

UNITE HERE HEALTH

Summary Plan Description

Delaware North Companies –

Travel Hospitality Services

Plan Unit 174 – Alternate Plans I and II

January 1, 2011

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

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

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



INTRODUCTION

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

Your Plan, Plan Unit 174, has been adopted by the Trustees for the payment of Medical, Dental, and other health and welfare benefits from the Fund. This booklet is your Summary Plan Description (SPD). It is a summary of the Base Plan's rules and regulations and describes:

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

If information contained in the SPD is inconsistent with those rules and regulations, the rules and regulations will govern.

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

ABOUT PLAN FINANCES

Who Pays for Your Benefits?

In general, Plan benefits are provided by the money employers participating in the Plan are required to contribute on behalf of eligible employees under the terms of the Collective Bargaining Agreements negotiated by your local union, including amounts you pay through payroll deduction.

What Benefits Are Provided Through Insurance Companies?

The Plan provides the following self-funded benefits: Comprehensive Major Medical Coverage, Prescription Drug Benefits, Dental Benefits, and Vision Care Benefits. "Self-funded" means that none of these benefits are funded by insurance contracts. Benefits and associated administrative expenses are paid directly from the Fund.

However, the Plan maintains contracts to help administer certain benefits. Prescription Drug Benefits are administered by Catalyst Rx; Dental Benefits are administered by Connecticut General Life Insurance Company (Connecticut General, also known as CIGNA).

In addition, precertification and utilization review services for the Plan's Medical and Surgical Benefits are provided by American Health Holding, Inc. (AHH).

IMPORTANT PHONE NUMBERS

Find a network doctor	(800) 810-BLUE (2583) Blue Cross Blue Shield of Illinois
Find a network pharmacy	(866) 884-4176 Catalyst Rx
Find a network dentist	(800) 244-6224 CIGNA Dental Core Network
Find a network vision care provider	(800) 999-5431 Davis Vision
The Nurse HelpLine	(800) 299-0274 Registered Nurse Counselors answer your health care questions and provide help seeking immediate care and treatment, 24 hours a day, seven days a week.

Mandatory Precertification

For hospital admissions and certain procedures (see page 19), call American Health Holding, Inc, (AHH) before treatment.

For emergency hospital treatment, call AHH the first business day following admission.

(866) 458-4609

\$150 benefit reduction if you do not call to certify!

Retrospective review may result in total denial of benefits.

To request claim forms, enrollment or election forms, report changes in your employment or family status, inquire about self-payments, or request additional information, contact:

UNITE HERE HEALTH

P.O. Box 6020

Aurora, IL 60598-0020

or call

(866) 261-5676

9:00 AM to 5:00 PM EST Monday - Friday

visit our website www.uniteherehealth.org

Este libro es un resumen, en inglés, de sus derechos y beneficios bajo su Plan, Unidad de Plan 174. Si Usted tiene dificultad comprendiendo cualquier parte de este libro, comuníquese a la Oficina del Fondo para asistencia.

Número gratuito (866) 261-5676

La oficina está abierta de lunes a viernes desde las 9:00 A.M. hasta las 5:00 P.M.

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*This Table of Contents is designed to help you find specific benefit information easily and quickly.
Look for the question that best describes what you want to know.*

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BENEFITS AT A GLANCE – Alternate Plan I

Please call customer service at (866) 261-5676 if you have specific questions about covered services.

Comprehensive Major Medical Benefits

In general, Plan benefits distinguish between treatment furnished by network providers and treatment furnished by non-network providers, as shown in the following table. The Comprehensive Major Medical benefit pays a percentage of the Plan's allowable charges for covered medical expenses. You are responsible for paying the deductible, copayments, your share of allowable charges the Plan doesn't pay, any amount over the maximum benefits, and any expenses that are not covered by the Plan.

Calendar Year Deductible

Applies to all covered expenses except office visit charges by network doctors other than: podiatric or chiropractic visits, covered preventive health care services, network hospital outpatient diabetes or nutrition training, certain routine colonoscopies, and routine hearing examination conducted in a doctor's office.

	Network	Non-Network
Individual	\$350	\$350
Family	\$1,000	\$1,000
Lifetime Maximum	\$1,000,000	

Major Medical Plan Payments

	BCBS NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Physician Office Visits	100% after \$20 copay for Primary Care	60%
Does not apply to chiropractors or podiatrists	100% after \$35 copay for Specialist	
Routine Physical Exams	100% after \$20 copay	Not Covered
Every year, including office visit, blood chemistry profile, EKG, and chest x-ray		
Preventive Health Care Services		
Well Baby/Well Child Examinations up to age 6	100%	Not Covered
Annual PAP Smear	100%	Not Covered
Routine Immunizations – except flu shots	100%	Not Covered
Flu Shots	100% after \$20 copay for Primary Care 100% after \$35 copay for Specialist	Not Covered
Mammography 1 at age 40; 1 every 2 years ages 41-50; 1 each year after age 50	100% after \$20 copay	Not Covered
Annual Prostate Examinations	100%	Not Covered
Colonoscopy, Routine	80%	Not Covered
Every 10 years beginning at age 50 or every 2 years if diagnosed as high risk		
Hospitalization	80%	60%
Emergency Room Treatment		
Emergency care to prevent serious and permanent physical impairment or death	80% after \$100 copay	80% after \$100 copay
Non-Emergency Care	50% after \$100 copay	50% after \$100 copay
Professional Ambulance	80%	60%
Outpatient Urgent Care Center	100% after \$20 copay	60%
Mental Health Visits	100% after \$20 copay Primary Care 100% after \$35 copay Specialist	60%
Substance Abuse Visits	100% after \$20 copay Primary Care 100% after \$35 copay Specialist	60%

Call AHH toll free (866) 458-4609 for emergency admission review, and precertification of certain medical procedures and treatments. \$150 Benefit Reduction for FAILURE to COMPLY.

	BCBS NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Diabetic Supplies	80%	60%
Diabetes Educator – \$200 calendar year maximum	100%	Not Covered
Registered Dietitian – \$200 calendar year maximum	100%	Not Covered
Routine Hearing Exam	100% after \$20 copay Primary Care 100% after \$35 copay Specialist	Not Covered
Chiropractic Services – \$1,000 combined calendar year maximum	100% after \$35 copay	60%
Durable Medical Equipment	80%	50%
Skilled Nursing Facility – 120-day combined maximum each calendar year	80%	60%
Home Health Care Services – 60-visit combined maximum each calendar year	100% after \$20 copay	60%
Hospice Care 210-day combined maximum each calendar year; additional 5-day combined maximum for bereavement counseling	80%	80%
Outpatient Rehabilitation Therapy – Physical, occupational or speech 60-visit combined maximum each calendar year; Special maximums apply to speech therapy for children	80%	60%
All Other Covered Expenses	80%	60%
Out-of-Pocket Spending Limit Per Calendar Year		
Per Person	\$2,000	\$2,000
Per Family	\$6,000	\$6,000

Once you incur out-of-pocket costs as shown (excluding certain charges – see page 27 for more information), benefits for the rest of the calendar year will be paid at 100% for network benefits and 80% for non-network benefits.

Prescription Drug Benefits *Catalyst Rx Network Pharmacies or Mail Order Only*

	Retail Copayment 34-day supply	Mail Order Copayment 90-day supply
Generic Drugs and Generic Diabetic Supplies	\$10 per prescription	\$20 per prescription
Formulary Brand-name Drugs	\$30 per prescription	\$60 per prescription
Non-formulary Brand-name Drugs	50% of the cost but not more than \$100	50% of the cost but not more than \$200

Dental Benefits *Only available if you elected Dental Benefits*

	CIGNA Dental Core Network Providers	Non-Network Providers
Preventive and Diagnostic Services	100%	100%
Basic Restorative Services	50%	50%
Major Restorative Services	50%	50%
Maximums		
Calendar Year Maximum	\$1,500	\$1,000
Lifetime Maximum for Orthodontic Services, children under age 19	\$1,500	

\$50 per person calendar year deductible (does not apply to preventive services)

Vision Benefits *Only available if you elected Vision Benefits*

	Davis Vision Network Providers	Non-Network Providers
Eye Exam	100% after \$10 copay	\$43 maximum benefit
Frames	100% after \$20 copay	\$45 maximum benefit

BENEFITS AT A GLANCE – Alternate Plan II

Please call customer service at (866) 261-5676 if you have specific questions about covered services.

Comprehensive Major Medical Benefits

In general, Plan benefits distinguish between treatment furnished by network providers and treatment furnished by non-network providers, as shown in the following table. The Comprehensive Major Medical benefit pays a percentage of the Plan's allowable charges for covered medical expenses. You are responsible for paying the deductible, copayments, your share of allowable charges the Plan doesn't pay, any amount over the maximum benefits, and any expenses that are not covered by the Plan.

Calendar Year Deductible

Applies to all covered expenses except office visit charges by network doctors other than: podiatric or chiropractic visits, covered preventive health care services, network hospital outpatient diabetes or nutrition training, certain routine colonoscopies, and routine hearing examination conducted in a doctor's office.

	Network	Non-Network
Individual	\$500	\$500
Family	\$1,500	\$1,500
Lifetime Maximum	\$1,000,000	

Major Medical Plan Payments

	BCBS NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Physician Office Visits	100% after \$30 copay for Primary Care	60%
Does not apply to chiropractors or podiatrists	100% after \$45 copay for Specialist	
Routine Physical Exams	100% after \$30 copay	Not Covered
Every year, including office visit, blood chemistry profile, EKG, and chest x-ray		
Preventive Health Care Services		
Well Baby/Well Child Examinations up to age 6	100%	Not Covered
Annual PAP Smear	100%	Not Covered
Routine Immunizations – except flu shots	100%	Not Covered
Flu Shots	100% after \$30 copay for Primary Care 100% after \$45 copay for Specialist	Not Covered
Mammography 1 at age 40; 1 every 2 years ages 41-50; 1 each year after age 50	100% after \$30 copay	Not Covered
Annual Prostate Examinations	100%	Not Covered
Colonoscopy, Routine	80%	Not Covered
Every 10 years beginning at age 50 or every 2 years if diagnosed as high risk		
Hospitalization	80%	60%
Emergency Room Treatment		
Emergency care to prevent serious and permanent physical impairment or death	80% after \$100 copay	80% after \$100 copay
Non-Emergency Care	50% after \$100 copay	50% after \$100 copay
Professional Ambulance	80%	60%
Outpatient Urgent Care Center	100% after \$30 copay	60%
Mental Health Visits	100% after \$30 copay Primary Care 100% after \$45 copay Specialist	60%
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Outpatient Rehabilitation Therapy – Physical, occupational or speech 60-visit combined maximum each calendar year; Special maximums apply to speech therapy for children	80%	60%
All Other Covered Expenses	80%	60%
Out-of-Pocket Spending Limit Per Calendar Year		
Per Person	\$3,000	\$3,000
Per Family	\$9,000	\$9,000

Once you incur out-of-pocket costs as shown (excluding certain charges – see page 27 for more information), benefits for the rest of the calendar year will be paid at 100% for network benefits and 80% for non-network benefits.

