dental benefits. Amounts you pay for medical, prescription drugs, or vision care will not apply to the \$50 and \$150 deductibles.

Maximum benefits

Dental care maximum benefit for non-orthodontic care

The Plan pays up to \$1,500 per person each year for both network and non-network dental care combined. However, if you are under age 19, amounts the Plan pays for dental exams will not count toward your \$1,500 maximum. Once the Plan pays \$1,500 for your dental care during a year, the Plan will not pay any more benefits for your dental care for the rest of that year.

Orthodontic care maximum benefit

The Plan pays up to a lifetime maximum of \$2,500 per person for both network and non-network orthodontic care combined. Once the \$2,500 maximum is reached, the Plan will not pay any more benefits for your orthodontic care.

Alternate course of treatment

If there is a different type of treatment that would be at least as effective as your dental treatment, but costs less, the allowable charge (*see page I-2*) will be based on the less expensive alternate type of treatment. This rule applies if the alternate type of dental treatment is both:

- Commonly used to treat your condition, as determined by UNITE HERE HEALTH or its representative.
- Recognized by most dentists to be appropriate based on current national dental practices.

What's covered

Covered expenses mean all allowable charges made by a dentist for the types of services and supplies listed below. In order to be considered a covered expense, Cigna must determine that the service or supply was based on a valid dental need and performed according to accepted standards of dental practice.

There are limits on how often certain services and supplies are covered. If the amount of time shown below has not passed since the service or supply was last provided, you may have to pay 100% of the cost. You can always contact your Care Coordinators to find out the last time the Plan paid benefits for a certain service or supply. A time limit starts on the date you last got the service or supply. Time limits are measured in consecutive months or years.

- **Diagnostic and preventive services** and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease, including exams, cleanings, and consultations with a non-treating dentist.
 - Prophylaxes (cleaning) and oral exams—2 every 12 months.
 - Bitewing x-rays—2 series every 12 months.
 - Full mouth x-rays (which include bitewing x-rays)—1 every 36 months. Panographic x-rays (including bitewings) are considered a full mouth x-ray.
 - Topical application of fluoride—once every 6 months.
 - Sealants to the first and second permanent molars—1 application during the person's lifetime. Sealants are covered only on the first or second molar, and only if the tooth is free of decay and has not had a restoration.
- **Emergency palliative care**, including treatment to temporarily relieve pain and discomfort.
- **Diagnostic x-rays** to diagnose a specific condition.
- **Oral surgery**, extractions and other surgical procedures, including pre-operative and post-operative care, and general anesthesia.

- **Endodontic services** and procedures to treat teeth with diseased or damaged nerves (for example, root canals).
 - Benefits for root canal treatment on primary teeth will be limited to the benefits provided for pulpotomy.
- **Periodontic services** to treat diseases of the gums and supporting structures of the teeth.
 - Periodontal surgery, including sub-gingival curettage—1 per quadrant every 24 months.
 - Periodontal scaling in the presence of gingival inflammation will be paid the same as standard prophylaxis.
 - Benefits for four quadrants of scaling and root planing performed in a 24-hour period will be limited to the benefits provided for full-mouth scaling and root planing.
- **Restorative services** to rebuild, repair, or reform the tissues of the teeth, including but not limited to:
 - Minor restorative services such as amalgam, synthetic porcelain, or resin restorations.
 - Major restorative services such as crowns, jackets, and gold restorations if the teeth cannot be restored with another filling.
 - Amalgam or resin restoration—1 per tooth surface every 12 months.
 - Benefits for multiple restorations on the same tooth will be limited to the benefit provided for one multi-surface restoration.
 - Benefits for resin restorations are limited to those shown for amalgam restorations if x-rays show decay in the molar or pre-molar on which the resin restoration is placed.
 - Benefits for cast restorations with cosmetic (elective) components will be limited to the benefits provided for cast metal restorations.
 - Benefits for teeth which cannot have cast restorations because of decay or missing tooth structure on less than four surfaces are limited to the benefits provided for amalgam or resin restorations.
 - Benefits for inlays will be limited to the benefits provided for comparable amalgam restorations.
 - Benefits for four-surface onlays will be limited to the benefits provided for three-surface onlays.
- **Prosthodontic services** and appliances that replace missing natural teeth, including bridges, partial dentures, and complete dentures.
 - Complete replacement of denture base materials or reline—1 every 24 months.

Dental Plan A

- Benefits for a fixed partial denture placed in a dental arch with three or more missing teeth are limited to the benefits provided for removable dentures. However, this limit does not apply to a pre-existing fixed partial denture that is considered covered.
- Benefits for pontics are limited to the benefit for one pontic if the space between teeth created by a missing tooth is greater than the size of the original tooth.
- Benefits for personalization of dentures, precision attachments, stress breakers, or specialized techniques are limited to the benefits provided for conventional dentures.
- **Prosthodontic repairs and relines** to prosthetic appliances.
- **Orthodontic services** including x-rays, diagnostic tests, casts and treatment, and fixed or removable appliances, including retention appliances. Only one appliance per person for tooth guidance or to control harmful habits will be covered. Each month of active treatment is a separate service.

If treatment is interrupted and another dentist completes the treatment, Cigna will determine the benefit (if any) to be paid to each dentist.

What's not covered

See page E-2 for a list of the types of treatments, services and supplies that are not covered by the Plan. In addition to that list, the following types of treatments, services, and supplies are not covered under Dental Plan A:

- Topically applied fluorides for persons age 19 or older.
- Space maintainers unless used as a passive appliance because primary teeth have been lost.
- Repair or recementing of space maintainers by the same office within six months of initial placement.
- Root canal therapy when x-rays show incompletely filled canals, unresolved periapical pathology, or canals filled with material not approved for endodontic therapy by the American Dental Association.
- Endodontic treatment of a tooth on which endodontic services were previously performed by the same office.
- Endodontic treatment performed in conjunction with removable prosthodontic appliances.
- Pulpal therapy on non-vital deciduous teeth.
- Alveolectomy/alveoloplasty performed in conjunction with extractions.
- Replacement of a cast restoration within 60 months after initial placement of an existing restoration.

- Crown buildup when x-rays show evidence of sufficient vertical height to support a cast restoration.
- Recementing of inlays, onlays, or crowns by the same office within six months of the initial placement.
- Repair of cast restorations.
- Periodontal surgery or therapy in the absence of x-ray evidence of bone loss.
- Grafts or gingivectomies performed in conjunction with osseous surgery.
- Guided tissue regeneration.
- Crown lengthening or gingivoplasty if not performed at least four weeks prior to crown preparation.
- Periodontal maintenance procedures performed within three months after active periodontal therapy.
- Replacement or repair of an existing prosthodontic appliance within 60 months after initial placement or repair.
- Prosthodontic appliances related to implants.
- Reline or rebase of an existing appliance within six months after initial placement.
- Fixed prosthodontics for anyone under age 16.
- Tissue conditioning.
- A pontic when the space between teeth created by a missing tooth is less than 50% of the size of the original tooth.
- Recementing of fixed partial dentures by the same office within 6 months after initial placement.
- Services for injuries or conditions for which you may be able to receive benefits under Workers' Compensation or Employer's Liability laws.
- Services that are available from:
 - Any federal or state government agency, other than programs provided under Title XIX of the Social Security Act, as amended (Medicaid).
 - Any municipality, county, or other political subdivision.
 - Any community agency, foundation, or similar entity.
- Services designed to correct developmental malformations.

- Cosmetic surgery or dentistry for cosmetic reasons.
- Services or appliances, including, but not limited to, prosthodontics (including crowns and bridges), completed before you are covered under the Plan. Although orthodontic treatment that is performed before you are eligible will not be covered, ongoing orthodontia treatment may be covered after you become eligible.
- Prescription drugs or their administration.
- Services of anesthetists or anesthesiologists.
- Services performed on second or third molars if there is no opposing tooth.
- Services performed on a tooth when less than 40% of the root is supported by bone.
- Services performed on a primary tooth when the tooth is about to be lost.
- Charges for completion of forms.
- Sealants for persons age 16 or older.
- Services:
 - That are not necessary and/or customary as determined by the standards of generally accepted dental practice.
 - For which no valid dental need can be demonstrated.
 - That are experimental or investigational (*see page I-4*).
 - Otherwise limited or excluded according to the procedures developed by Cigna.
- Appliances, surgical procedures, and restorations for:
 - Altering vertical dimension.
 - Replacing tooth structure loss resulting from attrition, abrasion, or erosion.
 - Correcting congenital or developmental malformations.
 - Aesthetic or cosmetic purposes.
 - Implantology techniques or edentulous ridge enhancement.
 - Anticipation of future fractures.
- Treatment by an individual operating outside the scope of his or her license.
- Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
- Services performed as a component of another procedure.

- Temporary services or procedures.
- Infection control procedures and fees associated with the rules of the Occupational Safety and Health Administration (OSHA).
- Placement of an additional appliance in the same dental arch less than 60 months following placement of the initial appliance.
- Services covered under the medical benefits (*see page D-3*).
- Services or supplies provided more frequently than allowed by the Plan.

Predetermination of dental benefits

If your dentist recommends dental work that is estimated to cost \$250 or more, you can ask Cigna to help you determine how much the Plan will pay. This is a voluntary program, but contacting Cigna before you have complex or expensive dental work will help you and your dentist understand what the Plan will pay for your proposed care. By contacting Cigna in advance, you will have a better idea of what your share of the costs will be so you don't get surprise bills.

If you take advantage of this program, Cigna will review your dentist's records and provide you and your dentist with an estimate of what you must pay, and what the Plan will pay.

Predetermination of benefits does not guarantee what benefits the Plan will pay or that any benefits will be paid for dental treatment or services provided. As always, any treatment decisions are between you and your dentist. All Plan rules will apply to any dental claims you file.

Dental benefits after eligibility ends

If your coverage ends, Plan benefits will only be paid for allowable charges incurred for covered expenses before your coverage ends.

However, if your coverage ends after your treatment starts for crowns, jackets, bridges, complete dentures, or partial dentures, the Plan continues to pay benefits for these, as long as treatment is completed within 60 days of the date you lose coverage.

See page I-11 for more information about how claims are paid if the Plan terminates.

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Plan 176B

Dental Plan B

Learn:

- What you pay for your covered dental care.
- What the maximum benefits are.
- What types of dental care the Plan covers.
- How to find out what your dental care will cost you before you get treatment.
- What types of dental care are not covered.

*This section applies only if you can elect and have elected benefits under Dental Plan B. If you are not sure if you have elected Dental Plan B, please call your Care Coordinators at **(866) 686-0003** to find out.*

Dental Plan B

Contact your Care Coordinators for information about your benefit options or your benefits.

UNITE HERE HEALTH has contracted with Cigna to administer the dental benefits provided to you and your dependents.

Dental Plan B	
Description of Services	Cigna DPPO Advantage Network
Dental Services (Non-Orthodontic Services)	
Maximum Benefit	\$1,000 per person every calendar year for non-orthodontic services
Calendar Year Deductible	\$100 per person and \$300 per family
What You Pay for Your Covered Dental Care	
Diagnostic and Preventive Services	\$0
Emergency Palliative Services	\$0
Diagnostic X-ray Services	\$0
Minor Restorative Services	40%
Periodontic Services	40%
Endodontic Services	40%
Oral Surgery	40%
Major Restorative Services	70%
Prosthodontic Services	70%

No benefits are paid for orthodontic services or for non-network providers.

- ✓ **Your network is the DPPO Advantage Network.** Be careful—dentists in the DPPO network are not in your network unless they are also **DPPO Advantage Network** providers.

To locate a network provider near you, contact:

Cigna Dental
toll free: **(800) 244-6224**
www.mycigna.com
(you will have to create an account)

Commencement of Legal Action

Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted. This requirement does not apply to your rights to an external review by an independent review organization (IRO) under the Affordable Care Act.

If you finish all internal appeals and decide to file a lawsuit against the Plan, that lawsuit must be commenced no more than 12 months after the date of the appeal denial letter. If you fail to commence your lawsuit within this 12-month time frame, you will permanently and irrevocably lose your right to challenge the denial in court or in any other manner or forum. This 12-month rule applies to you and to your beneficiaries and any other person or entity making a claim on your behalf.

What you pay

You must pay your cost-sharing (deductibles and coinsurance) for your share of covered expenses. You must also pay any expenses that are not considered covered expenses (*see page D-33* for information about excluded expenses), including any amounts over the allowable charge.

The deductibles do not apply to diagnostic and preventive services, emergency palliative services, diagnostic x-ray services, and orthodontic services.

Your \$100 and \$300 deductibles only apply to the dental benefits. Amounts you pay for medical, prescription drugs, or vision care will not apply to the \$100 and \$300 deductibles.

Maximum benefits

The Plan pays up to \$1,000 per person each year for both network and non-network dental care combined. However, if you are under age 19, amounts the Plan pays for dental exams will not count toward this \$1,000 maximum. Once the Plan pays \$1,000 for your dental care during a year, the Plan will not pay any more benefits for your dental care for the rest of that year.

Alternate course of treatment

If there is a different type of treatment that would be at least as effective as your dental treatment, but costs less, the allowable charge (*see page I-2*) will be based on the less expensive alternate type of treatment. This rule applies if the alternate type of dental treatment is both:

- Commonly used to treat your condition, as determined by UNITE HERE HEALTH or its representative; and
- Recognized by most dentists to be appropriate based on current national dental practices.

What's covered

Covered expenses mean all allowable charges made by a dentist for the types of services and supplies listed below. In order to be considered a covered expense, Cigna must determine that the service or supply was based on a valid dental need and performed according to accepted standards of dental practice.

There are limits on how often certain services and supplies are covered. If the amount of time shown below has not passed since the service or supply was last provided, you may have to pay

Dental Plan B

100% of the cost. You can always contact Cigna to find out the last time the Plan paid benefits for a certain service or supply. A time limit is measured from the date on which you last got the service or supply. Time limits are measured in consecutive months or years.

- **Diagnostic and preventive services** and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease, including exams, cleanings, and consultations with a non-treating dentist.
 - Prophylaxes and oral exams—2 every 12 months.
 - Bitewing x-rays—2 series every 12 months.
 - Full mouth x-rays (which include bitewing x-rays)—1 every 36 months. Panographic x-rays (including bitewings) are considered a full mouth x-ray.
 - Topical application of fluoride—once every 6 months.
 - Sealants to the first and second permanent molars—1 application during the person's lifetime. Sealants are covered only on the first or second molar, and only if the tooth is free of decay and has not had a restoration.
- **Emergency palliative care**, including treatment to temporarily relieve pain and discomfort.
- **Diagnostic x-rays** to diagnose a specific condition.
- **Oral surgery**, extractions and other surgical procedures, including pre-operative and post-operative care, and general anesthesia.
- **Endodontic services** and procedures to treat teeth with diseased or damaged nerves (for example, root canals).
 - Benefits for root canal treatment on primary teeth will be limited to the benefits provided for pulpotomy.
- **Periodontic services** to treat diseases of the gums and supporting structures of the teeth.
 - Periodontal surgery, including sub-gingival curettage—1 per quadrant every 24 months.
 - Periodontal scaling in the presence of gingival inflammation will be paid the same as standard prophylaxis.
 - Benefits for four quadrants of scaling and root planing performed in a 24-hour period will be limited to the benefits provided for full-mouth scaling and root planing.
- **Restorative services** to rebuild, repair, or reform the tissues of the teeth, including but not limited to:
 - Minor restorative services such as amalgam, synthetic porcelain, or resin restorations.

- Major restorative services such as crowns, jackets, and gold restorations if the teeth cannot be restored with another filling.
- Amalgam or resin restoration—1 per tooth surface every 12 months.
- Benefits for multiple restorations on the same tooth will be limited to the benefit provided for one multi-surface restoration.
- Benefits for resin restorations are limited to those shown for amalgam restorations if x-rays show decay in the molar or pre-molar on which the resin restoration is placed.
- Benefits for cast restorations with cosmetic (elective) components will be limited to the benefits provided for cast metal restorations.
- Benefits for teeth which cannot have cast restorations because of decay or missing tooth structure on less than four surfaces are limited to the benefits provided for amalgam or resin restorations.
- Benefits for inlays will be limited to the benefits provided for comparable amalgam restorations.
- Benefits for four-surface onlays will be limited to the benefits provided for three-surface onlays.
- **Prosthodontic services** and appliances that replace missing natural teeth, including bridges, partial dentures, and complete dentures.
 - Complete replacement of denture base materials or reline—1 every 24 months.
 - Benefits for a fixed partial denture placed in a dental arch with three or more missing teeth are limited to the benefits provided for removable dentures. However, this limit does not apply to a pre-existing fixed partial denture that is considered covered.
 - Benefits for pontics are limited to the benefit for one pontic if the space between teeth created by a missing tooth is greater than the size of the original tooth.
 - Benefits for personalization of dentures, precision attachments, stress breakers, or specialized techniques are limited to the benefits provided for conventional dentures.
- **Prosthodontic repairs and relines** to prosthetic appliances;

If treatment is interrupted and another dentist completes the treatment, Cigna will determine the benefit (if any) to be paid to each dentist.

What's not covered

See page E-2 for a list of the types treatments, services and supplies that are not covered by the Plan. In addition to that list, the following types of treatments, services, and supplies are not cov-

Dental Plan B

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ered under Dental Plan B:

- Orthodontic services.
- Treatment provided by a non-network dentist.
- Topically applied fluorides for persons age 19 or older.
- Space maintainers unless used as a passive appliance because primary teeth have been lost.
- Repair or recementing of space maintainers by the same office within six months of initial placement.
- Root canal therapy when x-rays show incompletely filled canals, unresolved periapical pathology, or canals filled with material not approved for endodontic therapy by the American Dental Association.
- Endodontic treatment of a tooth on which endodontic services were previously performed by the same office.
- Endodontic treatment performed in conjunction with removable prosthodontic appliances.
- Pulpal therapy on non-vital deciduous teeth.
- Alveolectomy/alveoloplasty performed in conjunction with extractions.
- Replacement of a cast restoration within 60 months after initial placement of an existing restoration.
- Crown buildup when x-rays show evidence of sufficient vertical height to support a cast restoration.
- Recementing of inlays, onlays, or crowns by the same office within six months of the initial placement.
- Repair of cast restorations.
- Periodontal surgery or therapy in the absence of x-ray evidence of bone loss.
- Grafts or gingivectomies performed in conjunction with osseous surgery.
- Guided tissue regeneration.
- Crown lengthening or gingivoplasty if not performed at least four weeks prior to crown preparation.
- Periodontal maintenance procedures performed within three months after active periodontal therapy.
- Replacement or repair of an existing prosthodontic appliance within 60 months after initial placement or repair.

- Prosthodontic appliances related to implants.
- Reline or rebase of an existing appliance within 6 months after initial placement.
- Fixed prosthodontics for anyone under age 16.
- Tissue conditioning.
- A pontic when the space between teeth created by a missing tooth is less than 50% of the size of the original tooth.
- Recementing of fixed partial dentures by the same office within six months after initial placement.
- Services for injuries or conditions for which you may be able to receive benefits under Workers' Compensation or Employer's Liability laws.
- Services that are available from:
 - Any federal or state government agency, other than programs provided under Title XIX of the Social Security Act, as amended (Medicaid).
 - Any municipality, county, or other political subdivision.
 - Any community agency, foundation, or similar entity.
- Services designed to correct developmental malformations.
- Cosmetic surgery or dentistry for cosmetic reasons.
- Services or appliances, including, but not limited to, prosthodontics (including crowns and bridges), completed before you are covered under the Plan.
- Prescription drugs or their administration.
- Services of anesthetists or anesthesiologists.
- Services performed on second or third molars if there is no opposing tooth.
- Services performed on a tooth when less than 40% of the root is supported by bone.
- Services performed on a primary tooth when the tooth is about to be lost.
- Charges for completion of forms.
- Sealants for persons age 16 or older.
- Services:
 - That are not necessary and/or customary as determined by the standards of generally accepted dental practice.

- For which no valid dental need can be demonstrated.
- That are experimental or investigational (*see page I-4*).
- Otherwise limited or excluded according to the procedures developed by Cigna.
- Appliances, surgical procedures, and restorations for:
 - Altering vertical dimension.
 - Replacing tooth structure loss resulting from attrition, abrasion, or erosion.
 - Correcting congenital or developmental malformations.
 - Aesthetic or cosmetic purposes.
 - Implantology techniques or edentulous ridge enhancement.
 - Anticipation of future fractures.
- Treatment by an individual operating outside the scope of his or her license.
- Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
- Services performed as a component of another procedure.
- Temporary services or procedures.
- Infection control procedures and fees associated with the rules of the Occupational Safety and Health Administration (OSHA).
- Placement of an additional appliance in the same dental arch less than 60 months following placement of the initial appliance.
- Services covered under the medical benefits (*see page D-3*).
- Services or supplies provided more frequently than allowed by the Plan.

Predetermination of dental benefits

If your dentist recommends dental work that is estimated to cost \$250 or more, you can ask Cigna to help you determine how much the Plan will pay. This is a voluntary program, but contacting Cigna before you have complex or expensive dental work will help you and your dentist understand what the Plan will pay for your proposed treatment. By contacting Cigna in advance, you will have a better idea of what your share of the costs will be so you don't get surprise bills.

If you take advantage of this program, Cigna will review your dentist's records and provide you and your dentist with an estimate of what you must pay, and what the Plan will pay.

Predetermination of benefits does not guarantee what benefits the Plan will pay or that any benefits will be paid for dental treatment or services provided. As always, any treatment decisions are between you and your dentist. All Plan rules will apply to any claims for benefits you file.

Dental benefits after eligibility ends

If your coverage ends, Plan benefits will only be paid for allowable charges incurred for covered expenses before your coverage ends.

However, if your coverage ends after your treatment starts for crowns, jackets, bridges, complete dentures, or partial dentures, the Plan continues to pay benefits for these, as long as treatment is completed within 60 days of the date you lose coverage.

See page I-11 for more information about how claims are paid if the Plan terminates.

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24-Month Vision Plan

Learn:

- What you pay for your covered vision care.
- What types of vision care the Plan covers.
- What types of vision care are not covered.

*This section applies only if you can elect and have elected benefits under the 24-Month Vision Plan. If you are not sure if you have elected the 24-Month Vision Plan, please call your Care Coordinators at **(866) 686-0003** to find out.*

24-Month Vision Plan

Contact your Care Coordinators for information about your benefit options or your benefits.

What you pay

\$0 (Plan benefits limited to \$200 per person every 24 months)

However, if you are under age 19, any amounts the Plan pays for your vision exam will not count toward your \$200 maximum benefit. (But the \$200 maximum **will** apply to your frames, lenses, and contacts.) To find out how much of the \$200 benefit you have left, or when a new \$200 benefit starts, call your Care Coordinators at: **(866) 686-0003**.

If you get vision care, you will pay the provider. Then, submit a claim form to the Fund to get reimbursed for covered expenses. (See page H-3 for more information about filing a claim.)

Commencement of Legal Action

Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted. This requirement does not apply to your rights to an external review by an independent review organization (IRO) under the Affordable Care Act.

If you finish all internal appeals and decide to file a lawsuit against the Plan, that lawsuit must be commenced no more than 12 months after the date of the appeal denial letter. If you fail to commence your lawsuit within this 12-month time frame, you will permanently and irrevocably lose your right to challenge the denial in court or in any other manner or forum. This 12-month rule applies to you and to your beneficiaries and any other person or entity making a claim on your behalf.

What's covered

- Exams, consultations, or treatment provided by a licensed vision care professional.
- Glass or plastic lenses, including single vision lenses, bifocal lenses, trifocal lenses, and lenticular lenses.
- Lens options, limited to:
 - Anti-reflective coatings
 - Hi-index lenses
 - Plastic photosensitive lenses
 - Polarized lenses
 - Progressive addition lenses
 - Scratch resistant coatings/protection
 - Tinting of plastic lenses

- ▶ Ultraviolet coating
- Frames.
- Daily wear or extended wear contact lenses.

What's not covered

See [page E-2](#) for a list of treatments, services and supplies that are not covered by the Plan. In addition to that list, the following treatments, services, and supplies are not covered under the 24-month vision care benefit:

- Services or supplies provided before you become eligible under the Plan.
- Services and supplies not specifically listed as covered.
- Non-prescription lenses.
- Two pairs of spectacle lenses instead of bifocals.
- Replacement of lost or broken lenses or frames before the beginning of a 24-month benefit period.

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Plan 176B

Davis Vision Plan

Learn:

- What you pay for your covered vision care.
- Why network providers can save you time and money.
- What types of vision care are covered.
- What types of vision care are not covered.

*This section applies only if you can elect and have elected benefits under the Davis Vision Plan. If you are not sure if you have elected the Davis Vision Plan, please call your Care Coordinators at **(866) 686-0003** to find out.*

Davis Vision Plan

Contact your Care Coordinators for information about your benefit options or your benefits.

UNITE HERE HEALTH has contracted with Davis Vision to administer the Davis Vision Plan provided to you and your dependents.