Prescription Drug Benefits *Catalyst Rx Network Pharmacies or Mail Order Only*

	Retail Copayment 34-day supply	Mail Order Copayment 90-day supply
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Maximums		
Calendar Year Maximum	\$1,500	\$1,000
Lifetime Maximum for Orthodontic Services, children under age 19	\$1,500	

\$50 per person calendar year deductible (does not apply to preventive services)

Vision Benefits *Only available if you elected Vision Benefits*

	Davis Vision Network Providers	Non-Network Providers
Eye Exam	100% after \$10 copay	\$43 maximum benefit
Frames	100% after \$20 copay	\$45 maximum benefit

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16 DEPENDENTS

17 ENROLLMENT REQUIREMENTS

18 PAYING FOR DEPENDENT
COVERAGE



WHO'S ELIGIBLE

Under certain circumstances employees can refuse coverage by signing the waiver of coverage portion of the Coverage Election Form. Special rules govern how and when coverage becomes effective after a waiver is revoked. Contact customer service for more information.

Contact customer service for details on domestic partner coverage and enrollment requirements.

In addition to any coverage provided under the Plan to domestic partners, benefits for a participant's domestic partner who does not satisfy the definition of a qualifying relative under the Internal Revenue Code shall include payment of the Employer and Employee portion of the Federal Insurance Contributions Act (FICA) tax corresponding to the value of such benefits, and payment of the amount owed under the Federal Unemployment Tax Act corresponding to the value of such benefits. With respect to a participant's portion of FICA, the Fund shall gross-up the value of such benefits in conformity with Internal Revenue Service Rev. Proc. 81-48, as modified and/or interpreted by the Internal Revenue Service.

Employees

You are eligible for coverage if:

- You work for an employer who is required by a Collective Bargaining Agreement to contribute to UNITE HERE HEALTH on your behalf;
- The necessary contributions, which include any contributions you make by payroll deduction, are received by the Fund; and
- You satisfy the Plan's eligibility rules.

Dependents

Your dependents become eligible for coverage on the date you become eligible or on the date you acquire your first dependent, which ever happens last.

Coverage for your dependents is not free. *You must arrange with your employer to make monthly payments by payroll deduction to cover the cost.* The Fund will tell you the amount of monthly payment required and when the associated Dependent Coverage begins.

Who Your Dependents Are

For benefit purposes, your dependents are:

- Your husband or wife, but only if there is a valid marriage license or marriage certificate;
- Your same sex domestic partner, but only in California, and his or her children;
- Your children, including:
natural children, step-children, adopted children, children placed with you for adoption and for whom you are legally required to provide support until the adoption is finalized, children entitled to coverage because of a Qualified Medical Child Support Order, or children for whom you are awarded legal guardianship or sole custody pursuant to state domestic relations law, who are under age 26.

To be covered on or after their 26th birthday, your unmarried children must be unable to support themselves because of a mental or physical handicap that began before age 19 and while they were covered under the Plan.

Enrollment Requirements

Employees

All employees must fill out a Coverage of Election Form. The Plan provides three categories of benefits: medical, including prescription drug, dental, and vision.

Electing Coverage

The Coverage Election Form allows you to specify the types of benefits and the levels of coverage that are best for you and your family.

- To elect medical benefits, the employee must choose one of the following levels of coverage: Employee Only, Employee + Children, Employee + Spouse, or Employee + Family.
- Dental benefits are only available to employees who have elected medical benefits and the level of benefits must correspond to the level of medical benefits elected.
- Vision benefits are only available to employees who have elected medical benefits and the level of benefits must correspond to the level of medical benefits elected.

The Coverage Election Form must be submitted to UNITE HERE HEALTH within 30 days after the date you become eligible.

- ✓ If you have more than one dependent, but do not elect Employee + Family, you may not enroll remaining dependents until the next Open Enrollment Period or when you qualify for Special Enrollment.

Dependents

In addition to a completed Coverage Election Form, you must submit a Dependent Enrollment Form if you want to provide coverage for your dependents. The Dependent Enrollment Form identifies the dependents you want covered and requests: your name, social security number, birth date, home address, telephone number, employer's name and address, and the dependent's name, sex, birth date, and social security number.

The Dependent Enrollment Form must be submitted to UNITE HERE HEALTH within 30 days after the date you become entitled to elect Dependent Coverage.

Dependent Documentation

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

- A certified copy of your marriage license or marriage certificate;
- A commemoration of marriage issued by a generally recognized denomination or organized religion;
- A certified copy of the birth certificate;
- Baptismal certificate;
- Hospital birth records;
- Written proof of adoption or legal guardianship;
- Copies of court decrees that obligate an employee to provide medical benefits for a dependent child;

Coverage for your dependents can not begin before your coverage begins. Even if you have elected Employee + Children or Employee + Family, you must still enroll newly acquired children and submit the required proof to the Fund Office.

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 customer service.

English translations for all documents must be provided as required.

See page 58 for information about when coverage for your dependents begins.

- Notarized copies of a participant's most recent Federal Income Tax return (Form 1040 or its equivalents);
- Certificates of Creditable Coverage issued in accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996, as amended;
- Documentation of dependent status issued and certified by the United States Immigration and Naturalization Service; or
- Documentation of dependent status issued and certified by a foreign embassy.

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

Paying for Dependent Coverage

Coverage for your dependents is available as long as you remain eligible and you continue to make the required monthly payments. ***All payments for Dependent Coverage must be made through your employer by payroll deduction.***

- ✓ For leaves of absence governed by the Family and Medical Leave Act (FMLA), coverage may be maintained by continuing to make the required payments directly to your employer.



IN THIS SECTION

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- 21 PROCESSING REQUESTS FOR PRECERTIFICATION OF BENEFITS
- 22 SPECIAL RULES FOR DECISIONS INVOLVING CONCURRENT CARE
- 22 IF A REQUEST FOR PRECERTIFICATION IS DENIED

MEDICAL MANAGEMENT REVIEW

Medical Management Review is a **mandatory** program requiring **precertification** as well as review of certain treatments and procedures.

UNITE HERE HEALTH has contracted with American Health Holding, Inc. (AHH) to provide the following medical and surgical utilization review services: **hospital pre-admission certification, emergency admission review, precertification of certain outpatient medical procedures and treatments, certain durable equipment, and retrospective review when precertification or authorization is not obtained as required.**

**To certify medical and surgical treatment, call
American Health Holding, Inc. (AHH)**

toll free
(866) 458-4609

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

Medical Management Review is **not** intended as and does not constitute **medical advice**. The **necessity for treatment**, the length of hospitalization, or any other recommendations regarding medical matters is **solely determined by you and your doctor**. UNITE HERE HEALTH is not responsible for any consequences resulting from decisions you or your doctor make based on the Plan's certification or determination of benefits the Plan will pay.

- ✓ It is your responsibility to see that the notice and information requirements imposed by Medical Management Review are followed.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with child-birth for the mother or a newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- ✓ Failure to follow the requirements of Medical Management Review will cause a **\$150 reduction in benefits** otherwise payable and subject the services to retrospective review. Retrospective review may result in a total denial of benefits. No coverage will be provided for services or supplies not approved for benefits.

Medical and Surgical Treatment

Hospital Admissions

For all non-maternity hospitalizations you, a family member, or your doctor **must** contact AHH:

- For all non-emergency confinements, any time prior to admission;
- For all emergency or urgent care confinements, the first business day following admission. However, the \$150 penalty will not apply if:
 - It was not reasonable to meet the deadline, and
 - AHH was notified as soon as reasonably possible.

UNITE HERE HEALTH has the final say in determining whether or not it was reasonable to meet the deadline and whether or not the required notification was made as soon as reasonably possible.

For maternity hospitalizations, benefits must be certified for any lengths of stay *exceeding*:

- 48 hours for the normal delivery of a newborn child; or
- 96 hours for the delivery of a newborn child by caesarean section.

Outpatient Surgeries & Diagnostic Tests

You must call AHH to pre-certify benefits before receiving any of the services listed below:

- Arthroscopy (knee);
- Blepharoplasty;
- Cardiac Catheterization;
- Carpal Tunnel Release;
- Cholecystectomy (laparoscopic);
- Colonoscopies, other than those in connection with, or as a part of, routine preventive services for early detection of colorectal cancer;
- Coronary Angioplasty (percutaneous);
- Diagnostic Laparoscopy;
- Diagnostic Imaging Procedures, such as:
 - CT Scan (Computed Tomography Scintiscan, also know as a CAT Scan – Computerized Axial Tomography Scintiscan),
 - CTA Scan (Computerized tomographic angiography),
 - DEXA Scan (densitometry, also known as a bone mineral density test),
 - MRA (Magnetic Resonance Angiography),

- MRI (Magnetic Resonance Imaging),
- PET-Scan (Positron Emission Tomography Scintiscan) and PET-CT;
- Endoscopy (upper gastrointestinal);
- Hysterectomy (vaginal, laparoscopic);
- Mammoplasty (reduction);
- Myelography;
- Percutaneous Diskectomy;
- Rhinoplasty;
- Septoplasty;
- Stem Cell Transplant;
- Submucous Resection;
- Uvulopalatopharyngoplasty;
- Durable Medical Equipment over \$500;
- Outpatient treatment for substance abuse after 15 visits; and
- Outpatient treatment for mental health conditions after 15 visits.
 - ✓ No precertification is required for outpatient services and procedures, such as CAT-Scans and MRIs, if they constitute emergency treatment or urgent care and are furnished in a hospital's emergency room.

Processing Requests for Precertification of Benefits

In general, AHH must process requests for precertification of benefits no later than 15 days from the date the request is received.

If More Time Is Needed

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

If Additional Information Is Needed

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

Special Rules for Decisions Involving Concurrent Care

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

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

If the request is not made more than 24 hours in advance, the determination must be made not later than 72 hours after receipt. If the request for an extension of the prescribed period is not a request involving urgent care, the request will be treated as a new request to certify benefits and be decided according to the general requirements described above.

If a Request for Precertification Is Denied

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

- The specific reasons certification of benefits was denied;
- The specific provisions of the Plan supporting the denial;
- A description of what additional information, if any, may allow benefits to be certified; and
- An explanation of AHH's appeal process.

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

Appealing the Denial of Benefit Certification

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

American Health Holding, Inc. – Attn: Appeals Department
100 W. Old Wilson Bridge Rd., 3rd Floor
Worthington, OH 43085

Appeals, other than those involving requests for urgent care, must be in writing, signed, and should include the claimant's name, address, date of birth, and the participant's Social Security number. Documents or records that support certification of benefits should also be included.



IN THIS SECTION

23 INJURIES AND SICKNESSES

23 ALLOWABLE CHARGES

24 MEDICALLY NECESSARY CARE AND TREATMENT

24 TREATMENT BY NETWORK AND NON-NETWORK DOCTORS AND HOSPITALS

24 DEFINITION OF DOCTOR

HOW PLAN BENEFITS ARE DETERMINED

Plan benefits for injuries or sicknesses are based on allowable charges for covered services resulting from medically necessary care and treatment prescribed or furnished by a doctor.

How the Plan makes these determinations is discussed below.

Injuries and Sicknesses

The Plan only provides medical benefits for the treatment of injuries or sicknesses not related to employment.

In addition to physical illness, *sickness* includes mental health conditions, alcohol or drug abuse, and pregnancy, including abortion. Benefits for pregnancy and abortion are available to employees and their covered spouses. No benefits are available for or in connection with the treatment of infertility or voluntary sterilization for non-spouse dependents.

Allowable Charges

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

- Allowable charges for treatment by network providers reflect discounted fees provided by your local BlueCross and BlueShield Plan. This means lower out-of-pocket costs for you and your family. You only pay the difference between the provider's discounted charge and the Plan benefit.
- Treatment by a non-network provider means higher out-of-pocket costs because allowable charges are determined by BlueCross and BlueShield of Illinois schedule for non-network providers. You pay the difference between the provider's billed charge and the Plan benefit.

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

See pages 49-50 for a complete list of the Plan's *General Exclusions and Limitations*.