Davis Vision Plan—What You Pay		
Description of Services	Davis Vision Provider	Non-Network Provider
Eye Exam	\$0	\$0 <i>Plan benefits limited to \$30 per person every 12 months (does not apply to exams for children under age 19)</i>
Frames	\$0 for frames in the Davis Fashion or Designer collection \$25 copay for frames in the Davis Premier collection \$0 for frames not in a Davis collection <i>Plan benefits for frames not in a Davis collection limited to \$150 per person every 12 months</i>	\$0 <i>Plan benefits limited to \$175 per person every 12 months for frames and lenses combined</i>
Lenses	\$0	
Elective Contacts (provided instead of glasses)	\$0 for contacts in the Davis collection \$0 for contacts not in a Davis collection <i>Plan benefits for contacts not in a Davis collection limited to \$120 per person every 12 months</i>	\$0 <i>Plan benefits limited to \$175 per person every 12 months</i>

You can get one eye exam and one set of eye wear (either glasses or contacts) every 12 months.

Commencement of Legal Action

Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted. This requirement does not apply to your rights to an external review by an independent review organization (IRO) under the Affordable Care Act.

If you finish all internal appeals and decide to file a lawsuit against the Plan, that lawsuit must be commenced no more than 12 months after the date of the appeal denial letter. If you fail to commence your lawsuit within this 12-month time frame, you will permanently and irrevocably lose your right to challenge the denial in court or in any other manner or forum. This 12-month rule applies to you and to your beneficiaries and any other person or entity making a claim on your behalf.

Network and non-network vision providers

The Plan pays benefits based on whether you get treatment from a network provider or a non-network provider.

To locate a network provider near you, contact:

Davis Vision
toll free: (800) 999-5431
www.davisvision.com/members

If you choose a network provider, you can also get discounts on frames and contacts that are not in the Davis collection.

See page A-7 for more information about how using network providers may save you time and money.

What you pay

You pay any copays shown in the chart at the beginning of this section. You also pay for any expenses the Plan does not cover, including costs that are more than a particular maximum benefit.

Upgrade options through network providers

Although the Plan will not pay for any upgrades or options, if you use a network provider, you can get certain upgrades or options for a set fee. Upgrades and options include, but are not limited to, progressive lenses, scratch protection, anti-reflective and ultraviolet coating, polycarbonate lenses, high index lenses, and polarized and photosensitive lenses. Get your questions about options answered by contacting Davis Vision, or by asking your network provider. Your cost for an upgrade depends on which upgrade(s) you pick.

What the Plan pays

The Plan pays 100% of covered expenses after you make any applicable copay. If you use a non-network provider, the Plan only pays up to the maximum shown in the table for your vision care. However, if you are under age 19, any amounts the Plan pays for your vision exam will not count toward the \$30 maximum benefit for non-network exams.

What's covered

- Exams, consultations, or treatment by a licensed vision care professional.
- Lenses, including single vision, bifocal lenses, trifocal lenses, or lenticular lenses.
- Frames.

- Daily wear or extended wear contact lenses.

You can also get low vision services if a network provider believes you need additional treatment. Davis must pre-approve any low vision services. Generally, the Plan pays 100% of low vision services, regardless of whether you use a network or a non-network provider, as long as Davis pre-approves the services. (Certain maximum benefits may apply to low vision services.) Contact Davis Vision for more information about low vision services, including any maximum benefits.

What's not covered

See [page E-2](#) for a list of the types of treatments, services and supplies that are not covered by the Plan. In addition to that list, the following treatments, services, and supplies are not covered under the Davis vision care benefit:

- Services and supplies not specifically listed as covered.
- Non-prescription lenses.
- Two pairs of spectacle lenses instead of bifocals.
- Any type of lenses, frames, services, supplies, or options that are not covered under the Davis contract.
- Low vision services or supplies that are not pre-approved, or that are more than the maximum benefits or frequency limits specified in the contract with Davis.
- Replacement of lost or broken lenses or frames before the beginning of a 12-month benefit period.

Short-Term disability benefits

Learn:

- What your short-term disability benefits are.
- What happens if you have more than one disability, or if your disability recurs.
- What types of accidents or sicknesses are ineligible for short-term benefits.

*This section applies only if you can elect and have elected short-term disability benefits. If you are not sure if you have elected the short-term disability benefits, please call your Care Coordinators at **(866) 686-0003** to find out.*

Short-Term disability benefits

Contact your Care Coordinators for information about your benefit options or your benefits.

Short-term disability benefits are for employees only. Dependents are not eligible for short-term disability benefits.

What the Plan Pays	
Weekly Amount	\$200
Maximum Length of Benefit	
13-Week Option	13 weeks
26-Week Option	26 weeks
When Benefits Start	
Disabled because of an Accident	1st day
Disabled because of a Sickness (including Pregnancy)	8th day

Commencement of Legal Action

Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted. This requirement does not apply to your rights to an external review by an independent review organization (IRO) under the Affordable Care Act.

If you finish all internal appeals and decide to file a lawsuit against the Plan, that lawsuit must be commenced no more than 12 months after the date of the appeal denial letter. If you fail to commence your lawsuit within this 12-month time frame, you will permanently and irrevocably lose your right to challenge the denial in court or in any other manner or forum. This 12-month rule applies to you and to your beneficiaries and any other person or entity making a claim on your behalf.

You are considered disabled if you are prevented from engaging in the normal activities of your job because of a non-occupational (non-work-related) injury or sickness. If you are disabled, the Plan pays short-term disability benefits directly to you. You must be eligible when your disability starts in order to get short-term disability benefits. No benefits are paid if your disability begins:

- Before you become initially eligible (*see page G-5*); or
- After your employment terminates.

You must submit a completed form and a doctor's statement showing you are totally disabled before benefits will be paid. You can get the form by contacting your Care Coordinators.

What the Plan pays

If a non-work related injury or sickness keeps you from doing your job, the Plan pays \$200 per week, up to either 13 weeks or 26 weeks for any one period of disability. Your CBA will state whether you are eligible for the 13-week or the 26-week maximum benefit, or you can call your

Short-Term disability benefits

Care Coordinators to find out which option applies.

If you are disabled for less than a full week (7 days) the Plan pays \$28.57 per day of disability.

Benefits begin:

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

Social Security taxes (FICA) will be withheld from any benefits paid.

Multiple periods of disability

Benefits are paid per period of disability. If you receive the maximum amount of benefits (13 weeks or 26 weeks), you will not be eligible for more short-term disability benefits until you begin a new period of disability.

Multiple periods of disability due to the same cause are considered one period of disability. A new period of disability begins when you return to work for at least 2 weeks, or when you have a new injury or sickness.

If you are disabled for unrelated causes, you must return to work for at least one day before a new period of disability will begin.

What's not covered

See page E-2 for a list of the Plan's General Exclusions and Limitations. No short-term disability benefits will be paid for any disability related to any of the exclusions or limitations on this list.

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Plan 176B

Life and AD&D benefits

Learn:

- What your life insurance benefit is.
- How you can continue your coverage if you are disabled.
- How to convert your life insurance to an individual policy if you lose coverage.
- What your AD&D benefit is.
- How to tell the Fund who should get the benefit if you die.
- How to file a claim for life or AD&D benefits.
- Additional benefits under the life and AD&D benefit.

*This section applies only if you are eligible for life and AD&D benefits. If you are not sure if you are eligible for these benefits, please call your Care Coordinators at **(866) 686-0003** to find out.*

Life and AD&D benefits

Contact your Care Coordinators for information about your benefit options or your benefits.

Life and Accidental Death and Dismemberment (AD&D) benefits are for employees only. Dependents are not eligible for life and AD&D benefits.

Event	Benefit	Who Receives
Life Insurance	\$10,000	Your beneficiary
Accidental Death & Dismemberment Insurance (full amount)	\$5,000	Your beneficiary (if you die)

Commencement of Legal Action

Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted. This requirement does not apply to your rights to an external review by an independent review organization (IRO) under the Affordable Care Act.

If you finish all internal appeals and decide to file a lawsuit against the Plan, that lawsuit must be commenced no more than 12 months after the date of the appeal denial letter. If you fail to commence your lawsuit within this 12-month time frame, you will permanently and irrevocably lose your right to challenge the denial in court or in any other manner or forum. This 12-month rule applies to you and to your beneficiaries and any other person or entity making a claim on your behalf.

Life insurance and AD&D insurance benefits are provided under a group insurance policy issued to UNITE HERE HEALTH by Dearborn National. The terms and conditions of your (the employee's) life and AD&D insurance coverage are contained in a certificate of insurance. The certificate describes, among other things:

- How much life and AD&D insurance coverage is available.
- When benefits are payable.
- How benefits are paid if you do not name a beneficiary or if a beneficiary dies before you do.
- 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 request a copy of the certificate of insurance by contacting your Care Coordinators or Dearborn National.

Life insurance benefit

Your life insurance benefit is \$10,000 and will be paid to your beneficiary(ies) if you die while you are eligible for coverage or within the 31-day period immediately following the date coverage ends.

Continuation if you become totally disabled

If you become totally disabled before age 62 and while you are eligible for coverage, your life and AD&D benefits will continue if you provide proof of your total disability. Your benefits will continue until the earlier of the following dates:

- Your total disability ends.
- You fail to provide satisfactory proof of continued disability.
- You refuse to be examined by the doctor chosen by UNITE HERE HEALTH.
- You become age 70.

For purposes of continuing your life insurance benefit, you are totally disabled if an injury or a sickness is expected to prevent you from engaging in any occupation for which you are reasonably qualified by education, training, or experience for at least 12 months.

You must provide a completed application for benefits plus a doctor's statement establishing your total disability. The form and the doctor's statement must be provided to UNITE HERE HEALTH within 12 months of the start of your total disability. (Forms are available from your Care Coordinators.) UNITE HERE HEALTH must approve this statement and your disability form. You must also provide a written doctor's statement every 12 months, or as often as may be reasonably required based on the nature of the total disability. During the first two years of your disability, UNITE HERE HEALTH has the right to have you examined by a doctor of its choice as often as reasonably required. After two years, examinations may not be more frequent than once a year.

Converting to individual life insurance coverage

If your insurance coverage ends and you don't qualify for the disability continuation just described, you may be able to convert your group life coverage to an individual policy of whole life insurance by submitting a completed application and the required premium to Dearborn National within 31 days after the date your coverage under the Plan ends.

Premiums for converted coverage are based on your age and the amount of insurance you select. Conversion coverage becomes effective on the day following the 31-day period during which you could apply for conversion if you pay the required premium before then. For more information about conversion coverage, contact Dearborn National.

Dearborn National
1020 31st Street
Downers Grove, IL 60515
(800) 348-4512

Life and AD&D benefits

Terminal Illness 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 pays a cash lump sum equal to 75% of the death benefit in force on the day proof of terminal illness is accepted. The remaining 25% of your death benefit will be paid to your named beneficiaries after your death.

Accidental death & dismemberment insurance benefit

If you die or suffer a covered loss within 365 days of an accident that happens while you are eligible for coverage, AD&D benefits will be paid as shown below.

Your AD&D Benefit for a loss (death or dismemberment) within 365 days of an accident		
Event	Benefit	Who Receives
Death	\$5,000	Your beneficiary
Loss of both hands or feet	\$5,000	You
Loss of sight in both eyes	\$5,000	You
Loss of one hand and one foot	\$5,000	You
Loss of one hand and sight in one eye	\$5,000	You
Loss of one hand or one foot	\$2,500	You
Loss of the sight in one eye	\$2,500	You
Loss of index finger and thumb on same hand	\$1,250	You

AD&D exclusions

AD&D benefits do not cover losses caused by:

- Any disease, or infirmity of mind or body, and any medical or surgical treatment thereof.
- Any infection, except an infection of an accidental injury.
- Any intentionally self-inflicted injury.
- Suicide or attempted while sane or insane.
- Losses caused while you are under the influence of narcotics or other controlled substances, gas or fumes.
- Losses caused while intoxicated.
- Losses caused by active participation in a riot.
- Losses caused by war or an act of war while serving in the military.

See your certificate for complete details.

Additional accidental death & dismemberment insurance benefits

The additional insurance benefits described below have been added to your AD&D benefits. The full terms and conditions of these additional insurance benefits are contained in a certificate made available by Dearborn National. If there is a conflict between these highlights and the certificate, the certificate governs.

- **Education Benefit**—If you have children in college at the time of your death, your additional AD&D coverage pays a benefit equal to 3% of the amount of your life insurance benefit, with a maximum of \$3,000 each year. Benefits will be paid for up to four years per child. If you have children in elementary or high school at the time of your death, your additional AD&D coverage pays a one-time benefit of \$1,000.
- **Seat Belt Benefit**—If you are wearing a seat belt at the time of an accident resulting in your death, your additional AD&D coverage pays a benefit equal to 10% of the amount of your life insurance benefit, with a minimum benefit of \$1,000 and a maximum benefit of \$25,000. If it is not clear that you were wearing a seat belt at the time of the accident, your additional AD&D coverage will only pay a benefit of \$1,000.
- **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 additional AD&D coverage pays a benefit equal to 5% of the amount of your life insurance benefit, with a minimum benefit of \$1,000 and a maximum benefit of \$5,000. If it is not clear that the air bag deployed, your additional AD&D coverage will only pay a benefit of \$1,000.
- **Transportation Benefit**—If you die more than 75 miles from your home, your additional AD&D coverage pays up to \$5,000 to transport your remains to a mortuary.