Experimental, investigational, or unproven procedures are those which are classified that way 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.

Reduced health care costs are the primary advantage to using network doctors and hospitals. Because services are provided at discounted rates, your out-of-pocket costs – the amounts you have to pay – are lower than they would otherwise be. You only have to pay the difference between Plan benefits and the provider's discounted rate. For treatment by a non-network provider, you pay the difference between Plan benefits and the provider's billed charge.

Medically Necessary Care and Treatment

Medically necessary care and treatment means services, supplies, or places where treatment is received which:

- Are consistent with and effective for the injury or sickness being treated;
- Constitute good medical practice according to professional standards recognized by the organized medical community in the United States; and
- Are neither experimental, investigational, 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, any determinations of medical necessity pertaining to mastectomies and associated reconstructive treatment shall be deemed to be satisfied if allowable charges for covered expenses are incurred as a result of treatment determined in consultation between the person and her doctor.

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

Treatment by Network or Non-Network Doctors and Hospitals

For benefit purposes, the Plan distinguishes between treatment by network providers and treatment by non-network providers. Treatment by non-network providers is generally reimbursed at lower levels.

Benefits for services by doctors specializing in emergency medicine, radiology, anesthesiology, or pathology, as well as in-hospital consultations furnished by non-network physicians, will be paid at the percent applicable to network providers. However, allowable charges will be determined according to the doctor's network or non-network status.

In addition, benefits for covered treatment by a non-network provider are payable at the percent applicable to network providers if:

- There is no network provider available in the required speciality; or
- Emergency medical treatment is required. (*Emergency medical treatment means medical services within 24 hours after the onset of injury or sickness reasonably expected to cause serious physical impairment or death.*)

Definition of Doctor

Doctor means a person who is licensed to practice medicine and surgery as a Doctor of Medicine (MD) or Osteopathy (DO), or a person who is a licensed Dentist (DDS or DMD), Podiatrist, Chiropractor, Optometrist, or Ophthalmologist practicing within the scope of his or her license.



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COMPREHENSIVE MAJOR MEDICAL BENEFITS

To help get the most for your health care dollar, UNITE HERE HEALTH has contracted with the BlueCross and BlueShield of Illinois National Network (BCBS) so you and your covered dependents can receive medical and surgical services from area hospitals and doctors participating in the BCBS Network.

**To find medical or surgical network providers, call the
BlueCross and BlueShield Provider Locator toll free
(800) 810-BLUE (2583)**

or visit them online at www.bcbsil.com

What the Plan Pays

For benefit purposes, the Plan distinguishes between network and non-network services. The highest level of medical and surgical benefits is only available for treatment by providers participating in the BCBS network; a lower level of benefits applies to covered treatment administered by a non-network provider.

For covered services furnished by a network provider, the Plan pays:

- 100% after a \$20 copayment (Alternate Plan I) or a \$30 copayment (Alternate Plan II), for primary care doctor office visits;
- 100% after a \$30 copayment (Alternate Plan I) or a \$45 copayment (Alternate Plan II), for specialist office visits, not including office visits for chiropractors or podiatrists;
- 100% after a \$30 copayment (Alternate Plan I) or a \$45 copayment (Alternate Plan II), for chiropractic visits; up to a combined network/non-network calendar year maximum of \$1,000;
- 100% after a \$20 copayment (Alternate Plan I) or a \$30 copayment (Alternate Plan II), for Home Health Care, up to a combined network/non-network calendar year maximum of 60 visits;

For California residents, BlueCross and BlueShield of Illinois contracts with Blue Cross of California.

Blue Shield of California providers will be treated as non-network providers for purposes of determining Comprehensive Major Medical Benefits.

See the *Benefits at a Glance* on pages 12-13 (Alternate Plan I) and 14-15 (Alternate Plan II) summarizing the percent of allowable charges the Plan pays.

- 100% after a \$20 copayment (Alternate Plan I) or a \$30 copayment (Alternate Plan II), for mammography, subject to frequency limitations;
- 100% after a \$20 copayment (Alternate Plan I) or a \$30 copayment (Alternate Plan II) for primary care doctors (a \$35 copayment (Alternate Plan I) or a \$45 copayment (Alternate Plan II) for specialists) for routine physical examinations,
- 100% for flu shots after a \$20 copayment (Alternate Plan I) or a \$30 copayment (Alternate Plan II) for primary care doctors (a \$35 copayment (Alternate Plan I) or a \$45 copayment (Alternate Plan II) for specialists);
- 100% for Preventive Health Care Services as follows:
 - Prostate screening,
 - Pap tests,
 - Well baby/well child care,
 - Immunizations other than flu shots;
- 100% of the covered services of a certified diabetes educator;
- 100% of the covered services of a registered dietitian;
- 100% after a \$20 copayment (Alternate Plan I) or a \$30 copayment (Alternate Plan II) copayment, for outpatient covered services at an urgent care center;
- 100% after a \$20 copayment (Alternate Plan I) or a \$30 copayment (Alternate Plan II) for a primary care doctor (a \$30 copayment (Alternate Plan I) or a \$45 copayment (Alternate Plan II), copayment for a specialist) for routine hearing examinations at a doctor's office;
- 100% after a \$20 copayment (Alternate Plan I) or a \$30 copayment (Alternate Plan II), for a primary care doctor (a \$30 copayment (Alternate Plan I) or a \$45 copayment (Alternate Plan II) copayment for a specialist) for outpatient mental health visits;
- 100% after a \$20 copayment (Alternate Plan I) or a \$30 copayment (Alternate Plan II), for a primary care doctor (a \$30 copayment (Alternate Plan I) or a \$45 copayment (Alternate Plan II) copayment for a specialist) for outpatient substance abuse visits;
- After satisfaction of the applicable calendar year deductible requirements, the Plan pays for all other covered expenses as follows:
 - 80% after a \$100 copayment, for emergency medical treatment in a hospital emergency room;
 - 50% after a \$100 copayment, for non-emergency medical treatment in a hospital emergency room; and
 - 80% for all other covered services.

For covered services furnished by a non-network provider, the Plan pays as shown below, after satisfaction of the applicable calendar year deductible requirements:

- 80% after a \$100 copayment, for emergency medical treatment in a hospital emergency room;
- 50% after a \$100 copayment, for non-emergency medical treatment in a hospital emergency room.
- 80% for the professional services of radiologists, anesthesiologists, pathologists, emergency medicine doctors;

- 80% for hospice covered services;
- 50% for durable medical equipment; and
- 60% for all other covered services.

What You Pay

You are responsible for paying the calendar year deductible, if applicable, any required copayments, any portion of allowable charges the Plan doesn't pay, any amount over the maximum benefits, and any services or supplies that are not covered by the Plan.

- For treatment by a network provider, you are only responsible for paying the difference between the applicable Plan benefit and the provider's contracted fee.
- For treatment by a non-network provider, you are responsible for paying the difference between the applicable Plan benefit and the provider's billed charge. This can be a substantial amount.

Copayments

A copayment is the amount you must pay at the time certain treatment is received. However, any copayment required for hospital emergency room treatment will be waived if the person is immediately thereafter admitted to the hospital.

For maternity care furnished by a network provider, a copayment will only apply to the first office visit.

Out-of-pocket Spending Limit

The Plan's out-of-pocket spending limit for covered services furnished by network providers is \$2,000 per person (Alternate Plan I) and \$3,000 per person (Alternate Plan II) and \$6,000 per family (Alternate Plan I) and \$9,000 per family (Alternate Plan II). The Plan's out-of-pocket spending limit for covered services furnished by non-network providers is also \$2,000 per person (Alternate Plan I) and \$3,000 per person (Alternate Plan II) and \$6,000 per family (Alternate Plan I) and \$9,000 per family (Alternate Plan II). Once the applicable limit is reached, benefits for that person will be paid at 100% for the rest of that calendar year for certain covered services furnished by a network provider and 80% for certain covered services furnished by a non-network provider.

The following amounts will not be used to satisfy an out-of-pocket spending limit:

- Charges reimbursed at 100%;
- Charges for services or supplies not covered by the Plan or that exceed Plan limitations or maximums; and
- Non-emergency treatment in a hospital emergency room.

About the Deductibles

Before any Comprehensive Major Medical Benefits are paid for certain kinds of covered services, you pay a portion of the allowable charges incurred each calendar year. The portion you pay is called the deductible. However, copayments can not be used to meet the deductible.

The deductible that applies to you and each covered dependent every calendar year for covered services furnished by network providers is \$350 per person (Alternate Plan I) and \$500 (Alternate Plan II). The deductible that applies to you and each covered dependent every calendar year for covered services furnished by non-network providers is also \$350 per person (Alternate Plan I) and \$500 (Alternate Plan II).

However, the deductible does not apply to the following covered services furnished by network providers:

- Office visits,
- Covered preventive health care services other than routine colonoscopies,
- Home health care,
- Diabetes education,
- Nutrition education; and
- Routine hearing examinations conducted in the doctor's office; and

Family Deductible Limit

The family deductible limit that applies to you and each covered dependent every calendar year for covered services furnished by network providers is \$2,000 (Alternate Plan I) and \$1,500 (Alternate Plan II). The family deductible limit that applies to you and each covered dependent every calendar year for covered services furnished by non-network providers is also \$2,000 (Alternate Plan I) and \$1,500 (Alternate Plan II). Once the applicable limit is reached, no further deductible will be required for covered services for the class of provider for which the limit is reached for the rest of that calendar year.

Lifetime Maximum Benefit

The maximum amount of Comprehensive Major Medical Benefits the Plan will pay during a person's lifetime for combined network and non-network covered services is \$1,000,000. Once this maximum amount is reached, no further Comprehensive Major Medical Benefits for covered services can be paid.

What's Covered

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

- **Hospital charges** for:
 - Room and board, and
 - Other inpatient or outpatient services actually administered by the Hospital;
- Professional medical and surgical **services of a physician**, other than a podiatrist or a chiropractor, provided that:
 - if more than one surgical procedure is performed through the same incision or natural body orifice during the same operative session, covered expenses will be limited to the allowable charge for the major operation plus up to 50% of the allowable charge for each additional operation of lesser value, and
 - covered expenses shall not include incidental procedures performed through the same incision during the same operative session;

- **Chiropractic care**, including x-rays, up to a combined calendar year maximum of \$1,000 for network/non-network services;
- **Outpatient rehabilitation** services by a licensed therapist for physical, occupational, and speech therapy for the restoration of speech lost as the result of injury or sickness, other than speech therapy services for dependent children described below, up to a combined network/non-network 60-visit per calendar year maximum;
- **Speech therapy services** furnished by a licensed speech therapist for dependent child speech therapy services, up to a maximum calendar year benefit of \$2,500, for:
 - Screening, detection, and treatment of autism, including Pervasive Developmental Disorders, and Asperger's,
 - Restoration or improvement of speech for speech-language and developmental delay disorders that are a result of a non-chronic sickness, intra-uterine trauma, hearing loss, difficulty swallowing, or acute sickness or injury, and
 - Treatment of speech delay that is associated with a specifically diagnosable disease, injury, or congenital defect, such as cleft lip and palate;
- **Home health care services**, including infusion therapy, but excluding general housekeeping services or custodial care, up to a combined network/non-network 60-visit per calendar year maximum;
- **Surgical supplies and dressings**, including casts and splints, prostheses, braces, canes, crutches, and trusses;
- **Anesthesia** and its administration;
- **Blood** and blood plasma and their administration;
- **Oxygen** and rental equipment for its administration;
- **X-rays and laboratory** examinations;
- **Chemotherapy and radiotherapy**;
- Transportation by a **professional ambulance** service to an area medical facility equipped to provide the required treatment, including such transportation when a person has no control over the circumstances under which the ambulance is called;
- **Pregnancy** and pregnancy-related conditions including childbirth, miscarriage or abortion for female employees, male employees' covered spouses;
- **Sterilization** for participants or covered spouses;
- Treatment of **mental health conditions**, provided that:
 - Treatment is rendered by psychiatrists, psychiatric nurses, masters degreed social workers, or clinical psychologists,
 - Inpatient treatment, in addition to hospitalization, encompasses:
 - residential care, i.e. confinement less restrictive than hospitalization but which provides 24-hour supervision and monitoring by the nursing staff and intensive psychiatric interventions more frequently than once each day, and
 - partial hospitalization, i.e. less restrictive than residential care but which requires nursing supervision and monitoring during confinements of at least 3 but less than 24 hours of each day, 5 days a week, and intensive psychiatric interventions;

With respect to ambulance service, the Plan's requirement that treatment or services be medically necessary will be met when a person has no control over the circumstances under which an ambulance is called, such as when an ambulance is called by a physician, nurse, or other medical professional; an employer; a law enforcement officer; or a school or other institution.

- **Skilled nursing facility** accommodations, up to a combined total of 120 days per calendar year for network and non-network treatment, provided that a doctor certifies that confinement is necessary for the treatment of the same injury or sickness treated in the immediately preceding hospitalization;
- Treatment of **substance abuse**, provided that:
 - Treatment is rendered by a doctor, a licensed chemical dependency therapist, masters degree social workers, or clinical psychologists,
 - Inpatient treatment, including partial hospitalization, i.e. treatment less restrictive than hospitalization but which requires nursing supervision and monitoring during confinements of at least 3 but less than 24 hours of each day, 5 days a week, with intensive psychiatric interventions;
- **Jaw reduction**, open or closed, for a fractured or dislocated jaw;
- **Repair of sound natural teeth** and their supporting structures, if the expense is incurred as a result of an injury and the treatment is received while covered under this Plan and within six months of the injury;
- **Tumors, cysts and lesions**; except non-malignant tumors, cysts and lesions of the mouth 1.25 cm. or smaller are not covered;
- **Ambulatory surgical facility services**, including general supplies, anesthesia supplies, medications, and operating and recovery rooms, but excluding professional services for surgical procedures not normally performed in the physician's office. However, if multiple surgical procedures are performed, covered expenses for allowable charges by an Ambulatory Surgical Facility shall be limited to such charges for the primary procedure only;
- Medical services for the following **organ transplants**: bone marrow, cornea, heart, heart/lung, kidney, liver, pancreas/kidney, provided that:
 - Benefits for donor expenses are only available to the extent that the donor has no other coverage, and
 - No benefits are provided if you or a covered dependent are a donor;
- **Hospice services** and supplies authorized by a physician for a person whose life expectancy is six (6) months or less, up to a combined total of 210 days per calendar year for network and non-network treatment, including an additional 5 days for bereavement counseling;
- The following **preventive health care services**, but **only** when furnished **by network providers**:
 - One routine gynecological examination, including a pelvic examination and pap smear, each calendar year for covered females age 16 or older,
 - Well baby/well child examinations up to age 6 performed according to the guidelines established by the American Academy of Pediatrics and the American Academy of Family Practitioners,
 - Flu shots and immunizations performed according to the guidelines established by the American Academy of Pediatrics and the American Academy of Family Practitioners,

- Routine mammography when performed according to the following frequencies:
 - 1 at age 40,
 - 1 every 2 years from ages 41-50, and
 - 1 each year after age 50,
- Routine prostate examinations when performed according to the following frequencies:
 - 1 at age 40,
 - 1 every 2 years from ages 41-50, and
 - 1 each year after age 50,
- Routine physical examinations, not otherwise covered above, limited to one such examination every year, conducted in the physician's office, and including a blood chemistry profile, EKG, and chest x-ray;
- **Routine outpatient colonoscopies** for early detection of colorectal cancer, but only when performed according to the following frequencies:
 - Once every ten years for persons of average risk for colon cancer, beginning at age 50 or older, and
 - Once every two years for persons diagnosed by his treating physician as high risk for colon cancer because of medical history of immediate family members,
- **Surgical services** for mastectomy (the excision of all or a portion of the breast, including removal of chest muscle and lymph nodes if required) including:
 - Reconstruction of the breast upon which the mastectomy is performed,
 - Surgical treatment of the other breast to produce a symmetrical appearance,
 - Breast implants, and
 - Treatment of physical complications resulting from a mastectomy, including lymphedema.

Moreover, any Plan requirements pertaining to "medically necessary treatment" shall be deemed to be satisfied if allowable charges for covered expenses are incurred as a result of treatment determined in consultation between the person and her physician;

- General or private duty **nursing services** performed by a registered graduate nurse (RN) or licensed practical nurse (LPN), and other specialized services performed by a Certified Registered Nurse Anesthetist (CRNA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), and Certified Nurse Midwife (CNM);
- **Lancets, glucose test strips, and glucometers;**
- **Facility charges by a clinic** when a physician also bills for an office visit in conjunction with the clinic visit;
- Professional services of a **Certified Registered Nurse First Assistant** (CRNFA) within the scope of his or her license, up to 20% of the surgeon's allowable charge, provided the CRNFA, under applicable State law, is allowed to bill for such professional services on his or her own behalf;

- **Dental procedures**, for treatment otherwise covered under a Plan's dental benefit provisions, requiring an institutional setting to safely administer such treatment to persons with medical or behavioral conditions that severely limit the person's ability to cooperate in the provision of medically necessary care, or to prevent severe physical impairment that might be reasonably anticipated in the absence of such treatment, covered expenses under a Plan's medical benefit provisions shall include allowable charges made:
 - By a facility in which such dental treatment is furnished, including such charges for anesthesia and other ancillary services, and
 - For the administration of anesthesia by an anesthesiologist;
- Professional services of a network, licensed **certified diabetes educator** pertaining to education or training for the care, monitoring, or treatment of diabetes, up to a maximum benefit per person each calendar year of \$200;
- Professional services of a network, licensed **registered dietitian**, up to a maximum benefit per person each calendar year of \$200;
- Professional services of a podiatrist for **non-routine podiatry**, but if more than one surgical procedure is performed during the same operative session, covered expenses will be limited to the allowable charge for the major procedure plus up to 50% of the allowable charge for each additional procedure of lesser value performed on the same foot;
- Outpatient **cardiac therapy**, up to a combined network/non-network maximum of 36 visits per episode;
- Outpatient **sleep studies**;
- Outpatient **transfusion services**, including services at a hemophilia center;
- **Urgent care center** services;
- **Routine hearing examinations** in a doctor's office, but only when conducted by a network provider;
- **Acupuncture services**, but only when furnished by a MD or DO;
- **Durable medical equipment** for all non-disposable, medically necessary devices or items prescribed by a physician, 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 that are:
 - primarily and customarily used for, or in the furtherance of, the treatment or monitoring of injuries or sicknesses,
 - capable of withstanding repeated use,
 - helpful in improving the overall medical care of a patient in an outpatient setting, or
 - approved for payment under Title XVIII of the United States Social Security Act of 1965, as amended (Medicare).

Rental fees will qualify as covered expense if the DME is only available for rental, and purchase prices will qualify as covered expense if the DME is only available for purchase.

However, if DME can be either rented or purchased at the option of the participant, and if the rental fees for the prescribed course of treatment are expected to exceed the equipment's purchase price, the Fund may limit covered expense to the equipment's purchase price.

Whether DME is rented or purchased, benefits will be determined when allowable charges are actually incurred. If DME is purchased, subsequent costs for repair or maintenance are also considered covered expenses.

What's Not Covered

In addition to the Plan's *General Exclusions and Limitations* (see pages 49-50), no Comprehensive Major Medical Benefits will be provided for:

- Ambulatory surgical facility fees for procedures normally performed in a doctor's office;
- Prescription drugs, other than those consumed or administered at the place where they are dispensed;
- Cosmetic, plastic, or reconstructive surgery, unless that surgery is for:
 - the correction of injuries sustained in an accident and occurs within 24 months after the accident, or
 - breast reconstruction following a mastectomy;
- To the extent of any penalty assessed for any treatment or services requiring the medical management program, when this mandatory program is not used as required;
- Birth control devices;
- Any elective procedure, except sterilization or abortion, that is not for the correction or cure of bodily injury or sickness. If there is a question as to the elective nature of the procedure, the decision of the Trustees will be final;
- Procedures for the reversal of voluntary sterilization;
- Treatment for or in connection with infertility; unless specifically listed as covered by the Plan;
- Sex transformation;
- Any services or supplies for or in connection with the treatment of teeth, natural or otherwise, and supporting structures, unless specifically covered by the Plan;
- Any services or supplies for or in connection with the treatment of teeth, natural or otherwise, and supporting structures, except charges made by a hospital, or other facility, for dental procedures covered under the Plan's Dental Benefit provisions (see pages 41-45) when those procedures are for the treatment of a person suffering from medical or behavioral conditions, such as autism or Alzheimer's, that either:
 - severely limit the person's ability to cooperate with the dentist attempting to provide the necessary care, or
 - prevent treatment of a dental condition that can reasonably be expected to result in severe physical impairment if not treated in an institutional setting;

See pages 35-40 for information about Prescription Drug Benefits.

Cosmetic or Reconstructive Surgery is any surgical procedure performed primarily:

- to improve physical appearance,
- to change or restore bodily form without materially correcting a bodily malfunction, or
- to prevent or treat a Mental or Nervous Disorder through a change in bodily form.

See pages 41-45 to find more information about your Dental Benefits.

- Surgery to modify jaw relationships including, but not limited to, LeFort-type operations, osteoplasty, and genioplasty procedures;
- Hospital charges for personal comfort items, including but not limited to telephone, television, cosmetics, guest trays, magazines, and bed or cots for family members or other guests;
- Supplies or equipment for personal hygiene, comfort or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, home traction unit, tanning bed, or water bed;
- Home construction for any reason;
- Any expense or charge by a rest home, old age home, or a nursing home;
- Any charges incurred while confined in a hospital, nursing home, or other facility or institution, or portions thereof, which are primarily for education, training, or custodial care;
- Weight loss programs, unless for the treatment of morbid obesity under the direct supervision of a doctor;
- Smoking cessation programs, or any treatment, drug, or device to assist in the cessation of smoking;
- Eye examinations or hearing examinations, unless specifically included as a covered expense, or unless such examinations are made for the diagnosis or treatment of accidental bodily injury, and the examinations are made within 12 months after the date of the accident and while still covered under the Plan;
- Eye refractions, eyeglasses, or contact lenses, unless specifically covered by the Plan; or
- Hearing aids.



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PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are provided under a contract between UNITE HERE HEALTH and Catalyst Rx, a national pharmacy benefit management company. Benefits are only available for prescription drugs purchased at a Catalyst Rx network pharmacy.

To find a participating pharmacy, call

Catalyst Rx toll free

(866) 884-4176

or visit Catalyst Rx online at www.catalystrx.com

What You Pay

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

- **\$10 for generic drugs** and generic disposable insulin syringes and needles; and generic lancets;
- **\$30 for:**
 - brand-name drugs on the Catalyst Rx Formulary,
 - Formulary insulin,
 - Formulary disposable insulin syringes and needles,
 - Formulary brand-name test strips for diabetes (such as Roche Accu-Chek®, and Bayer Ascensia®) and lancets; and
- **50% of the cost, but not more than \$100 per prescription, for brand-name drugs not on the Catalyst Rx Formulary** for which there are no generic equivalents, non-formulary disposable insulin syringes and needles, non-formulary lancets, and non-formulary test strips.