Naming a beneficiary

Your beneficiary is the person or persons you want Dearborn National to pay if you die. Beneficiary designation forms are available from your Care Coordinators. You can name anyone you want and you can change beneficiaries at any time. However, beneficiary designations will only become effective when a completed form is received.

If you don't name a beneficiary, death benefits will be paid to your surviving relatives in the following order: your spouse; your children in equal shares; your parents in equal shares; your brothers and sisters in equal shares; or your estate. However, Dearborn National may pay up to \$2,000 to anyone who pays expenses for your burial. The remainder will be paid in the order described above.

If a beneficiary is not legally competent to receive payment, Dearborn National may make payments to that person's legal guardian.

Additional services

In addition to the benefits described above, Dearborn National has also made the following services available. These services are not part of the insured benefits provided to UNITE HERE HEALTH by Dearborn National but are made available through outside organizations that have contracted with Dearborn National. They have no relationship to UNITE HERE HEALTH or the benefits it provides.

- **Online Will Preparation**—Online will preparation gives you the ability to easily and quickly create a will, free of charge. Online will preparation services are administered by ComPsych®, a major provider of global employee assistance programs.
- **Beneficiary Resource Services**—Beneficiary Resource Services is available to beneficiaries of an insured person who dies and to an insured person who qualifies for the Terminal Illness Benefit. The program combines grief, legal, and financial counseling provided by Bensinger, DuPont & Associates, a nationwide organization utilizing masters degreed grief counselors, licensed attorneys, and Certified Consumer Credit Counselors. Services are provided via telephone, face-to-face contact, and referrals to local support resources.
- **Travel Resource Services**—Europ Assistance USA, Inc. provides 24-hour emergency medical and related services for short-term travel more than 100 miles from home. Services include: assistance with finding a doctor, medically necessary transportation, and replacement of medications or eyeglasses. Other non-medical related travel services are also available. Europ Assistance USA, Inc. arranges and pays for covered services up to the program maximum.

Contact Dearborn National at **(800) 348-4512** when you have questions about these benefits.

General exclusions and limitations

Learn:

- The types of care that are not covered by the Plan.

General exclusions and limitations

Each specific benefit section has a list of the types of treatment, services, and supplies that are not covered. In addition to those lists, the following types of treatment, services and supplies are also excluded for all medical care, prescription drugs, dental care, vision care, and short-term disability benefits. No benefits will be paid under the Plan for charges incurred for or resulting from any of the following:

- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a healthcare provider.
- Any injury, sickness, or dental or vision treatment which arises out of or in the course of any occupation or employment, or for which you have gotten or are entitled to get benefits under a workers' compensation or occupational disease law, whether or not you have applied or been approved for such benefits.
- Any treatment, services, or supplies:
 - For which no charge is made.
 - For which you, your spouse or your child is not required to pay.
 - 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 more than the Plan's allowable charge (*see page I-2*).
- Treatment, services, or supplies not recommended or approved by the attending healthcare provider, or not medically necessary in treating the injury or sickness as defined by UNITE HERE HEALTH (*see page I-5*).
- Experimental treatment (*see page I-4*), or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH.
- Any treatment that is denied or not covered because you did not get prior authorization for the care as required.
- 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 you, your spouse, or your child, or who normally lives in your home.
- Any treatment, services, or supplies purchased or provided outside of the United States (or its Territories), unless for a medical emergency. The decision of the Trustees in determining whether an emergency existed will be final.
- Any treatment, services or supplies for or in connection with the pregnancy of a dependent child except for routine preventive healthcare services. With respect to the pregnancy of a

General exclusions and limitations

dependent child, ultrasounds, treatment associated with a high-risk pregnancy, and delivery of a baby are not covered.

- Any treatment, services, or supplies for or in connection with the child of your dependent child, unless such child meets the definition of a dependent (*see page G-3*).
- Sex transformation.
- Treatment for or in connection with infertility, including but not limited to fertility treatment with the goal of becoming pregnant (including but not limited to in vitro fertilization or other treatment intended to cause pregnancy).
- Weight loss programs or treatment, except to treat morbid obesity if the program is under the direct supervision of a healthcare provider, or as covered as a preventive healthcare service.
- Any smoking cessation treatment, drug, or device to help you stop smoking or using tobacco other than counseling covered as a preventive healthcare service.
- 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 elective procedure (other than sterilization or abortion, or as otherwise specifically stated as covered) that is not for the correction or cure of a bodily injury or sickness.
- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault.
- Massage therapy, rolfing, acupressure, or biofeedback training.
- Naturopathy or naprapathy.
- Athletic training.
- Services provided by or through a school, school district, or community or state-based educational or intervention program, including but not limited to any part of an Individual Education Plan (IEP).
- Court-ordered or court-provided treatment of any kind, including any treatment otherwise covered by this Plan when such treatment is ordered as a part of any litigation, court ordered judgment or penalty.
- Treatment, therapy, or drugs designed to correct a harmful or potentially harmful habit rather than to treat a specific disease, other than services or supplies specifically stated as covered.
- Megavitamin therapy, primal therapy, psychodrama, or carbon dioxide therapy.

General exclusions and limitations

- Genetic testing or counseling unless the result of the test will directly impact the treatment of a patient with a diagnosed medical condition, including pregnancy. The decision about whether genetic testing will be covered is based on the medical policies established by or selected by the Fund or its designated representative. However, in all cases, UNITE HERE HEALTH makes the final determination as to whether genetic testing affects the patient's medical treatment.
- Christian Science practitioners and treatment.
- 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.



Coordination of benefits

Learn:

- How benefits are paid if you are covered under this Plan plus other plan(s).

Coordination of benefits

The Plan's Coordination of Benefits provisions only apply to medical benefits, dental benefits (both dental options) and the 24-month vision plan.

If you or your dependents are covered under this Plan and are also covered under 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 the 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 trustees plans, employee organization benefit plans, or employer organization benefit plans.
- Any coverage under governmental programs or provided by any statute, except Medicaid.
- 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.

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 the Fund is primary, it will pay its full benefits. However, if the Fund 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 your Care Coordinators 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 your Care Coordinators when 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 under age 18 whose

parents are not separated, 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.

- With respect to plans that have COB and cover dependent children under age 18 whose parents are separated or divorced:
 - Plans covering the parent whose financial responsibility for the child's healthcare expenses is established by court order pay first.
 - If there is 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 stepparent with custody.
 3. The plan of the parent without custody.
- With respect to plans that have COB and cover adult dependent children age 18 and older under both parents' plans, regardless of whether these parents are separated or divorced, or not separated or divorced, the plan that covers the parent whose birthday falls earlier in a year pays before the plan covering the parent whose birthday falls later in the year, unless a court order requires a different order.
- With respect to plans that have COB and cover adult dependent children age 18 and older under one or more parents' plan and also under the dependent child's spouse's plan, the plan that has covered the dependent child the longest will pay first.

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 prior authorization

When this Plan is secondary (pays its benefits after the other plan) and the primary plan's prior authorization or utilization management requirements are satisfied, you or your dependent will not be required to comply with this Plan's prior authorization or utilization management requirements. The Plan will accept the prior authorization or utilization management determinations made by the primary plan.

Special rules for Medicare

If you are 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 you after employment ends (such as COBRA coverage - [see page G-20](#)).

If you are entitled to Medicare benefits, the Plan will pay its benefits as if you have enrolled in both Medicare Part A (Hospital Benefits) and Part B (Doctor's Benefits), even if you have not enrolled in Part A and/or Part B. If you are entitled to Medicare but do not enroll in Medicare, you will have to pay 100% of the costs that would have been paid for under Medicare had you enrolled.

If you and your spouse are both employees under this Plan

If both you and your spouse (including your domestic partner) are covered as employees under this Plan and you or your spouse cover the other person as your dependent, the Plan will coordinate benefits with itself. The person who incurred the claim will still have to pay any cost sharing, such as deductibles and copays, and any maximum benefits will still apply to the person.

This rule also applies when coordinating benefits for your children if you and your spouse (or domestic partner) are both covered as employees under this Plan, or if you and your dependent child are both covered as employees under the Plan.



Subrogation

Learn:

- Your responsibilities and the Plan's rights if your medical expenses are from an accident or an act caused by someone else.

The Plan's right to recover payments

When injury is caused by someone else

Sometimes, you or your dependent suffer injuries and incur medical expenses as a result of an accident or act for which someone other than UNITE HERE HEALTH is financially responsible. For benefit repayment purposes, "subrogation" means that UNITE HERE HEALTH takes over the same legal rights to collect money damages that a participant had.

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 may 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.

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.

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 rule, including the terms outlined in the Repayment Agreement.

Although UNITE HERE HEALTH expects full reimbursement, there may be times when full recovery is not possible. The Trustees 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

Eligibility for coverage

Learn:

- Who is eligible for coverage (who your dependents are).
- How you enroll yourself and your dependents.
- When and how you become eligible for coverage.
- How you stay eligible for coverage.
- When your dependents become eligible.
- When you can add and drop dependents.

Eligibility for coverage

You establish and maintain eligibility by working for an employer required by a Collective Bargaining Agreement (CBA) to make contributions to UNITE HERE HEALTH on your behalf. There may be a waiting period under your CBA before your employer is required to begin making those contributions. You may also have to satisfy other rules or eligibility requirements described in your CBA before your employer is required to contribute on your behalf. Any hours you work during a waiting period or before you meet all of the eligibility criteria described in your CBA do not count toward establishing your eligibility under UNITE HERE HEALTH. You should look at your CBA—it will tell you when your employer will start making contributions for your coverage, as well as any other rules you may have to follow, or criteria you may have to meet, in order to become eligible.

The eligibility rules described in this section will not apply to you until and unless your employer is required to begin making contributions on your behalf.

Some CBAs allow you to refuse or decline coverage by signing a waiver of coverage form. You may have to provide proof of other coverage in order to get a waiver. Special rules govern how and when your coverage becomes effective after you change your mind about waiving coverage. Contact your Care Coordinators for more information about waiving coverage.

Who is eligible for coverage

Employees

You are eligible for coverage if you meet all of the following rules:

- You work for an employer who is required by a CBA to contribute to UNITE HERE HEALTH on your behalf.
- The contributions required by that CBA are received by UNITE HERE HEALTH.
- You meet the Plan's eligibility rules.

Your CBA states whether or not you must pay for part of the cost of your coverage. If so, you should arrange to have your employer take this money out of your paycheck (a payroll deduction). These payments are in addition to any cost sharing you pay for specific healthcare services and supplies.

If your CBA allows you to, you may be able to decline coverage under UNITE HERE HEALTH. You do this by signing a form that says you are waiving your coverage. You can decline coverage when you are first given the chance to sign up for coverage. However, if you decline coverage, you must wait until an open enrollment period or special enrollment period (*see page G-9*) before you have another chance to sign up. Call your Care Coordinators at (866) 686-0003 when you have questions about declining coverage, or how to get coverage again if you have declined coverage.

Dependents

If you have dependents when you become eligible for coverage, you can also sign up (enroll) your dependents for coverage during your initial enrollment period. Your dependents' coverage will start when yours does (not before). You cannot decline coverage for yourself and sign up your dependents.

You can add dependents after your coverage starts. See Enrollment Periods starting *on page G-9* for more information.

You must sign up any dependent you want covered and make any required payments for your share of the cost of dependent coverage. If you don't sign up your dependent, or don't make any required payment for your dependent, the Plan will not pay benefits for that person.

You must sign up any dependent you want covered and make any required co-premium for your share of the cost of dependent coverage. You may have to pay for part of the cost of your dependents' coverage, called a "co-premium." If so, you should arrange to have your employer take your co-premium out of your paycheck (a payroll deduction). Your co-premiums are in addition to any cost sharing you pay for your specific healthcare services and supplies. Contact your employer when you need more information about the amount of your co-premium for your share of your or your dependent's coverage, or for help setting up your payroll deduction. Contact your Care Coordinators at **(866) 686-0003** for more information about when your dependents' coverage starts.

Who your dependents are

Your **dependent** is any of the following, provided you show proof of your relationship to them:

- Your **spouse**. In some situations, your spouse may be your opposite-sex or same-sex domestic partner. When you need more information about domestic partners, contact your Care Coordinators.
- Your **children** who are under age 26, including:
 - Natural children.
 - Step-children.
 - Adopted children or children placed with you for adoption, if you are legally responsible for supporting the children until the adoption is finalized.
 - Children for whom you are the legal guardian or for whom you have sole custody under a state domestic relations law.
 - Any children of your domestic partner (if your domestic partner meets the definition of a spouse and is also covered).
 - Children entitled to coverage under a Qualified Medical Child Support Order.