You now have access to more than 55,000 retail pharmacies nation wide and over 20,000 independent community pharmacies and regional chains.

The **Formulary** is a list of safe, effective, high-quality brand-name drugs that do not have generic equivalents; and certain supplies. Items listed in the formulary are subject to change. You will be notified as changes occur.

Free Flu Inoculations at Catalyst Rx Network Pharmacies

Inoculations against influenza are provided free of charge to you and your covered dependents when obtained at Catalyst Rx network pharmacies offering inoculation services.

Benefits include the cost of administration.

The availability of inoculations for covered dependent children is subject to certain age restrictions imposed by state or federal law.

When you have a covered prescription filled at the mail order pharmacy, the Plan pays 100% of allowable charges after you pay:

- **\$20** per prescription **for generic drugs;**
- **\$60** per prescription **for brand-name drugs on the Catalyst Rx Formulary;** and
- **50% of the cost, but not more than \$200 per prescription, for brand-name drugs not on the Catalyst Rx Formulary** for which there are no generic equivalents, non-formulary disposable insulin syringes and needles, non-formulary lancets, and non-formulary test strips:

Generic Drug Policy

If you or your doctor insist on a brand-name drug when a generic equivalent is available, you must pay the difference between the cost of the brand-name drug and the Fund's cost of the generic equivalent. *For example, if the cost of the brand-name drug is \$80 and the Fund's cost for the generic equivalent is \$30, you must pay \$50.*

However, the following drugs are exempt from the Generic Drug Policy because they require intensive monitoring and very small changes in dosage levels could have toxic effects:

- Synthroid, Levothroid, Levoxyl;
- Lanoxin;
- Uniphyl, Theo-24;
- Dilantin;
- Zarontin; and
- Coumadin.

Under certain other limited circumstances, Catalyst Rx may override the Plan's generic substitution rule and allow a brand name drug when:

- A person's medical condition has been effectively stabilized using a brand-name drug before a generic equivalent became available; and
- The brand-name drug is being used to treat medical conditions:
 - in which variance in blood serum medication levels could have potentially life threatening consequences or pose an imminent threat to the person's well being, and
 - for which, in the professional clinical judgment of Catalyst Rx, there is not enough medical evidence to conclude that stabilized patients can change to the generic equivalent without an unacceptable level of risk.

When this happens, you only have to pay the applicable brand name copayment.

What's Covered

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

- Drugs, medications which may only be lawfully obtained upon the written prescription of a doctor, including oral and injectable contraceptives, vitamins, minerals and medications mixed to order by a pharmacist, if they contain at least one medicinal substance and one prescription drug;

- Insulin and diabetic test strips;
- Disposable syringes and needles, and lancets; and
- Inoculations against influenza and associated professional fees.

Drugs Requiring Pre-authorization

The following drugs require pre-authorization by the Fund:

- Crinone, regardless of the form administered;
- Oxycontin;
- Palladone;
- Retin-A or Avita for persons over age 30;
- Proton pump inhibitors (prescription drugs used to treat heartburn, acid reflux, gastroesophageal reflux disease, and ulcers);
- Certain oral and injectable specialty drugs covered under the Catalyst Rx Specialty Drug Management Program (for more information, contact Catalyst Rx or the Fund Office);
- Sensipar;
- Restasis;
- Selzentry;
- Vfend;
- Provigil;
- Butorphanol nasal spray, Onsolis;
- Celebrex;
- Flector, Voltaren gel;
- Penlac;
- Regranex; and
- Emend, Zuplenz, Sancuso Patch.

Prescription drugs for the treatment of male impotence must also be pre-authorized by the Fund.

- The covered person must be a male at least 18 years old and be diagnosed as having either organic or non-organic erectile dysfunction. The diagnosis of organic dysfunction must be made by a urologist; a psychiatrist must make the diagnosis if the dysfunction is non-organic.
- Prescriptions may not exceed amounts necessary to provide six applications each month and the first prescription may not exceed a three-month supply.
- Refill prescriptions for erectile dysfunction (ED) medications may be written by either a person's treating physician (a urologist or psychiatrist), or by the person's primary care physician. However, refills authorized by the person's primary care physician will only be allowed during a 12-month period beginning with the date of the initial evaluation or subsequent re-evaluation by the treating urologist or psychiatrist.

The active ingredient in Retin-A is tretinoin, the same active ingredient found in two other acne medications, Avita and Renova. Of these three brand name drugs, only Renova is used for strictly cosmetic reasons and continues to be excluded by the Plan.

In general, pre-authorization for Proton Pump Inhibitors involves the use of step therapy, a process whereby a person using a brand name medication may be required to try a generic medication or over-the-counter medication, such as Zantac, Axid, Tagamet, or Pepcid, before benefits will be available for the brand-name medication.

In addition, pre-authorization is required for any prescription drug that the U.S. Food and Drug Administration has taken regulatory action against in the form of requiring the drug's manufacturer to submit a Risk Evaluation and Mitigation Strategy.

Mail Order Refills

If you or your covered dependents need maintenance drugs or other prescription drugs that are taken over a long period of time, those prescriptions may be refilled by mail order. When you refill a prescription by mail order, you pay only one mail order copayment instead of three retail copayments for a 90-day supply (12 applications for treatment of male impotency). **Catalyst Rx's mail service is provided through** their mail service program **Immediate Pharmaceutical Services, Inc. (IPS)**. **For more information** about the mail service, **call IPS at (800) 763-0044**.

Dispensing Limitations

Each prescription and refill is limited to a 34-day supply. However:

- Prescriptions for treatment of male impotency are limited to 6 applications per month; and
- Prescription refills obtained through the Catalyst Rx mail-service shall not exceed a 90-day supply. However, any prescription for treatment of male impotency shall be limited to 12 applications per month;
- Prescriptions only available in 90-day supplies shall be subject to copayments equal to three times the applicable copayment if filled or refilled at a retail network pharmacy or the applicable mail order copayment if refilled under the Catalyst Rx mail-service;
- Smoking cessation products are limited as follows:
 - Chantix® is limited to 6 months of therapy per calendar year;
 - Other prescription products or over-the-counter products are limited to 12 weeks of therapy per calendar year.

A prescription cannot be refilled until at least 75% of the existing supply is used, unless a refill after some lesser amount has been pre-authorized by the Fund.

In the case of foreign travel, a prescription may be refilled early, but only for a period of time not to exceed the person's eligibility for benefits.

What's Not Covered

In addition to the Plan's *General Exclusions and Limitations* (see pages 49-50), no Prescription Drug Benefits are provided for:

- Drugs, other than insulin, that do not have a label that reads "Caution: Federal Law prohibits dispensing without a prescription";
- Experimental or investigational drugs;
- Birth control devices;
- Fertility drugs;
- Prescriptions or refills exceeding the applicable dispensing limitations;

Effective May 1, 2011, Catalyst Rx's mail service will be provided by Catalyst Mail. Call Catalyst Mail toll free at (866) 814-7105 for more information.

Free Glucometers

To get your free glucometer, simply call Global Medical Direct (800) 505-1623

New glucometers will not be available more often than once every 12 months.

Glucometers are not available under the Prescription Drug Benefit. If you don't want one of the free glucometers, you must pay the full cost and then submit a claim under the Plan's Comprehensive Major Medical provisions. Benefits, if any, are subject to the Plan's deductible and coinsurance requirements.

- Over-the-counter vitamins or dietary aids or supplements;
- Non-sedating antihistamines;
- Rogaine and other drugs to prevent hair loss;
- Medication consumed or administered at the place where it is dispensed;
- Diagnostics or biologicals other than thyrogen;
- Drugs used for cosmetic reasons;
- Human growth hormone, except when used in the treatment of emaciation connected with AIDS; and
- Covered expenses not purchased from a network pharmacy.

Processing Requests for Pre-authorization

In general, Catalyst Rx must process requests for pre-authorization as soon as possible, but no later than 15 days from the date the prescription is presented at a network pharmacy, 72 hours in the case of emergency treatment/urgent care.

If More Time Is Needed

However, the 15-day period may be extended by another 15 days if necessitated by matters beyond Catalyst Rx's control, including the failure to submit information sufficient to pre-authorize the prescription. If an extension is required, you will be notified before the end of the 15-day period of the reasons for the extension and when a decision can be expected.

In the case of emergency treatment/urgent care you will be notified within 24 hours if more information is required to pre-authorize the prescription.

If Additional Information Is Needed

Generally, requested information must be submitted no later than 45 days after the request is received. The 15-day period for processing will be suspended from the date the notification of extension is sent until the date Catalyst Rx receives a response. Failure to provide any required information within 45 days will result in the denial of the requested pre-authorization. In the case of emergency treatment/urgent care you have no less than 48 hours to provide any required information. Catalyst Rx will then notify you of its determination as soon as possible, but no later than 48 hours after the receipt of the requested information.

If a Request for Pre-authorization Is Denied

If a request for pre-authorization is denied, the claimant will receive a written denial, containing:

- The specific reasons certification of benefits was denied;
- The specific provisions of the Plan supporting the denial;
- A description of what additional information, if any, may allow benefits to be certified; and
- An explanation of the appeal process.

The denial will also describe the rights to obtain a copy of any policy or other administrative criteria used to deny pre-authorization. If Catalyst Rx relied on medical judgment in reaching its decision, the denial will describe the rights to obtain an explanation of the sci-

entific or clinical judgment used and its applicability to the request for certification. The denial will also describe the right to bring legal action if the denial is upheld upon appeal.

Appealing the Denial of a Request for Pre-authorization

All appeals for denied pre-authorizations must be made within 12 months of the date of denial to:

The Appeals Subcommittee

UNITE HERE HEALTH

711 N. Commons Dr.

Aurora, Illinois 60504-4197

Appeals, other than those involving requests for urgent care, must be in writing, signed, and should include the claimant's name, address, date of birth, and the participant's Social Security number. Documents or records that support certification of benefits should also be included.

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



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DENTAL BENEFITS

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

Dental Benefits are self-funded, which means that all benefits will be paid directly from the Fund. However, Connecticut General Life Insurance Company (Connecticut General, also known as CIGNA), provides claim administration services and access to the dentists in the CIGNA Dental Core Network.

Benefits distinguish between network and non-network services. The highest level of benefits applies to covered services furnished by CIGNA Dental Core Network providers. The highest amount of out-of-pocket cost results from treatment by non-network providers. The difference between network and non-network benefits is significant.

To locate a network provider near you, call

CIGNA Dental

toll free

(800) 244-6224

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

What the Plan Pays

The Plan pays the benefits highlighted below for covered services furnished by a dentist during a calendar year up to \$1,500 for network providers and \$1,000 for out-of-network providers. In addition, the Plan provides lifetime benefits of \$1,500 for orthodontia services for dependent children under age 19.

Certain services are subject to a calendar year deductible.

Payments for orthodontic treatment are made in installments every three months. The first payment is equal to 25% of the allowable charge for the entire course of treatment; later payments are prorated over the estimated length of treatment and are paid at the end of each three-month period. If coverage ends or treatment ceases, payment for the last three-month period will be prorated.

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

DENTAL BENEFITS

Allowable Charges

An allowable charge is the amount upon which benefits are based for covered treatment, services, or supplies. The Board of Trustees has the sole authority to determine the level of allowable charges the Plan will use, and in all cases, the Trustees' determination will be final and binding. For services furnished by network providers, allowable charge means the rate specified in the contract between UNITE HERE HEALTH and the applicable provider network. The Plan will not consider any amount exceeding the allowable charge for a particular service or supply.