Eligibility for coverage

- ✓ 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 your Care Coordinators.

Your child may be covered after age 26 if he or she can't support himself or herself because of a mental or physical handicap. The handicap must have started before the child turned 19, and the child must have been covered under the Plan on the day before his or her 19th birthday. For more information, [see page G-12](#). (Special rules apply to children with a mental or physical handicap when a new employer begins participation in the Food Service Plan. Contact the Fund with questions.)

Enrollment requirements

Employees

You must complete any required forms in order to enroll. You must fill out the form even if your employer pays the entire cost of your coverage. You choose the level of coverage right for you:

- Coverage for just yourself (the employee),
- Coverage for yourself and one dependent, or
- Coverage for yourself and more than one dependent (family coverage).

You must provide the required information by the end of your initial enrollment period. The Plan will tell you the date the forms are due. If you don't provide the required information by the deadline, you will not be covered by UNITE HERE HEALTH. You must wait for the next open enrollment or special enrollment period to sign up ([see page G-9](#) for more information).

Dependents

- ✓ You cannot choose to cover only your dependents. You can only cover your dependents if you enroll for coverage, too.

In order to enroll your dependents, you must provide information about them when you enroll. You must provide the requested information during your initial enrollment period. UNITE HERE HEALTH will tell you when this information is due. If you do not enroll a dependent, or if you do not provide the requested information by the due date, you may have to wait to enroll your dependents until the next open enrollment or special enrollment period ([see page G-9](#) for more information).

[See page G-7](#) for information about when coverage for your dependents starts.

You must also show that each dependent you enroll meets the Fund's definition of a dependent. You must provide at least one of the following for each of your dependents:

- A certified copy of the marriage certificate.
- A commemoration of marriage from a generally recognized denomination of organized religion.
- A certified copy of the birth certificate.
- A baptismal certificate.
- Hospital birth records.
- Written proof of adoption or legal guardianship.
- Court decrees requiring you to provide medical benefits for a dependent child.
- Notarized copies of your most recent federal tax return (Form 1040 or its equivalents).
- A certificate of creditable coverage.
- Documentation of dependent status issued and certified by the United States Immigration and Naturalization Service (INS).
- Documentation of dependent status issued and certified by a foreign embassy.

Your or your spouse's name must be listed on the proof document as the dependent child's parent.

When your coverage begins (initial eligibility)

Your coverage begins at 12:01 a.m. on the first day of the Coverage Period corresponding to the first Work Period for which contributions are required on your behalf.

For purposes of establishing initial eligibility:

- **Work Period** means the calendar month for which your employer must make contributions to UNITE HERE HEALTH on your behalf, including any amount you are required to contribute under the terms of your Collective Bargaining Agreement.
- **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.

Eligibility for coverage

Example: Establishing Initial Eligibility

Work Period	Lag Period	Coverage Period
July	August	September

Suppose you work during the month of July and employer contributions are required on your behalf. Your coverage will begin on September 1 and will continue for the rest of that month.

Continuing eligibility

Once you establish eligibility, you continue to be eligible as long as you meet the work requirements explained in your CBA.

For purposes of continuing eligibility:

- **Work Period** means a calendar month for which your employer must make a contribution to UNITE HERE HEALTH on your behalf, including any amount you are required to contribute under the terms of your Collective Bargaining Agreement.
- **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 - Continuing Eligibility

Work Period	Lag Period	Coverage Period
August	September	October
September	October	November
October	November	December

Suppose you became covered September 1 because your employer was required to make contributions on your behalf during the July work period. If a contribution is required on your behalf for August, your coverage continues during October. A contribution for September continues your coverage for November, October will continue your coverage for December, and so on.

Self-payments during remodeling or restoration

If your work place closes or partially closes because it's being remodeled or restored, you may make self-payments to continue your coverage until the remodeling or restoration is finished. However, you may only make self-payments for up to 18 months from the date your work place began remodeling or restoration.

Self-payments during a strike

You may also make self-payments to continue coverage if all of the following rules are met:

- Your CBA has expired.
- Your employer is involved in collective bargaining with the union and an impasse has been reached.
- The Union certifies that affirmative actions are being taken to continue the collective bargaining relationship with the Employer.

You may make self-payments to continue your coverage for up to 12 months as long as you do not engage in conduct inconsistent with the actions being taken by the union.

When dependent coverage starts

Dependent coverage cannot start before your coverage starts. Dependent coverage cannot continue after your coverage ends.

If you have dependents on the date you become eligible, dependent coverage also starts on the date your coverage starts. If you do not have dependents when you become initially eligible, you will become eligible for dependent coverage on the date you first get a dependent.

When you become eligible for dependent coverage, you can choose family coverage for all of your dependents or you can choose coverage for just one dependent. Your cost for providing coverage may depend on whether you choose to cover only one dependent or all your dependents. Remember, you must enroll your dependents before the Plan will pay benefits (*see page G-4*).

If you enroll dependents when you become initially eligible

Coverage for your dependents begins on the 1st day of the 2nd month following the month your first required payment, if any, is made. You must provide any required enrollment materials and payments for the cost of your dependents' coverage during your initial enrollment period. UNITE HERE HEALTH will tell you the date this information is due.

If you want your dependents' coverage to start immediately, you can make a payment directly to your employer. This payment is equal to 2 months of payments for dependent coverage, plus an amount equal to the number of payments required until the month during which your first payroll deduction is made. Call your Care Coordinators for more information about immediate coverage and payment requirements.

Examples showing when dependent coverage begins

The tables below show when dependent coverage begins. In both of these examples, you became eligible August 1, you enrolled yourself, and you enroll your dependents by the deadline for enrolling dependents.

Eligibility for coverage

Example: If You Want Immediate Dependent Coverage

First Eligible for Dependent Coverage	Payroll Deductions Begin	Dependent Coverage Begins
August 1	September	August 1 if 3 months payments are made

You decide you want your dependents' coverage to begin right away by making a payment directly to your employer. In this example, you must make 3 months of payments to your employer: two months for immediate coverage, plus one month of coverage for August (the month before the month during which your first payroll deduction is made).

Example: If You Don't Want Dependent Coverage to Start Immediately

Payroll Deductions Begin	Lag Period	Dependent Coverage Begins
September 1	October	November 1

Your payroll deductions begin September 1. Dependent coverage begins on November 1 (the 1st day of the 2nd month following the month during which your payroll deductions begin).

If you add dependents after you become initially eligible

- **If you chose coverage for yourself or for yourself plus one dependent** when you became initially eligible, you have to wait until the next open enrollment or special enrollment period to enroll dependents.
- **If you elected coverage for yourself and your family** when you became initially eligible, you can add dependents at any time. The dependents' coverage will start as explained below:
 - If you have a new dependent (you get married, a child is born, adopted or placed with you for adoption, or moves to the US to live with you), this is considered a special enrollment event, and the rules for special enrollment events (see "Special Enrollment Periods" below) will determine when the child becomes covered.
 - You can enroll other dependents who meet the Fund's definition of a "dependent" any time during the year. You don't have to wait for an open enrollment or special enrollment event. As long as you provide all required proof documentation within the deadline for providing this proof, coverage for that dependent will begin on the first day of the month following the date you tell the Fund about the dependent.

Continued coverage for dependents

Your dependents will remain covered as long as you remain eligible *and* you make any required

payments for your share of your dependents' coverage. Payments for your share of the cost of dependent coverage should be made by payroll deduction.

- ✓ If you are on a temporary layoff or an approved leave of absence, you must make any payments for your share of your dependents' coverage directly to your employer.

Enrollment periods

Open enrollment periods

Open enrollment periods give you the chance to elect coverage for yourself and your dependents if you declined coverage. It also gives you a chance to add dependents if you did not choose family coverage (you chose single-only coverage, or single-plus-one dependent coverage). If you want to enroll yourself or more dependents, you must provide the required enrollment material and arrange to make any required payments. Your open enrollment materials will describe the deadlines for enrollment and when coverage will start.

Special enrollment periods

In a few special circumstances, you do not need to wait for the open enrollment period to enroll yourself or your dependents. You can enroll yourself or any dependents for coverage within 60 days after any of the following events:

- Termination of other group health coverage, including COBRA continuation coverage, that you had when you first became eligible for coverage under the Plan (or your dependents first became eligible for coverage under the Plan), unless you lost that coverage because you stopped making premium payments.
- 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.
- When you or a dependent becomes eligible for state financial assistance under a Medicaid or Child Health Insurance Program to help pay for the cost of UNITE HERE HEALTH's Dependent Coverage.

If you provide the required enrollment materials and arrange to make any required payments, coverage for your dependents will begin on the 1st day of the 2nd month following the month in

Eligibility for coverage

which your first required payment is made.

However, you have the option to have dependent coverage start sooner by making required payments directly to your employer. When you have questions about making payments for the cost of your dependents' coverage, talk to your employer. Under this option, dependent coverage will start:

- If you get married, or the other coverage terminates (including coverage for Medicaid or CHIP plan), or become eligible for state financial assistance under a Medicaid or CHIP the first day of the month following that date.
- If your child is born, if you adopt a child, if a child is placed with you for adoption, or if a dependent comes to the United States to take up residence with you on the date the child meets the definition of a dependent, or the date the child comes to the United States to take up residence with you.

If you do not take advantage of a special enrollment period, you must wait until the next open enrollment period or special enrollment period to enroll yourself or your dependents.



Termination of coverage

Learn:

- When your coverage and your dependents' coverage ends.

Termination of coverage

Your and your dependents' coverage continues as long as you maintain your eligibility as described [on page G-6](#) and you make any required self-payments. However, your coverage ends if one of the events described below happens. If your coverage terminates, you may be eligible to make self-payments to continue your coverage (called COBRA continuation coverage). [See page G-20.](#)

If you (the employee) are absent from covered employment because of uniformed service, you may elect to continue healthcare coverage under the Plan for yourself and your dependents for up to 24 months from the date on which your absence due to uniformed service begins. For more information, including the effect of this election on your COBRA rights, contact UNITE HERE HEALTH at **(866) 686-0003**.

When employee coverage ends

Your (the employee's) coverage ends on the earliest of any of the following dates:

- The date the Plan is terminated.
- The last day of the coverage period for which your employer was required to make a contribution on your behalf during the corresponding work period ([see page G-5](#)). For example, if your employer's last required contribution on your behalf was for the August work period, your coverage continues through the end of October.
- The last day of the coverage period for which you last made a timely self-payment, if allowed to do so.

[See page G-13](#) for special rules that apply if your employer's CBA expires.

When dependent coverage ends

Dependent coverage ends on the earliest of any of the following dates:

- The date the Plan is terminated.
- Your (the employee's) coverage ends.
- The dependent enters any branch of the uniformed services.
- The last day of the last coverage period for which you made a timely self-payment, if allowed to do so.
- The last day of the month in which your dependent no longer meets the Plan's definition of a dependent.

If your child is age 26 or older, his or her coverage may continue. In order to continue coverage, the child must have been diagnosed with a physical or mental handicap, must not be able to

support himself or herself, and must continue to depend on you for support. Coverage for the disabled child will continue as long as:

- You (the employee) remain eligible;
- The child's handicap began before age 19; and
- The child was covered by the Plan on the day prior to his or her 19th birthday.

You must provide proof of the mental or physical handicap within 30 days after the date coverage would end because of the child reaching age 26. The Trustees may also require you to provide proof of the handicap periodically. (Special rules apply to children with a mental or physical handicap when a new employer begins participation in the Food Service Plan.) Contact your Care Coordinators for more information on how to continue coverage for a child with a serious handicap.

Certificate of creditable coverage

You may request a certificate of creditable coverage within the 24 months immediately following the date your or your dependents' coverage ends. The certificate shows the persons covered by the Plan and the length of coverage applicable to each. However, the Fund will not automatically send you a certificate of creditable coverage. Contact your Care Coordinators when you have questions about certificates of creditable coverage.

Special termination rules

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. If there is a change in your collective bargaining representative, 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, a new Collective Bargaining Agreement is not established during the 12-month period immediately following the CBA's expiration, 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.

Termination of coverage

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.

You should always stay informed about your union's negotiations and how these negotiations may affect your eligibility for benefits.

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 affected 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 advance notice of the planned termination of coverage.



Re-establishing eligibility

Learn:

- How you can re-establish your and your dependents' eligibility.
- Special rules apply if you are on a leave of absence due to a call to active military duty.
- Special rules apply if you are on a leave of absence due to the Family Medical Leave Act.