Claims for dental services should be sent to:

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

Description of Services	CIGNA Dental Core Network Dentists	Non-Network Dentists
Diagnostic & Preventive Services	100%	100%
Diagnostic X-Ray Services	100%	100%
Basic Restorative Services	50%	50%
Major Restorative Services	50%	50%
Orthodontic Services	50%	50%

What You Pay

You are responsible for paying the calendar year deductible, if applicable, any portion of allowable charges the Plan doesn't pay, any amount over the maximum benefits, and any expenses that are not covered by the Plan.

- For treatment by a network provider, you are only responsible for paying the difference between the applicable Plan benefit and the provider's contracted fee.
- For treatment by a non-network provider, you are responsible for paying the difference between the applicable Plan benefit and the provider's billed charge. This can be a substantial amount.

About the Deductibles

Before any Dental Benefits are paid for Basic or Major Restorative Services, you pay a portion of the allowable charges incurred each calendar year. The portion you pay is called the deductible.

The deductible that applies to you and each covered dependent every calendar year is \$50.

Family Deductible Limit

Once you have paid at least \$150 towards the calendar deductibles for you and your covered dependents, no further deductible amounts will be required for the rest of that year.

Alternate Course of Treatment

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

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

What's Covered

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

■ Class I Services: Diagnostic and Preventive

- clinical oral examination, limited to two such examinations per person each calendar year,
- prophylaxis, limited to two per person each calendar year,
- topical application of fluoride (excluding prophylaxis); limited to persons under age 19 and no more than one per person each calendar year,
- bitewing x-rays, limited to two per person each calendar year,
- full mouth or Panoramic (Panorex) x-rays, limited to one per person in any three calendar years,
- palliative treatment for dental pain, including minor procedures, when no other definitive dental services are performed, provided that x-rays taken in connection with such treatment shall be treated as a separate dental service,
- topical application of sealant per tooth on a posterior tooth; limited to persons under age 14 and no more than one treatment per tooth in any three calendar years,
- space maintainers (fixed unilateral); limited to non-orthodontic treatment,
- histopathologic examinations.

■ Class II Services: Basic Restorations

- fillings,
- oral surgery:
 - simple extractions.
 - other than simple extractions,
- surgical extraction of impacted teeth,
- anesthesia,
- minor and major periodontic procedures,
- root canal therapy,
- relines, rebases, and adjustments to dentures,
- repairs to bridges, crown, and inlays,

■ Class III Services: Major Restorations

- crowns,
- dentures:
 - complete (full) dentures, upper or lower,
 - partial dentures,
- fixed appliances:
 - bridge pontics,
 - retainer crowns,
 - recement bridge.

- **Class IV Services: Orthodontic Services**

- orthodontic work-up, including x-rays, diagnostic tests, casts and treatment, and the first month of active treatment, including all active treatment and retention appliances,
- continued active treatment after the first month,
- fixed or removable appliances, but not more than one appliance per Person for tooth guidance or to control harmful habits.

Each month of active treatment is a separate dental service.

What's Not Covered

In addition to the Plan's *General Exclusions and Limitations* (see pages 49-50), no Dental Benefits are provided for:

- Services performed solely for cosmetic reasons;
- Crown restoration services unless the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic, or plastic restoration;
- Flap entry and closure when not performed as part of osseous surgery;
- Replacement of a lost or stolen appliance;
- Replacement of a bridge, crown, or denture within five years after the date it was originally installed, unless:
 - the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of normal teeth, or
 - the bridge, crown, or denture, while in the mouth, has been damaged beyond repair as a result of an injury;
- Any replacement of a bridge, crown, or denture which is or can be made useable according to common dental standards;
- Procedures, appliances, or restorations (except full dentures) whose main purpose is to:
 - change vertical dimension,
 - diagnose or treat conditions or dysfunction of the temporomandibular joint,
 - stabilize periodontally involved teeth, or
 - restore occlusion;
- Porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second, and third molars;
- Bite registrations, precision or semi-precision attachments, or splinting;
- Instruction for plaque control, oral hygiene, and diet;
- Dental services that do not meet common dental standards;
- Services that are deemed to be medical services;
- Services and supplies received from a hospital;

- The surgical placement of an implant body or framework of any type, surgical procedures in anticipation of implant placement, any device, index, or surgical template guide used for implant surgery, treatment or repair of an existing implant, pre-fabricated or custom implant abutments, or removal of an existing implant;
- Treatment in progress before a person's coverage begins, but only to the extent charges for that treatment are incurred before coverage begins;
- Orthodontic services or supplies for any person other than a dependent child under age 19.

If treatment in progress is interrupted and then completed later by another dentist, CIGNA will determine the amount of payment, if any, due each dentist.

Predetermination of Dental Benefits

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

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

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

Dental Benefits After Eligibility Ends

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

However, if coverage ends after covered treatment for crowns, jackets, bridges, complete dentures, or partial dentures begins, benefits for the completion of that treatment will be paid, provided the treatment is completed within 60 days of the date coverage ends.

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

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VISION CARE BENEFITS

Vision Care Benefits are self-funded by UNITE HERE HEALTH. However, UNITE HERE HEALTH has contracted with Davis Vision, Inc. so you and your covered dependents have access to local providers participating in the Davis Vision network.

For benefit purposes, the Plan distinguishes between network and non-network services. Generally, the highest level of benefits applies to covered services furnished by Davis Vision network providers.

To locate a network provider near you, call:

Davis Vision

toll free

(800) 999-5431

or visit them online at www.davisvision.com

What's Covered

The following services and supplies are available to you or a covered dependent when furnished by licensed vision professionals:

- A routine eye examination, including dilation when professionally indicated;
- Spectacle lenses, single vision, bifocal, or trifocal, including:
 - plastic, including tinting, or polycarbonate lenses for dependent children and monocular patients and patients with prescriptions +/- 6.00 diopters or greater,
 - glass, and
 - oversize lenses;
- Frames; and
- Collection contact lenses (soft, daily-wear, disposable, or planned replacement), including evaluation, fitting and follow-up care, in place of eyeglasses. Medically necessary contact lenses are available with prior approval by Davis Vision, Inc. Non-collection contact lenses are also available.

Benefits are available during 12 or 24-month benefit periods, measured from the first day of the month in which the applicable allowable charges are incurred for covered expenses. For example, if covered expenses subject to a 12-month benefit period are first furnished September 20, the 12-month benefit period would begin September 1, and maximum benefits would again be available the following September 1.

What the Plan Pays

- **For Network Services . . .** the Plan pays:
 - ▶ 100% after a \$10 copayment for routine eye examinations, but not more frequently than once during a 12 consecutive month Benefit Period,
 - ▶ 100% after a \$20 copayment for spectacle lenses during a 24 consecutive month Benefit Period,
 - ▶ For frames during a 24 consecutive month Benefit Period:
 - 100% after a \$20 copayment for “fashion level” and “designer level” frames,
 - 100% up to a maximum benefit of \$225 after a \$25 copayment for “premier level” frames, and
 - 100% up to a maximum of \$130, with a 20% discount applicable to any overage, for frames other than fashion level, designer level, or premier level frames,
 - ▶ 100% after a \$10 copayment for collection contact lenses, including evaluation, fitting, and follow-up care,
 - ▶ 100% up to a maximum benefit of \$130, with a 15% discount applicable to any overage, for non-collection contact lenses, including evaluation, fitting, and follow-up care.
- **For Non-network Services . . .** the Plan pays up to:
 - ▶ \$43 for eye examinations, but not more frequently than once during a 12 consecutive month Benefit Period, and
 - ▶ Up to the maximum shown below during a 24 consecutive month Benefit Period as follows:
 - \$45 for frames,
 - \$35 for single vision lenses,
 - \$51 for bifocal lenses,
 - \$68 for trifocal lenses,
 - \$85 for lenticular lenses,
 - \$105 for elective contact lenses, and
 - \$210 for medically necessary contact lenses.

What You Pay

You pay any amounts in excess of what the Plan pays. However, for options and upgrades available at network providers, you only have to pay the amounts shown below:

- \$20 for scratch-resistant coating;
- \$30 for polycarbonate lenses, except that polycarbonate lenses are covered at 100% for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater;
- \$12 for ultraviolet coating;
- \$35 for standard anti-reflective coating;
- \$48 for premium anti-reflective coating;
- \$60 for ultra anti-reflective coating;
- \$50 for standard progressive lenses;
- \$90 for premium progressive lenses;
- \$30 for intermediate-vision lenses;
- \$20 for blended-segment lenses;
- \$55 for high-index lenses;
- \$75 for polarized lenses;
- \$20 for photochromic glass lenses; and
- \$65 for plastic photosensitive lenses.

What's Not Covered

In addition to the Plan's *General Exclusions and Limitations* (see pages 49-50), no Vision Care Benefits are provided for:

- Lens designs or coatings not specifically listed;
- Replacement of lost eyewear;
- Non-prescription lenses;
- Two pairs of spectacle lenses instead of bifocals; or
- Contact lenses and eyeglasses during the same 12-month period.



GENERAL EXCLUSIONS & LIMITATIONS

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

- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a doctor;
- Any injury, sickness, or dental or vision treatment which arises out of or in the course of any occupation or employment, or for which a person has received or is entitled to receive benefits under a workers' compensation or occupational disease law, whether or not application has been made or approved for such benefits;
- Any treatment, services, or supplies:
 - for which no charge is made,
 - for which a person is not required to pay, or
 - which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish, or municipal hospital when there is no legal requirement to pay for such treatment, services, or supplies;
- Any charge which is in excess of the Plan's allowable charge;
- Treatment, services, or supplies not recommended or approved by the attending doctor, or not medically necessary in treating the injury or sickness as defined by the Fund;
- Experimental treatment, or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by the Fund;
- Any expense or charge for failure to appear for an appointment as scheduled, or charge for completion of claim forms, or finance charges;
- Any treatment, services, or supplies provided by an individual who is related by blood or marriage to the employee or dependent, or who normally lives in the employee's home;

For more information about allowable charges, see *How Plan Benefits Are Determined*, pages 23-24.

- Any treatment, services, or supplies purchased or provided outside the 50 United States of America, unless for the treatment of a medical emergency. The decision of the Trustees in determining the emergency will be final;
- Any charges incurred for treatment, services, or supplies as a result of a declared or undeclared war or any act thereof; or any loss, expense or charge incurred while a person is on active duty or in training in the Armed Forces, National Guard, or Reserves of any state or any country;
- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault;
- Any expense greater than the Plan's maximum benefits, or any expense incurred before eligibility for coverage begins or after eligibility terminates, unless specifically provided for under the Plan.



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COORDINATION OF BENEFITS

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

This Plan coordinates benefits with the following types of plans:

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

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

Which Plan Pays First

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

The Plan's Coordination of Benefits provisions only apply to Comprehensive Major Medical Benefits, Dental Benefits, Vision Care Benefits, and Alternative Coverage Benefit, when applicable.

Order of Payment

The general rules that determine which plan pays first are summarized below. Contact the Fund Office if you have any questions.

- Plans that do not contain COB provisions always pay before those that do.
- Plans that have COB and cover a person as an employee always pay before plans that cover the person as a dependent.
- With respect to plans that have COB and cover dependent children of parents who 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 whose parents are separated or divorced:
 - plans covering the parent whose financial responsibility for the child's health care expenses is established by court order pay first,
 - if there's no court order establishing financial responsibility, the plan covering the parent with custody pays first,
 - if the parent with custody has remarried and the child is covered as a dependent under the plan of the stepparent, the order of payment is as follows:
 1. The plan of the parent with custody.
 2. The plan of the stepparent with custody.
 3. The plan of the parent without custody.

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

COB and Precertification

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

Special Rules for Medicare

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

- The Plan is primary for the first 30 months a person is eligible for and entitled to Medicare because of end stage renal disease (ESRD).
- Medicare is primary with respect to any coverage under the Plan provided for a person after employment ends. If a person is entitled to Medicare benefits, but has not enrolled, Plan benefits will be determined as if the person has enrolled in both Medicare Part A (Hospital Benefits) and Part B (Doctor's Benefits).

Husband and Wife or Domestic Partner Employees Under This Plan

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



SUBROGATION

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

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. 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, the Fund 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 the Fund 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 the Fund 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 the Fund 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 the Fund office 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 the Fund 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 the Fund is satisfied.

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 the Fund is entitled to should be reduced, send your written request to:

Subrogation Coordinator

UNITE HERE HEALTH

P.O. Box 6020

Aurora, IL 60598-0020

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ELIGIBILITY FOR COVERAGE

Certain Collective Bargaining Agreements allow employees to refuse coverage by signing a waiver of coverage form. Special rules govern how and when coverage becomes effective after a waiver is revoked. Contact customer service for more information.

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

When Your Coverage Begins

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 the Fund on your behalf.
- **Coverage Period** means the calendar month for which coverage is in force as determined by the corresponding Work Period.
- **Lag Period** means the calendar month between the end of a Work Period and the beginning of the corresponding Coverage Period.

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 maintain eligibility when you continue to meet work requirements specified in your Collective Bargaining Agreement during the corresponding Work Periods.

For purposes of continuing eligibility:

- **Work Period** means a calendar month for which your employer must make a contribution to the Fund on your behalf.
- **Coverage Period** means the calendar month during which coverage is in force as determined by the corresponding Work Periods.
- **Lag Period** means the calendar month between the end of a Work Period and the beginning of the corresponding Coverage Period.

Example - Continuing Eligibility

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

Suppose you became initially eligible October 1 because your employer was required to make contributions on your behalf for the August work period. If a contribution is required on your behalf for September, coverage will be continued for the November Coverage Period. A contribution for October will continue coverage for December, November will continue coverage for January, and so on.

Self-payments During a Work Place Closing

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

Self-payments During a Strike

Eligible employees may make self-payments if:

- Your Collective Bargaining Agreement has expired;
 - Your Employer is involved in collective bargaining with the Union and impasse has been reached; and
 - The Union certifies that affirmative actions are being taken to continue the collective bargaining relationship with the Employer.
- ✓ You may self-pay for a maximum of 12 months as long as you do not engage in conduct inconsistent with the actions being taken by the Union.

In no event will Dependent Coverage begin before your coverage begins or continue after your coverage ends.

Payments for Dependent Coverage are made by payroll deduction.

Payments for immediate coverage should be made directly to your employer.

When Dependent Coverage Begins

Existing Dependents

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

When you become eligible for Dependent Coverage, you can elect to provide the following levels of coverage: Employee + Spouse, Employee + Children, or Employee + Family. The cost of providing coverage will vary according to the election you make.

Example: When Dependent Coverage Begins

The tables below show when Dependent Coverage begins for an employee who becomes eligible August 1 and enrolls his or her current dependents within 30 days of that date.

First Payroll Deduction	Lag Period	Dependent Coverage Begins
September 1	October	November 1

This employee arranged to make payroll deductions beginning September 1. Dependent Coverage begins on the 1st day of the 2nd month following the month the payroll deduction is made, in this case, November 1.

or

First Eligible for Dependent Coverage	First Payroll Deduction	Dependent Coverage Begins
August 1	September	August 1 if 3 monthly payments are made

If the employee wants Dependent Coverage to begin immediately, he or she can make an initial payment equal to two monthly payments plus an amount equal to the number of monthly payments required until the month in which the first payroll deduction is made. In this example, 3 monthly payments are required: two for immediate coverage plus one for August, the month before the month in which the first payroll deduction is made.

By submitting the required enrollment material and arranging to make the applicable payroll deductions within 30 days after you become eligible for Dependent Coverage, the form of Dependent Coverage you elected will begin on the 1st day of the 2nd month following the month your first payroll deductions is made.

However, Dependent Coverage may begin earlier if you make an initial payment equal to two monthly payments plus any additional monthly payment required until the month in which your first payroll deduction is made. Call customer service for more information about immediate coverage and payment requirements.

In the example illustrating immediate coverage, the first two payments provide coverage for August and September. The August payment provides coverage for October. The September payroll deduction provides coverage for November.

Additional Dependents

Once you have elected Dependent Coverage, coverage for additional dependents depends on the level of Dependent Coverage you elected.

- If you elect to provide coverage for all your dependents (Employee + Family) when you are first entitled to do so, coverage for newly acquired dependents becomes effective on the date the dependent is acquired.
- If you only elect Employee + Spouse or Employee + Children when you are first entitled to do so, coverage for newly acquired dependents or dependents not initially covered becomes effective according to the applicable special enrollment requirements or after the next annual enrollment period.

Enrollment Periods

Annual Enrollment Periods

Annual Enrollment Periods take place each year, during the time period established by UNITE HERE HEALTH. They provide you with the opportunity to elect coverage for yourself and your dependents if you didn't when you first became eligible to do so. You must submit the required enrollment material and arrange to make the required payroll deductions. Coverage will begin on the 1st day of the 2nd month following the month in which your first payroll deduction is made.

In addition, Annual Enrollment Periods allow you to elect or change categories of benefits or levels of coverage.

If you have coverage under Alternate Plan I, you may also elect to provide benefits for you and your family under Alternate Plan II. However, Alternative Plan II provides lower overall levels of reimbursement than Alternate Plan I. Once you elect Alternate Plan II, you may not change back to Alternate Plan I.

For more information about the benefits provided under the alternate benefit plans and the monthly costs associated with each, contact customer service.

Employee Special Enrollment Periods

If you waived all health care coverage under the Plan because of other health care coverage existing when you first became eligible under the Plan, you may be able to enroll for coverage in the Plan when that other coverage is lost. You do not need to wait for an Annual Enrollment Period. If you waived coverage for reasons other than the existence of other coverage, you may be able to enroll for coverage upon the occurrence of the triggering events described below.

Dependent Special Enrollment Periods

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

- Termination of other group health coverage, including COBRA continuation coverage, existing when you first became eligible for Dependent Coverage under the Plan, unless that coverage ended because required premium payments were stopped;
- Your marriage;
- The birth of your child;
- The adoption or placement for adoption of a child under age 18;
- A dependent previously residing in a foreign country comes to the United States and takes up residence with the participant;
- The loss of your or a dependent's eligibility for Medicaid or Child Health Insurance Program benefits; or
- When you or a dependent becomes eligible for state financial assistance under a Medicaid or Child Health Insurance Program with the cost of the Fund's Dependent Coverage.

If you submit the required enrollment material as specified above and arrange to make the required payroll deductions, coverage for your dependents will begin on the 1st day of the 2nd month following the month in which your first payroll deduction is made.

However, if you make an initial payment directly to your employer and equal to two monthly payments plus any additional monthly payment required until the month in which your first payroll deduction is made, coverage for your dependents can begin as shown:

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

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



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TERMINATION OF COVERAGE

Coverage for you and your dependents will continue as long as eligibility is maintained and you make any required self-payments. Situations that can cause termination of coverage are listed below. In some cases, you and your dependents can temporarily continue coverage beyond the date it would otherwise cease by enrolling for COBRA continuation coverage.

When Employee Coverage Ends

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

- The Plan is terminated;
- The last day of the Coverage Period corresponding to the last Work Period during which you were last credited with the minimum work requirements necessitating a contribution on your behalf;
- The last day of the Coverage Period for which a required payroll deduction was taken.

See page 63 for special rules that apply if your employer's Collective Bargaining Agreement expires.

When Dependent Coverage Ends

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

- The Plan is terminated;
- Your coverage ends;
- The dependent enters any branch of the uniformed services;
- The last day of the Coverage Period for which a timely payroll deduction was taken for Dependent Coverage;
- The last day of the month in which the dependent no longer meets the Plan's definition of dependent.

Who, when, and how long coverage can be continued through COBRA is explained on pages 67-71.

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

See page 16 for the Plan's definition of a dependent.

Totally Disabled or Total Disability

An employee is considered to be totally disabled if prevented by injury or sickness from engaging in any occupation for wages or profit, for which he or she is reasonably qualified by education, training, or experience.

A dependent is considered to be totally disabled if he suffers from any medically determinable physical or mental impairment of comparable severity.

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

Coverage for children under age 19, diagnosed with a physical or mental handicap, who cannot support themselves, and who continue to depend on you for support, may be continued after their 26th birthday as long as you remain eligible. To do so, you must provide proof of the mental or physical handicap within 30 days after the date coverage would end because the dependent child reaches any age limits. The Trustees may also request that you provide proof of the handicap periodically while the handicapped dependent continues to be covered. Contact UNITE HERE HEALTH for more information on how to continue coverage for your handicapped children.

Certificate of Creditable Coverage

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

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

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

For details on COBRA, see pages 67-71. If you have questions about the right to receive a certificate of creditable coverage or the information it contains, contact the Participant Services Department:

(866) 711-4373

If You Are Disabled When Coverage Ends

If you or a covered dependent are totally disabled from a non-occupational injury or sickness when coverage ends, either because you lose eligibility or COBRA continuation coverage terminates, the Plan's medical benefits will continue to be available for the condition causing total disability up to the earlier of:

- The end of the third month following the month in which coverage ends;
- The end of the total disability;
- The date the disabled person:
 - ▶ becomes eligible under any other group health care coverage,
 - ▶ becomes enrolled in Medicare, or
- The date the Plan's lifetime maximum is reached.

This extension of benefits is subject to written proof of total disability satisfactory to the Fund.

When Your Employer's Collective Bargaining Agreement Expires

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

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

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

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

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

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

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 the Fund,

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

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

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RE-ESTABLISHING ELIGIBILITY

Re-establishing Employee Coverage

If you lose eligibility for reasons other than a leave of absence governed by and conforming to the requirements of the Uniformed Services Employment and Reemployment Rights Act (USERRA), you can re-establish eligibility by satisfying the Plan's continuing eligibility rules if your loss of eligibility is less than 12 months. A loss of eligibility for 12 months or more means you must again satisfy the Plan's initial eligibility rules.

Re-establishing Dependent Coverage

If you remain eligible but Dependent Coverage terminates because you stop making the required payments, you will not be able to re-enroll your dependents until:

- You qualify for a Special Enrollment Period (see page 59); or
- The Annual Enrollment Period following the termination of Dependent Coverage, whichever happens first.

However, if you stop making payments because you lose eligibility for reasons other than termination of employment or leaves of absence governed by the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA), you will be able to re-establish Dependent Coverage as follows:

- **USERRA Leaves of Absence**
For losses of eligibility due to leaves of absence governed by USERRA, Dependent Coverage will be reestablished immediately upon your return to covered employment, provided you also resume payroll deductions at the same time.
- **FMLA Leaves of Absence**
For losses of eligibility due to a leave of absence governed by FMLA, Dependent Coverage will be reestablished on the first day of the second month immediately following the month in which payroll deductions for Dependent Coverage are resumed provided they are resumed immediately upon your return to covered employment.

- **Loss of Eligibility Other than Termination of Employment**

For losses of eligibility for reasons other than termination of employment, Dependent Coverage will be re-established on the first day of the second month immediately following the month in which payroll deductions are resumed, provided they are resumed immediately upon a return to covered employment.