Re-establishing eligibility

Re-establishing employee coverage

If you lose eligibility, and your loss of eligibility is less than 12 months, you can re-establish your eligibility by satisfying the Plan's continuing eligibility rules (*see page G-6*). If your loss of eligibility lasts for 12 months or more you must again satisfy the Plan's initial eligibility rules (as of the date this SPD was printed, the initial eligibility rules are the same as the continuing eligibility rules). If you lose eligibility because of a leave of absence under the Uniformed Services Employment and Reemployment Rights Act, other rules apply.

Re-establishing dependent coverage

If you remain eligible but your dependents' coverage terminates because you stop making the required payments, you will not be able to re-enroll your dependents until the next special enrollment period or the next open enrollment period (*see page G-9*), whichever happens first.

However, if you stop making payments for your dependents' coverage because you lose eligibility, your dependents' coverage will be re-established as follows:

Uniformed Services Employment and Reemployment Rights Act (USERRA) leaves of absence

For losses of eligibility due to leaves of absence under USERRA, your dependents' coverage will be reestablished immediately upon your return to covered employment, as long as you also start making any required payments for dependent coverage at the same time.

Family Medical Leave Act (FMLA) leaves of absence

For losses of eligibility due to a leave of absence under FMLA, your dependents' coverage will be reestablished on the first day of the second month immediately following the month in which you once again make payments for dependent coverage, as long as you start making payments as soon as you return to covered employment.

Loss of eligibility other than termination of employment

For losses of eligibility for reasons other than termination of your employment, your dependents' coverage will be re-established on the first day of the second month immediately following the month in which you once again begin making payments for dependent coverage, as long as you begin making payments immediately upon your return to covered employment.

Portability

If you are covered by one UNITE HERE HEALTH Plan Unit when your employment ends but you start working for an employer participating in another UNITE HERE HEALTH Plan Unit within 90 days of your termination of employment with the original employer, you will become

eligible under the new Plan Unit on the first day of the month for which your new employer is required to make contributions on your behalf.

- In order to qualify under this rule, within 60 days after you begin working for your new employer, you, the union, or the new employer must send written notice to the Services and Operations Department in the Aurora Office stating that your eligibility should be provided under the portability rules. Your eligibility under the new Plan Unit will be based on that Plan Unit's rules to determine eligibility for the employees of new contributing employers (immediate eligibility).
- If written notice is not provided within 60 days after you begin working for your new employer, your eligibility under the new Plan Unit will be based on that Plan Unit's rules to determine eligibility for the employees of current contributing employers.

Family and Medical Leave Act (FMLA)

- ✓ Eligibility will be continued for you and your dependents during your leave of absence under the Family and Medical Leave Act (FMLA).

If you are making payments for dependent coverage when FMLA leave begins, you can maintain your and your dependents' coverage during the leave by making the required payments for dependent coverage to your employer. If you stop making payments, your dependents' coverage will terminate. Your dependents will become eligible again on the first day of the month for which your employer is required to make a contribution on your behalf after your return to work, as long as you start making self-payments for dependent coverage immediately upon your return to work.

The effect of uniformed service

If you are honorably discharged and returning from military service (active duty, inactive duty training, or full-time National Guard service), or from absences to determine your fitness to serve in the military, your coverage and your dependents' coverage will be reinstated immediately upon your return to covered employment if all of the following are met:

- You provide your employer with advance notice of your absence, whenever possible.
- Your cumulative length of absence for "eligible service" is not more than 5 years.
- You report or submit an application for re-employment within the following time limits:
 - For service of less than 31 days or for an absence of any length to determine your fitness for uniformed service, you must report by the first regularly scheduled work period after the completion of service PLUS a reasonable allowance for time and travel (8 hours).

Re-establishing eligibility

- For service of more than 30 days but less than 181 days, you must submit an application no later than 14 days following the completion of service.
- For service of more than 180 days, you must return to work or submit an application to return to work no later than 90 days following the completion of service.

However, if your service ends and you are hospitalized or convalescing from an injury or sickness that began during your 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 will 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 your Care Coordinators.



COBRA continuation coverage

Learn:

- How you can make self-payments to continue your coverage.

COBRA continuation coverage

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.

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).

Who can elect COBRA continuation coverage?

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

You or your dependent is a qualified beneficiary if you or your dependent loses coverage due to a qualifying event and you or your dependent were covered by the Plan on the day before the earliest qualifying event occurs. However, a child born to, or placed for adoption with, you (the employee) while you have COBRA continuation coverage is also a qualified beneficiary.

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 coverage:

- Your death.
- Your loss of eligibility due to:
 - Termination of your employment (except for gross misconduct).
 - A reduction in your work hours below the minimum required to maintain eligibility.
- The last day of a leave of absence under FMLA 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 (*see page G-3*).
- 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.)
- Your employer withdraws from UNITE HERE HEALTH.

What coverage can be continued?

By electing COBRA continuation coverage, you have the same benefit options and can continue the same healthcare coverage available to other employees who have not had a qualifying event.

In addition to medical benefits, COBRA continuation coverage includes prescription drug benefits, vision benefits, and dental benefits (if applicable). Life and AD&D and short-term disability benefits cannot be continued. However, you may be able to convert your life insurance to an individual policy. Contact your Care Coordinators for more information.

How long can coverage be continued?

The maximum period of time for which you can continue your coverage under COBRA 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:
 - Your employment ends.
 - Your work hours 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 under FMLA.
 - Your employer withdraws from UNITE HERE HEALTH.

However, you may be able to continue coverage for yourself and your dependents for up to an additional 11 months, for a total of 29 months. The Social Security Administration must determine 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, as long as those qualifying events would have resulted in a loss of coverage despite the occurrence of any previous qualifying event.

However, the following rules 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-month or 29-month continuation period, affected qualified beneficiaries may continue their coverage up to 36 months from the date coverage would have originally ended.

COBRA continuation coverage

- 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.

Notifying UNITE HERE HEALTH when qualifying events occur

Your employer must notify UNITE HERE HEALTH of your death, termination of employment, reduction in hours, or failure to return to work at the end of a FMLA leave of absence. UNITE HERE HEALTH uses its own records to determine when a participant's coverage under the Plan ends.

You or a dependent must inform UNITE HERE HEALTH by contacting the Care Coordinators within 60 days of the following:

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

You must inform the Fund before the end of the initial 18 months of continuation coverage if Social Security determines you to be disabled. You must also inform the Fund within 30 days of the date you are no longer considered disabled by Social Security. You can inform the Fund by contacting the Care Coordinators.

You should use UNITE HERE HEALTH's forms to provide notice of any qualifying event, if you or a dependent are determined by the Social Security Administration to be disabled, or if you are no longer disabled. You can get a form by calling your Care Coordinators.

If you don't use UNITE HERE HEALTH's forms 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 UNITE HERE HEALTH in writing. Be sure you sign and date your submission.

However, regardless of the method you use to notify the Fund, you must also include the additional information described below, depending on the event that you are reporting:

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

COBRA continuation coverage

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 your death: the date of death, the name, Social Security number, address, telephone number, date of birth of the eligible dependent, and a copy of the death certificate.
- For your or your 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.

If you or your dependent does not provide the required notice and documentation, you or your dependent will lose the right to elect COBRA continuation coverage.

In order to protect your family's rights, you should keep the Fund informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund or that the Fund sends you.

Election and payment deadlines

COBRA continuation coverage is not automatic. You must elect COBRA continuation coverage, and you must pay the required payments when they are due.

When the Fund gets notice of a qualifying event, it will determine if you or your dependents are entitled to COBRA continuation coverage.

- If you or your dependents are not entitled to COBRA continuation coverage, you or your dependent will be mailed a notice that COBRA continuation coverage is not available within 14 days after UNITE HERE HEALTH has been notified of the qualifying event. The notice will explain why COBRA continuation coverage is not available.
- If you or your dependents are entitled to COBRA continuation coverage, you or the dependent will be mailed a description of your COBRA continuation coverage rights and the applicable election forms. The description of COBRA continuation coverage rights and the election forms will be mailed within 45 days after UNITE HERE HEALTH has been notified of the qualifying event. These materials will be mailed to those entitled to continuation coverage at the last known address on file.

If you or your dependents want COBRA continuation coverage, the completed election form must be mailed to UNITE HERE HEALTH within 60 days from the earliest of the following dates:

- The date coverage under the Plan would otherwise end.

COBRA continuation coverage

- The date the Fund sends the election form and a description of the Plan's COBRA continuation coverage rights and procedures, whichever occurs later.

If your or your dependents' election form is received within the 60-day election period, you or your dependents will be sent a premium notice showing the amount owed for COBRA continuation coverage. The amount charged for COBRA continuation coverage will not be more than the amount allowed by federal law.

- UNITE HERE HEALTH must receive the first payment within 45 days after the date it receives your 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. This means that your first payment may be for more than one month of COBRA continuation coverage.
- 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: Service & Operations Department
P. O. Box 6557
Aurora, IL 60598-0557

Termination of COBRA continuation coverage

COBRA continuation coverage will end when the maximum period of time for which coverage can be continued is reached.

However, on the occurrence of any of the following, continuation coverage may end on the first to occur of any of the following:

- The end of the month for which a premium was last paid, if you or your dependents do not pay any required premium when due.
- The date the Plan terminates.
- The date Medicare coverage becomes effective if it begins after the person's election of 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).
- The date the Plan's eligibility requirements are once again satisfied.
- 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.

COBRA continuation coverage

- The date coverage begins under any other group health plan.

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

To get more information

If you have any questions about COBRA continuation coverage, your rights, or the Plan's notification procedures, please call UNITE HERE HEALTH at **(866) 686-0003**.

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

Claim filing and appeal provisions

Learn:

- What you need to do to file a claim.
- Where you need to send the claim information.
- The deadline to file a claim.
- When you will get a decision on your claim.
- How to appeal if your claim is denied.
- When you will get a decision on your appeal.
- Your right to external claim review.

Claim filing and appeal provisions

Non-assignment of claims

You may not assign your claim for benefits under the Plan to a non-network provider without the Plan's express written consent. A non-network provider is any doctor, hospital or other provider that is not in a PPO or similar network of the Plan.

This rule applies to all non-network providers, and your provider is not permitted to change this rule or make exceptions on their own. If you sign an assignment with them without the Plan's written consent, it will not be valid or enforceable against the Plan. This means that a non-network provider will not be entitled to payment directly from the Plan and that you may be responsible for paying the provider on your own and then seeking reimbursement for a portion of the charges under the Plan rules.

Regardless of this prohibition on assignment, the Plan may, in its sole discretion and under certain limited circumstances, elect to pay a non-network provider directly for covered services rendered to you. Payment to a non-network provider in any one case shall not constitute a waiver of any of the Plan's rules regarding non-network providers, and the Plan reserves all of its rights and defenses in that regard.

Commencement of legal action

Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted. This requirement does not apply to your rights to an external review by an independent review organization ("IRO") under the Affordable Care Act.

If you finish all internal appeals and decide to file a lawsuit against the Plan, that lawsuit must be commenced no more than 12 months after the date of the appeal denial letter. If you fail to commence your lawsuit within this 12-month time frame, you will permanently and irrevocably lose your right to challenge the denial in court or in any other manner or forum. This 12-month rule applies to you and to your beneficiaries and any other person or entity making a claim on your behalf.

Remedies for fraud

If you or a dependent submit information that you know is false or if you purposely do not submit or you conceal important information in order to get any Plan benefit, the Trustees may take actions to remedy the fraud, including: asking for you to repay any benefits paid, denying payment of any benefits, deducting amounts paid from future benefit payments, and suspending and revoking coverage.

Filing a benefit claim

Your claim for benefits must include all of the following information:

- Your name.
- Your Social Security number.
- A description of the injury, sickness, symptoms, or other condition upon which your claim is based.

A claim for healthcare benefits should include any of the following information that applies:

- Diagnoses.
- Dates of service(s).
- Identification of the specific service(s) furnished.
- Charges incurred for each service(s).
- Name and address of the provider.
- When applicable, your dependent's name, Social Security number, and your relationship to the patient.

Claims for life or AD&D benefit claims must include a certified copy of the death certificate. All claims for benefits must be made as shown below. If you need help filing a claim, contact your Care Coordinators at **(866) 686-0003**.

Healthcare claims

Network providers will generally file the claim for you. However, if you need to file a claim, for example because you used a non-network provider, all claims for hospital, medical, or surgical treatment must be mailed to Blue Cross and Blue Shield.

Blue Cross and Blue Shield of Illinois

P. O. Box 805107.

Chicago, Illinois 60680-4112

Prescription drug claims

If you use a participating pharmacy, the pharmacy should file a claim for you. No benefits are payable if you use a pharmacy that does not participate in the pharmacy network. However, if you need to file a prescription drug claim for a prescription drug or supply purchased at a participating pharmacy, you should send it to:

UNITE HERE HEALTH

Attn: HospitalityRx

P.O. Box 6020

Aurora, IL 60598-0020

Claim filing and appeal provisions

Dental claims

Cigna DPPO Advantage dentists will generally file dental claims for you. However, if you need to file a claim, for example because you used a non-network provider, you should send the claim to Cigna.

Cigna Dental
P.O. Box 188037
Chattanooga, TN 37422-8037

Vision claims if you are in the Davis Vision option

Network vision providers will generally file vision claims for you. However, if you need to file a claim, for example because you used a non-network vision provider, the claim should be sent to Davis Vision.

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

If you are in the 24-month vision care benefit, your claim should be filed as described in the paragraph titled “All Other Benefit Claims.”

Life and AD&D insurance claims

Contact your Care Coordinators to file a claim for benefits:

UNITE HERE HEALTH
P.O. Box 6020
Aurora, IL 60598-0020
(866) 686-0003

After you have contacted your Care Coordinators to file a claim for life or AD&D benefits, Dearborn National will contact you to complete the claim filing process.

- No filing deadlines apply to claims for life benefits.
- A claim for life or AD&D insurance benefits must include a certified copy of the death certificate.
- For AD&D claims, Dearborn National must receive written notice of your covered AD&D loss within 31 days of the loss, or as soon as reasonably possible. Dearborn National must receive written proof of your loss within 90 days of the loss, or as soon as reasonably possible. Generally, Dearborn will not pay for claims submitted more than one year after the proof is due. However, Dearborn may extend this claim filing deadline. Other deadlines may apply to your additional AD&D insurance benefits—your certificate of coverage provides more information.

Claim filing and appeal provisions

All other benefit claims

All short-term disability claims, 24-month vision care benefit claims, and any claims for any services or supplies denied because you are not eligible should be mailed to:

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

Deadlines for filing a benefit claim

Only those benefit claims that are filed in a timely manner will be considered for payment. The following deadlines apply:

- Claims for short-term disability benefits and healthcare benefits, including medical/surgical claims, mental health/substance abuse claims, prescription drug claims, and dental or vision claims, must be filed no later than 18 months after the date of service.
- Dearborn National must receive written *notice* of your covered AD&D loss within 31 days of the loss, or as soon as reasonably possible. Dearborn National must receive written *proof* of your loss within 90 days of the loss, or as soon as reasonably possible. If you are legally incapacitated this time frame may be extended. Other deadlines may apply to your additional AD&D insurance benefits—your certificate of coverage provides more information.
- No filing deadlines apply to claims for life insurance benefits.

If you do not file a benefit claim by the appropriate deadline, your claim will be denied unless you can show that it was not reasonably possible for you to meet the claim filing requirements, and that you filed your claim as soon after the deadline as was reasonably possible.

Individuals who may file a benefit claim

You, a healthcare provider (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 a form acceptable to the Fund and submit it to:

UNITE HERE HEALTH
Attention: Claims Manager
P.O. Box 6020
Aurora, Illinois 60598-0020

In the case of an urgent care/emergency treatment claim, a healthcare provider with knowledge of

Claim filing and appeal provisions

your medical condition may act as your authorized representative.

If UNITE HERE HEALTH determines that you are incompetent or incapable of naming an authorized representative to act on your behalf, any of the following individuals may be recognized as your authorized representative without the appropriate form:

- Your spouse (or domestic partner).
- An individual who has power of attorney, or who is executor of your estate.

Your authorized representative may act on your behalf until the earlier of the following dates:

- The date you inform UNITE HERE HEALTH, either verbally or in writing, that you revoke the individual's authority to act on your behalf.
- The date a final decision on your appeal is issued.

Payment of claims

Concurrent care decisions

If your ongoing course of treatment to be provided to you over a period of time or a number of treatments has been approved, any decision to reduce or terminate benefits payable for the course of treatment (other than by amendment or Plan termination) is considered a denial of your claim.

In the event of such a denial of benefits, you will be notified of the decision in time to allow you to appeal before the benefit is reduced or terminated.

If your request that your course of treatment be extended 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 your situation. You will be notified of the decision (whether adverse or not) no later than 24 hours after its receipt of your claim.

Life and AD&D benefit claims

In general, you will be notified of the decision on your claim for life and AD&D benefits no later than 90 days after receiving your claim.

This 90-day period may be extended for up to an additional 90 days if special circumstances require additional time. Dearborn will notify you in writing if it requires more processing time before the end of the first 90-day period.

Short term disability claims

In general, you will be notified of the decision on your claim for short-term disability benefits no later than 45 days after receiving your claim.

This 45-day period may be extended for up to an additional 45 days if special circumstances require additional time. The Fund will notify you in writing if it requires more processing time before the end of the first 45-day period.

Claim filing and appeal provisions

Healthcare claims not involving concurrent care decisions

You will be notified of the decision within a reasonable period of time appropriate to your medical circumstances, but no later than 30 days after it gets your claim. In general, benefits for medical/surgical services will be paid to the provider of those services.

This 30-day period may be extended one time for up to an additional 15 days if necessary. If a 15-day extension is required, you will be notified before the end of the original 30-day period. You will also be notified why the extension is needed, and when a decision is expected. If this extension is needed because you do not submit the information needed, you have 60 days from the date you are told more information is needed. You will be told what additional information you must submit. If you do not provide the required information within 60 days, your claim will be denied, and any benefits otherwise payable will not be paid.

Rules for prior authorization of benefits

In general, your request for prior authorization must be processed no later than 15 days from the date the request is received. In the case of an emergency, your request will be processed within 72 hours.

However, this 15-day period may be extended by 15 days for circumstances beyond the control of the prior authorization company, including if you or your healthcare provider did not submit all of the information needed to make a decision. If extra time is needed, you will be informed, before the end of the original 15-day period, why more time is needed and when a decision will be made.

If you are asked for more information, you must provide it within 45 days after you are asked for it. Once you are told that an extension is needed, the time you take to respond to the request for more information will not count toward the 15-day time limit for making a decision. If you do not provide any required information within 45 days, your request for prior authorization will be denied.

In the case of emergency treatment/urgent care, you have no less than 48 hours to provide any required information. A decision will be made as soon as possible, but no later than 48 hours, after you have provided all requested information.

Special rules for decisions involving concurrent care

Concurrent care decisions are decisions about courses of treatment authorized for a definite or indefinite period of time.

If an extension of the period of time your healthcare provider prescribed is requested, and involves emergency treatment/urgent care, a decision must be made as soon as possible, but no later than 24 hours after your request is received, as long as your request is received at least 24 hours before the end of the authorized period of time.

If your request is not made more than 24 hours in advance, the decision must be made no later

Claim filing and appeal provisions

than 72 hours after your request is received. 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 have benefits prior authorized and will be decided subject to the rules for a new request.

If a request for prior authorization is denied

If all or part of a request for a benefit prior authorization is denied, you will receive a written denial. The denial will include all of the information federal law requires. The denial will explain why your request was denied, and your rights to get additional information. It will also explain how you can appeal the denial, and your right to bring legal action if the denial is upheld after review.

Appealing a benefit prior authorization denial

If your request for a benefit prior authorization is denied, in whole or in part, you may appeal the decision. The next section explains how to appeal a benefit prior authorization denial.

If a benefit claim is denied

If your claim for benefits, or request for prior authorization, is denied, either in full or in part, you will receive a written notice explaining the reasons for the denial, including all information required by federal law. The notice will also include information about how you can file an appeal and any related time limits, including how to get an expedited (accelerated) review for emergency treatment/urgent care, if appropriate.

Life and AD&D claims

The claim processing rules, time limits, and appeal procedures Dearborn must follow are described in the contract with Dearborn. Generally, Dearborn will respond to your claim within 90 days (but Dearborn may request a 90-day extension). You can file an appeal within 60 days of Dearborn's decision. Dearborn will generally respond to your appeal within 60 days (but may request a 60-day extension). If you need help filing a claim or appeal, or have questions about how Dearborn's claim and appeal process works, contact Dearborn.

Appealing the denial of a claim

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 must be in writing (except for appeals involving urgent care), signed, and should include the claimant's name, address, and date of birth, and your (the employee's) Social Security number. You should also provide any documents or records that support your claim.

Claim filing and appeal provisions

Two levels of appeal for prior authorization denials made by the Care Coordinators

First level of appeal

All appeals for medical/surgical or mental health/substance abuse benefit claims denied by your Care Coordinators (prior authorization denials, denials based on retrospective review, or extensions of treatment beyond limits previously approved) must be sent within 12 months of the date the claim was denied to:

Care Coordinators by Quantum Health
1491 Polaris Parkway, Suite 229
Columbus, OH 43240

Second level of appeal

If all or any part of the original denial is upheld (meaning that the claim is still denied, in whole or in part, after your first appeal) and you still think the claim should be paid, you or your authorized representative must submit a second appeal of a prior authorization denial within 45 days of the date the first level denial was upheld to:

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

Two levels of appeals for prescription drug claim denials made by HospitalityRx

First level of appeal

If a prescription drug claim, including a prior authorization claim, is denied, the claim has two levels of appeals.

The first appeal of a prescription drug claim denial must be sent within 180 days of the date on HospitalityRx's denial letter to:

UNITE HERE HEALTH
Attn: HospitalityRx
P.O. Box 6020
Aurora, IL 60598-0020

Second level of appeal

If all or any part of the original denial is upheld (meaning that the claim is still denied, in whole or in part, after your first appeal) and you still think the claim should be paid, you or your authorized representative must submit a second appeal within 45 days of the date the first level denial was upheld to:

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

Claim filing and appeal provisions

One level of appeal for most other claims

If you disagree with all or any part of a short-term disability claim denial, dental claim denial, vision claim denial, or healthcare claim denial, and you wish to appeal the decision, you must follow the steps in this section. (For steps on appealing a prior authorization denial by the Care Coordinators, *see page H-9*. For steps on appealing a prescription drug denial, *see page H-9*.)

You must submit an appeal 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:

- You could not reasonably file the appeal within the 12-month filing limit because of:
 - Circumstances beyond your control, as long as you file the appeal as soon as reasonably possible.
 - Circumstances in which the claim was not processed according to the Plan's claim processing requirements.
- The Appeals Subcommittee would have overturned the original benefit denial based on its standard practices and policies.

Appeals involving urgent care claims

If you are appealing a denial of benefits that qualifies as a request for emergency treatment/urgent care, you can orally request an expedited (accelerated) appeal of the denial by calling **(866) 686-0003**. All necessary information may be sent by telephone, facsimile or any other available reasonably effective 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 made after the due date.
- Late COBRA payments and applications to continue coverage under the COBRA provisions.
- Late applications, including late applications to enroll for dependent coverage.

You must submit your appeal within 12 months of the date the late self-payment or late application was refused to:

Claim filing and appeal provisions

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

Review of appeals

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 on behalf of UNITE HERE HEALTH in connection with the denial of your claim. You are entitled to this information even if this information was not relied on when your appeal was denied.
- Designate someone to act as your authorized representative (*see page H-5* for details).

In addition, UNITE HERE HEALTH must review your appeal based on the following rules:

- UNITE HERE HEALTH may not defer to the initial denial of your claim.
- Review of your appeal must be conducted by a named fiduciary of UNITE HERE HEALTH who is neither the individual who initially denied your claim, nor a subordinate of such individual.
- If the 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 must consult with a healthcare provider who has appropriate training and experience in the field of medicine involved in the medical judgment. This healthcare provider 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:

- As soon as possible, taking into account your medical circumstances, but not later than 72 hours (36 hours in the case of a second level appeal) after UNITE HERE HEALTH's 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

Claim filing and appeal provisions

than 30 days (15 days in the case of a second level appeal) after UNITE HERE HEALTH's receipt of an appeal regarding prior authorization of services other than those pertaining to concurrent care decisions.

- Within a reasonable period of time, but not later than 45 days after UNITE HERE HEALTH's receipt of an appeal for short-term disability benefits (this 45-day period may be extended for an additional 45 days in some circumstances).
- Within a reasonable period of time, but not later than 60 days (30 days for each level of appeal, if applicable) after UNITE HERE HEALTH's receipt of an appeal of healthcare claims for services not requiring prior authorization.

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.

If your appeal is denied, you will be provided with a written notice of the denial which includes all of the information required by federal law, including a description of the Plan's external review procedures (where applicable), how to appeal for external review, and the time limits applicable to such procedures.

Independent external review procedures

Within four months after the date you receive a final notice from the Plan's Appeals Subcommittee 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 for external review, you must meet all of the following requirements:

- You must have been eligible for benefits at the time you incurred the medical expense.
- Your claim must relate to an issue other than the Plan's eligibility rules.
- You must have exhausted your internal appeal rights.
- 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 send your information to the review organization. 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.