Portability

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

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

Family and Medical Leave Act

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

If you are making payments for Dependent Coverage when leave begins, coverage during the leave can be maintained by continuing to make the required payments to your employer. If payments are discontinued, Dependent Coverage will be re-established the first day of the month for which your employer is required to make a contribution on your behalf after you return to work, provided you immediately resume making self-payments for Dependent Coverage.

The Effect of Uniformed Service

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

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

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

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

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

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

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



COBRA CONTINUATION COVERAGE

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

Who Can Elect COBRA Coverage?

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

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

What Is a Qualifying Event?

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

- Your death;
- Your loss of eligibility due to:
 - termination of your employment (except for gross misconduct),
 - a reduction in your hours of work below the minimum required to maintain eligibility;
- The last day of a leave of absence governed by and conforming to the requirements of the Family and Medical Leave Act of 1993, as amended, if you don't return to work at the end of that leave;
- Divorce or legal separation from your spouse;

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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.

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

- A child no longer meeting the Plan's definition of dependent;
- Your *coverage under Medicare* (Medicare coverage means you are eligible to receive coverage under Medicare; you have applied or enrolled for that coverage, if an application is necessary; and your Medicare coverage is effective); or
- Your employer withdraws from the Fund.

What Coverage Can Be Continued?

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

In addition to hospital and medical benefits, health care coverage includes prescription drug, dental, and vision care benefits, if available.

How Long Can Coverage Be Continued?

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

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

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

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

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

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

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

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

Termination of COBRA Coverage

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

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

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

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

Notifying UNITE HERE HEALTH When Qualifying Events Occur

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

Adding Dependents

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

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

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

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

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

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

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

However, regardless of the method you use to notify the Participant Services Department, **you must also include the supplemental 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 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, over age 19 but not a full-time student, marriage).
- **For a participant's death:** the date of death, the name, social security number, address, telephone number, and date of birth of the eligible dependent, and a copy of the death certificate.
- **For a participant's or dependent's disability status:** the disabled person's name, the date on which the disability began or ended, and a copy of the Social Security Administration's determination of disability status.

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

Election and Payment Deadlines

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

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

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

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

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

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

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

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

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

If you have any questions about COBRA continuation coverage, your rights, or the Plan's notification procedures, please call the Participant Services Department at:

(866) 711-4373

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GENERAL CLAIM PROVISIONS

Filing a Benefit Claim

Your claim for benefits must include 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.

In addition to the above information, a claim for health care benefits should include the following information:

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

All claims for benefits must be made as shown:

Health Care Claims

All claims for **hospital, medical, or surgical treatment** must be mailed to the local BlueCross and BlueShield plan where you were treated.

Dental Claims

All claims for **dental treatment** must be mailed to:

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

Non-network Vision Claims

All claims for **non-network vision services** must be mailed to:

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

All Other Benefit Claims

All vision claims or prescription drug services denied because you are not eligible must be mailed to:

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

Deadlines for Filing a Benefit Claim

The Fund will consider only those Benefit Claims that are filed in a timely manner. Claims for health care benefits must be filed not later than 18 months after the date of service.

If you fail to file a benefit claim by the appropriate deadline, your claim will be denied unless you can show that it was not reasonably possible to comply with the filing requirements within the time allotted, and that you filed your claim as soon after the deadline as was reasonably possible.

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.

Individuals Who May File a Benefit Claim

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

Who Is an Authorized Representative?

You may delegate authority to an individual to act on your behalf in regard to a claim for benefits or review of a denial of your claim. If you would like to designate an Authorized Representative, you and the person whom you wish to designate as an Authorized Representative must complete and sign an Authorized Representative Designation Form and submit the form to the Fund at the following address:

UNITE HERE HEALTH

Attention: Claims Manager

P.O. Box 6020

Aurora, Illinois 60598-0020

If the Fund determines that you are incompetent or incapable of naming an Authorized Representative to act on your behalf, the Fund may recognize any of the following individuals as your Authorized Representative without completion of an Authorized Representative Designation Form:

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

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

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

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

Payment of Claims

Concurrent Care Decisions

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

In the event of such a denial of benefits, the Fund shall notify you of such decision at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on appeal before the benefit is reduced or terminated.

If you request that your course of treatment be extended beyond the period of time or number of treatments and such request is an Urgent Care/Emergency Treatment Claim, the Fund will make a decision regarding your request as soon as possible, taking into account the medical exigencies of the situation. The Fund will notify you of its decision (whether adverse or not) not later than 24 hours after its receipt of your claim.

Health Care Claims Not Involving Concurrent Care Decisions

The Fund will notify you of its decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after its receipt of the claim. In general, benefits for medical/surgical services will be paid to the provider of those services.

The Fund reserves the right to extend this 30-day period for a single time for up to an additional 15 days if it determines that the extension is necessary due to matters beyond its control, and notifies you prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of the time and date by which it expects to render a decision. If this extension is necessary because you failed to submit the information necessary to enable the Fund to decide the claim, you shall be afforded 60 days from the receipt of such notice within which to provide the necessary information. The necessary information that you must submit to the Fund will be specified in the notice of extension.

If a Benefit Claim Is Denied

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

- The specific reason or reasons why your claim was denied;
- Reference to the specific SPD provisions on which the denial is based;
- Description of any material necessary to process the claim properly and why the materials are needed;
- A description of the Plan's review procedures and any time limits applicable to such procedures;
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial of your claim on appeal;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in denying your claim, a statement that a copy of such rule, guideline, protocol or criterion will be provided to you free of charge upon request;
- If your claim was denied based upon a medical necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your medical circumstances will be provided to you free of charge upon request; and
- If your claim concerned benefits that qualify as a request for emergency treatment/urgent care, a description of the expedited review process applicable to such claims.

Special Rules for Denials of Prescription Drug Card Benefits

If services are denied because the participant is not eligible, benefit claims must be submitted according to the rules applicable to All Other Benefit Claims as described in Filing a Benefit Claim and Deadlines for Filing a Benefit Claim on pages 72 and 73.

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 in the instance of appeals involving urgent care), signed, and should include the claimant's name, address, and date of birth, and the participant's Social Security Number. You should also provide any documents or records that support your claim.

Claims Subject to Two Levels of Appeal

First Level of Appeal

All appeals for denied medical/surgical benefit **claims involving** requests for **precertification**, including denials based on retrospective review, or **extensions of treatment** beyond limits previously approved (Concurrent Care Decisions) must be sent within 12 months of the date the claim was denied to:

American Health Holding, Inc. – Attn: Appeals Department

100 W. Old Wilson Bridge Rd., 3rd Floor

Worthington, OH 43085

Final Level of Appeal

If AHH upholds all or a portion of the original denial and you still disagree with the decision, a claimant, or his or her authorized representative, must make application within 45 days of the date the denial was upheld to:

The Appeals Subcommittee

UNITE HERE HEALTH

711 N. Commons Dr.

Aurora, Illinois 60504-4197

Claims Subject to One Level of Appeal

If all or a portion of **health care claims for services not requiring precertification, prescription drug, or dental claims** are denied and you disagree with that decision, you must make application within 12 months of the date the claim was denied to:

The Appeals Subcommittee

UNITE HERE HEALTH

711 N. Commons Dr.

Aurora, Illinois 60504-4197

For appeals submitted on or after July 1, 2005, the Appeals Subcommittee will not enforce the Plan's 12 month filing limit when:

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

Appeals to the Fund Involving Urgent Care Claims

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

Appeals Under the Sole Authority of the Plan Administrator

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

- The Fund's refusal to accept self-payments made after the due date;
- Late COBRA payments and applications to continue coverage under the Plan's COBRA provisions; and
- Late applications to enroll for Dependent Coverage.

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

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

Review of Appeals

The Fund will review all appeals (whether first or second level) in accordance with the following provisions.

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

- Examine and obtain copies, free of charge, of all Plan documents, records and other information that affect your claim;
- Submit written comments, documents, records, and other information relating to your claim;

- Information identifying the medical or vocational experts whose opinion was obtained on behalf of the Fund in connection with the denial of your claim (You are entitled to this information even if the Fund did not rely on the information in denying your appeal);
- Designate someone to act as your authorized representative in the review procedure (see page 74 for details).

In addition, the Fund must review your appeal in accordance with the following rules:

- The Fund may not afford deference to the initial denial of your claim.
- Review of your appeal must be conducted by a named fiduciary of the Fund who is neither the individual who initially denied your claim, nor a subordinate of such individual.
- If denial of your initial claim was based, in whole or in part, on a medical judgment (including decisions as to whether a drug, treatment, or other item is experimental, investigational, or not medically necessary or appropriate), a named fiduciary of the Fund must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional cannot be an individual who was consulted in connection with the initial determination on your claim, nor the subordinate of such individual.

Notice of the Fund's Decision on Your Appeal

The Fund will notify you of its decision on your appeal. Such notice will be provided to you:

- As soon as possible, taking into account the medical exigencies, but not later than 72 hours (36 hours in the case of a second level appeal) after the Fund'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 than 30 days (15 days in the case of a second level appeal) after the Fund's receipt of an appeal regarding precertification of services other than those pertaining to concurrent care decisions;
- Within a reasonable period of time, but not later than 60 days (30 days in the case of a second level appeal) after the Fund's receipt of an appeal of health care claims for services not requiring precertification.

If your appeal is denied, the Fund will provide you a written notice of the denial which includes the following information:

- The specific reason or reasons for the denial of your appeal;
- Reference to the specific Plan provisions on which the denial is based;
- A statement that you are entitled to receive, free of charge upon request, access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial of your claim on appeal;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim on appeal, a statement that a copy of such rule, guideline, protocol or criterion will be provided to you free of charge upon request;
- 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.

IN THIS SECTION

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OTHER IMPORTANT INFORMATION

Interpretation of Plan Provisions

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 the Fund,
 - ▶ the right to obtain or provide information needed to coordinate benefit payments with other plans,
 - ▶ the right to obtain second medical or dental opinions or to have an autopsy performed when not forbidden by law;
- Interpret all Plan provisions and associated administrative rules and procedures;
- 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.

Amendment or Termination of the Plan

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

If the Plan is terminated, benefits for claims incurred before the termination date will be paid based on available assets. Full benefits may not be available if the Plan owes more than it has money to pay. If there is money left over, the Trustees may use it in a manner

consistent with the purposes for which the Plan was created or they may transfer it to another fund providing similar benefits.

Providers

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

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

Workers' Compensation

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

Type of Plan

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

Employer and Employee Organizations

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

Plan Administrator

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

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

Employer Identification Number

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

Plan Number

The Plan Number is 501.

Plan Year

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



In This Section

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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).

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 Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for copies not required by law to be furnished free-of-charge.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

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.

Creditable Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

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

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you

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

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Las Vegas, NV 89109

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711 North Commons Drive
Aurora, IL 60504-4197



PROVIDER ORGANIZATION PHONE NUMBERS AND ADDRESSES

American Health Holding, Inc.

100 W. Old Wilson Bridge Rd., 3rd Fl.
Worthington, OH 43085
(866) 458-4609

Catalyst Rx Prescription Services

9525 Hillwood Drive, Suite 100
Las Vegas, NV 89134
(888) 869-4600

Blue Cross and Blue Shield of Illinois

Health Care Service Corporation
300 East Randolph Street
Chicago, IL 60601-5099
(312) 653-6000

Davis Vision

159 Express Street
Plainview, NY 11803
(800) 328-4728

Connecticut General Life Insurance Company

Hartford, CT 06152
(800) 244-6224