Claim filing and appeal provisions

This information may include any of the following:

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

Within forty-five days of receiving the request for review, you will be given notice 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.

Definitions

Learn:

- The definition of some of the terms the Plan uses.
- The Plan may also define some other words or terms.
- Call your Care Coordinators if you aren't sure what a word or phrase means.

Allowable charges

An **allowable charge** is the amount of charges for covered treatments, services, or supplies that the Plan uses to calculate the benefits it pays for a claim. The allowable charge may be less than the provider's actual charges. This usually happens if you choose a non-network provider, and you must pay this difference between the actual charges and the allowable charges. Any charges that are more than the allowable charge are not covered. The Plan will not pay benefits for charges that are more than the allowable charge.

The Board of Trustees has the sole authority to determine the level of allowable charges the Plan will use. In all cases the Trustees' determination will be final and binding.

- Allowable charges for services furnished by network providers are based on the rates specified in the contract between UNITE HERE HEALTH and the provider network. Providers in the network usually offer discounted rates to you and your family. This means lower out-of-pocket costs for you and your family.
- Treatment by a non-network provider means you pay more out-of-pocket costs. The Plan calculates benefits for non-network providers based on established discounted rates, like the BCBSIL rate. The Plan will not pay the difference between what a non-network provider actually charges, and what the Plan considers an allowable charge. You pay this difference in cost. (This is sometimes called "balance billing.")

Copay or copayment

A fixed amount (for example, \$10) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. Usually, once you have paid your **copay**, the Plan pays the rest of the covered expenses.

For example, each time you go to your network PCP, a \$10 copay applies. Each time you go to the emergency room, a \$100 copay applies.

Your copayments count toward your out-of-pocket limits.

You can get more information about your medical, prescription drug, dental, or vision copays in the appropriate section of this SPD. (See the beginning of the SPD for the table of contents.)

Coinsurance

Your share of the costs of a covered expense, calculated as a percent (for example, 20%) of the allowable charge for the service. You pay your **coinsurance** plus any deductibles or copays. For example, if the allowable charge for network durable medical equipment is \$100, your 20% coinsurance equals \$20. The Fund pays the rest of the allowable charge.

Your coinsurance counts toward your out-of-pocket limits.

Cosmetic or reconstructive surgery

Cosmetic or reconstructive surgery is any surgery intended mainly to improve physical appearance or to change appearance or the form of the body without fixing a bodily malfunction. Cosmetic or reconstructive surgery includes surgery to prevent or treat a mental health or substance abuse disorder by changing the body.

Mastectomies, and reconstruction following a mastectomy, will not be considered cosmetic or reconstructive surgery (*see page D-5*).

Covered expense

A treatment, service or supply for which the Plan pays benefits. **Covered expenses** are limited to the allowable charge.

Deductible

The amount you owe for covered expenses before the Fund begins paying benefits. For example, the Fund will not start paying dental benefits on your behalf until you meet your \$50 or \$100 individual **deductible**.

The deductible may not apply to all services, including services that have a copay. For example, your \$50 or \$100 dental deductible does not apply to regular preventive care, like x-rays and regular cleanings.

Amounts you pay for healthcare the Plan does not cover will not count toward your deductible. This includes but is not limited to, excluded services and supplies, charges that are more than the allowable charge, amounts over a benefit maximum or limit, and other charges for which the Plan does not pay benefits.

You can get more information about your dental deductibles in the appropriate section of this SPD. (See the beginning of the SPD for the table of contents.)

Durable medical equipment (DME)

Durable medical equipment (DME) must meet all of the following rules:

- Mainly treats or monitors injuries or sicknesses.
- Withstands repeated use.
- Improves your overall medical care in an outpatient setting.
- Is approved for payment under Medicare.

Some examples of DME are: wheelchairs, hospital-type beds, respirators and associated support systems, infusion pumps, home dialysis equipment, monitoring devices, home traction units, and other similar medical equipment or devices. The supplies needed to use DME are also considered DME.

Experimental, investigational, or unproven (experimental or investigational)

Experimental, investigational, or unproven procedures or supplies are those procedures or supplies which are classified as such by agencies or subdivisions of the federal government, such as the Food and Drug Administration (FDA) or the Office of Health Technology Assessment of the Centers for Medicare & Medicaid Services (CMS); or according to CMS's Medicare Coverage Issues Manual.

However, routine patient costs associated with clinical trials are not considered experimental, investigational, or unproven.

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 or bodily organs or body parts.

Healthcare provider

A healthcare provider is any person who is licensed to practice any of the branches of medicine and surgery by the state in which the person practices, as long as he or she is practicing within the scope of his or her license.

A primary care provider (PCP) is defined as a provider who specializes in:

- Family medicine.
- General practice.
- Internal medicine.
- Pediatric medicine (for children).
- Obstetrics or gynecology (while you or a dependent is pregnant).

A **specialist** is a healthcare provider who does not practice in one of the specialties listed above.

A **dentist** is a healthcare provider licensed to practice dentistry or perform oral surgery in the state in which he or she is practicing, as long as he or she practices within the scope of that license. Another type of healthcare provider may be considered a dentist if the healthcare provider is performing a covered dental service and otherwise meets the definition of “healthcare provider.”

A **provider** may be an individual providing treatment, services, or supplies, or a facility (such as a hospital or clinic) that provides treatment, services, or supplies.

Injuries and sicknesses

The Plan only pays benefits for the treatment of injuries or sicknesses that are not related to employment (non-occupational injuries or sicknesses).

Sickness also includes mental health conditions and substance abuse. For employees and spouses only, sickness also includes pregnancy and pregnancy-related conditions, including abortion.

The Plan only pays benefits for preventive healthcare for a pregnant dependent child. **Maternity charges for a pregnant dependent child that are not preventive healthcare** ([see page I-7](#)) **are not covered by the Plan.** “Non-preventive maternity care” includes but is not limited to ultrasounds, care for a high-risk pregnancy, and the actual childbirth and delivery. No benefits are payable for the child of your child (unless the child meets the Plan’s definition of a dependent—[see page G-3](#)).

The Plan will also consider voluntary sterilization procedures for you, your spouse, and your female children who meet the definition of a dependent, to be a sickness.

Treatment of infertility, including fertility treatments such as in-vitro fertilization or other such procedures, is not considered a sickness or an injury.

Medically necessary

Medically necessary services, supplies, treatment are:

- Consistent with and effective for the injury or sickness being treated;

Definitions

- Considered good medical practice according to standards recognized by the organized medical community in the United States; and
- Not experimental or investigational (*see page I-4*), nor unproven as determined by appropriate governmental agencies, the organized medical community in the United States, or standards or procedures adopted from time-to-time by the Trustees.

However, with respect to mastectomies and associated reconstructive treatment, allowable charges for such treatment is considered medically necessary for covered expenses incurred based on the treatment recommended by the patient's healthcare provider, as required under federal law.

The Board of Trustees has the sole authority to determine whether care and treatment is medically necessary, and whether care and treatment is experimental or investigational. In all cases, the Trustees' determination will be final and binding. However, determinations of medical necessity and whether or not a procedure is experimental or investigative 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 healthcare provider and should be based on all appropriate factors, only one of which is what benefits the Plan will pay.

Out-of-Pocket limit for network care and treatment

In order to protect you and your family, the Plan limits what you have to pay for your cost-sharing (copays, coinsurance, and deductibles) for medical care and for prescription drugs. This is called an **out-of-pocket limit**. Once your out-of-pocket costs for network covered expenses meets the out-of-pocket limit, the Plan will usually pay 100% for your (or your family's) network covered expenses during the rest of that year.

Amounts you pay out-of-pocket for services and supplies that are not covered, such as amounts over the allowable charges, or care or treatment once you have met a maximum benefit, do not count toward your out-of-pocket limit. Non-network care or treatment does not count toward your out-of-pocket limit. The Plan will not pay 100% for services or supplies that are not covered, or that are provided by a non-network provider, even if you have met your out-of-pocket limit for the year.

You can get more information about your medical and prescription drug out-of-pocket limits in the appropriate section of this SPD. (See the beginning of the SPD for the table of contents.)

Plan Document

The rules and regulations governing the Plan of benefits provided to eligible employees and dependents participating in the Food Service Plan.

Preventive healthcare

Under the medical and prescription drug benefits, the Plan covers preventive healthcare at 100%—there is no cost to you—when you use a network provider and meet any age, risk, or frequency rules. **Preventive healthcare** is defined under federal law as:

- Services rated “A” or “B” by the United States Preventive Services Task Force (USPSTF).
- Immunization recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention.
- Preventive care and screenings for women as recommended by the Health Resources and Services Administration.
- Preventive care and screenings for infants, children, and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration.
- PSA tests (prostate-specific antigen tests) for males between ages 40 and 69.

The Plan may cover certain preventive healthcare more liberally (for example, more frequently or at earlier/later ages) than required. For example, mammograms may be covered for women under age 40 who are at high risk for developing breast cancer.

Contact your Care Coordinators with questions about what types of preventive care is covered, and to find out if any age, risk, or frequency limitations apply. You can also go to: <https://www.healthcare.gov/preventive-care-benefits> for a summary.

The list of covered preventive care changes from time to time as preventive care services and supplies are added to or taken off of the list of required preventive care. The Fund follows federal law that determines when these changes take effect.

I-8

Plan 176B

Other important information



Other important information

Who pays for your benefits?

In general, Plan benefits are provided by the money (contributions) employers participating in the Plan must contribute on behalf of eligible employees under the terms of the Collective Bargaining Agreements (CBAs) negotiated by your union. Plan benefits are also funded by amounts you may be required to pay for your share of your or your dependent's coverage.

What benefits are provided through insurance companies?

The Plan provides the medical benefits, the prescription drug benefits, the vision care benefits (both options), the short-term disability benefits and the dental benefits (both options) on a self-funded basis. Self-funded means that none of these benefits are funded by insurance contracts. Benefits and associated administrative expenses are paid directly from UNITE HERE HEALTH.

The Plan provides the life and accidental death & dismemberment (AD&D) benefits on a fully insured basis. These benefits are funded and guaranteed under group contracts underwritten by Dearborn National.

The Plan also contracts with other organizations to help administer certain benefits. Prescription drug benefits are administered by HospitalityRx, a wholly owned subsidiary of UNITE HERE HEALTH. Cigna Health and Life Insurance Company (Cigna) administers the dental benefits. Davis Vision administers the Davis vision benefit. Specialist referral services, prior authorization and other utilization review services, case management and chronic condition management for the Plan's Medical and Surgical Benefits are provided by Quantum Health through your Care Coordinators.

Interpretation of Plan provisions

For claims subject to independent external review (*see page H-12*), the IRO has the authority to make decisions about benefits, and decide all questions 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;

Other important information

- Interpret all Plan provisions and associated administrative rules and procedures;
- Authorize all payments under the Plan or recover any amounts in excess of the total amounts required by the Plan.

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 if the Board of Trustees of UNITE HERE HEALTH, in their sole and exclusive discretion, decide that the applicant is entitled to them.

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.

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 the assets available. If there is money left over, the Trustees may use it in a method consistent with the purposes for which the Plan was created or they may transfer it to another fund providing similar benefits.

Free choice of provider

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 which specific 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' Com-

Other important information

pensation 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 healthcare and other benefits, including life insurance and accidental death and dismemberment 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 review at the Aurora, Illinois, Office, and within 10 days of a request to review, 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 review at the Aurora, Illinois, Office and, within 10 days of a request for review, 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 and agent for service of legal process

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

UNITE HERE HEALTH
Chief Executive Officer
711 North Commons Drive
Aurora, IL 60504

(630) 236-5100

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 set by the Board of Trustees for the purpose of maintaining UNITE HERE HEALTH's financial records. Plan years begin each April 1 and end the following March 31.

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 (termination scheduled to occur in the future) is not a rescission. Additionally, the Plan may retroactively terminate coverage in any of 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.
- As otherwise permitted by law.

Your Rights Under ERISA



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 healthcare 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.

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

Care Coordinators by Quantum Health

1491 Polaris Parkway, Suite 229

Columbus, OH 43240

(866) 686-0003

Blue Cross and Blue Shield of Illinois

Healthcare Service Corporation

300 East Randolph Street

Chicago, IL 60601-5099

(312) 653-6000

Cigna Health and Life Insurance Company (Cigna)

900 Cottage Grove Road

Bloomfield, CT 06002

(800) 244-6224

Davis Vision

P.O. Box 1525

Latham, NY 12110

(800) 999-5431

Dearborn National

1020 31st Street

Downers Grove, IL 60515-5591

(800) 348-4512

Walgreens Specialty Pharmacy

60173-6801

(877) 647-5807

WellDyneRx

60173-6801

(844) 813-3860



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