UNITE HERE HEALTH

Pittsburgh Plan Unit 106

Summary Plan Description

Your Health and Welfare Benefits

UNITE HERE HEALTH

Summary Plan Description

Pittsburgh

Plan Unit 106

Effective October 1, 2017

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

Table of Contents

Using this book

Learn:

- What UNITE HERE HEALTH is.
- What this book is and how to use it.

Please take some time to review this book.

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

What is UNITE HERE HEALTH?

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

Your coverage is being offered under the Pittsburgh Plan Unit 106, which has been adopted by the Trustees of UNITE HERE HEALTH to provide medical and other health and welfare benefits through the Fund. Other SPDs explain the benefits for other Plan Units.

What is this book and why is it important?

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

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

In the event of a conflict between this Summary Plan Description and the Plan Document governing the Plan, the Plan Document will govern.

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

How do I use my SPD?

This SPD is broken into sections. A summary of the topics is shown at the start of each section. When you have questions, you should always contact your Care Coordinators at **(866) 686-0003**. They can help you understand how your benefits work.

Read your SPD for important information about what your benefits are (***see page B-2***), how your benefits are paid, and what rules you may need to follow. For example, if you want to know more about your life or AD&D benefits, read the section titled "Life and AD&D Benefits." If you want more information about your medical benefits, read the section titled "Medical benefits."

Some terms are defined for you in the section titled "Definitions" starting *on page I-2*. The SPD will also explain what some commonly used terms mean. When you have questions about what certain words or terms mean, contact your Care Coordinators at **(866) 686-0003**.

How can I get help?

Learn:

- How to reach your Care Coordinators.

How can I get help?

Care Coordinators
(866) 686-0003

Call your Care Coordinators:

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

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

This booklet contains a summary in English of your plan rights and benefits under UNITE HERE HEALTH. If you have difficulty understanding any part of this booklet, you can visit or contact the Atlantic City regional office at 1801 Atlantic Avenue, Suite 200, Atlantic City, New Jersey 08401, or call (888) 437-3480 (TTY: (855) 386-3889). Office hours are from 9:00 a.m. to 5:00 p.m. (Eastern Time), Monday through Friday. You may also call your Care Coordinators at (866) 686-0003 for assistance.

Este folleto contiene un resumen en inglés de sus derechos y beneficios de su plan bajo UNITE HERE HEALTH. Si tiene dificultad para comprender cualquier parte de este folleto, puede visitar o contactar a la oficina regional de Atlantic City en 1801 Atlantic Avenue, Suite 200, Atlantic City, New Jersey 08401, o llame al (888) 437-3480 (TTY: (855) 386-3889). El horario de la oficina es de 9:00 AM hasta las 5:00 PM de lunes a viernes. También puede llamar a Coordinadores de Atención al (866) 686-0003 para obtener asistencia.

How do I get the most from my benefits?

Learn:

- Why you should get a primary care provider.
- Why you should get preventive healthcare.
- How to reduce your costs for urgent care.
- Why you should call your Care Coordinators.
- How to use network providers to save time and money.

Get a primary care provider

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

Make sure you or your PCP calls your Care Coordinators before your first visit to a specialist. **You can save $10 if you call the Care Coordinators before you see a specialist.**

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

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

Get preventive healthcare

Your Plan covers certain types of preventive healthcare if you use a network provider—*see page D-3* for information about what types of preventive care are covered. Getting preventive healthcare helps you stay healthy by looking for signs of serious medical conditions. If preventive healthcare or tests show there is a problem, the sooner you get diagnosed, the sooner you can start treatment. The Plan won't pay for preventive healthcare if you use a non-network provider.

Re-think emergency room care

Is it really an emergency? If you don't need emergency services, you pay less when you go to an urgent care center.

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

Call your Care Coordinators

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

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

Get prior authorization for your care

You or your provider must call your Care Coordinators before you get certain types of care. *See page C-2* for information about your Care Coordinators. If you don't call first, you may pay more

for your healthcare—you may even have to pay all of the cost.

Care Coordinators
(866) 686-0003

Use network providers

Reduce your costs with a network provider

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

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

Example of Your Costs for Outpatient Surgery			
	Class I & Class III PPO Network Provider	**Class II PPO Network Provider**	**Non-Network Provider**
A. Total charge	$10,000	$10,000	$20,000
B. Network discount	-$4,000	-$4,000	n/a
C. Allowable charge (*See page I-2*)	$6,000	$6,000	$6,000
What you pay			
D. Amount over allowable charge	$0 *(A minus B minus C)*	$0 *(A minus B minus C)*	$14,000 *(A minus C)*
E. Deductible	$100	$250	$500
F. Your cost sharing (coinsurance)	$590 *(10% of C minus E)*	$1,150 *(20% of C minus E)*	$2,750 *(50% of C minus E)*
Your total payment	**$690** *(D plus E plus F)*	**$1,400** *(D plus E plus F)*	**$17,250** *(D plus E plus F)*

How do I get the most from my benefits?

Network benefits will be applied to non-network emergency treatment, and to treatment provided by non-network healthcare providers who specialize in emergency medicine, radiology, anesthesiology, or pathology, as well as for in-hospital consultations with non-network providers. However, the allowable charge will be based on whether or not the provider is in the network. **You must still pay the difference between the allowable charge and what the non-network provider charges.**

How do I stay in the network?

- Blue Cross Blue Shield of Illinois provides access to a national network of doctors, hospitals, and other healthcare providers. Your network is the Participating Provider Organization (PPO) network.
- Hospitality Rx provides access to a national network of participating pharmacies that you must use in order to get benefits for prescription drugs.

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

Summary of benefits

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

Class I Medical Benefits

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

This section shows what you pay for your care (called your "cost-sharing"). You pay any copays, deductibles, your coinsurance share, any amounts over a maximum benefit, and any expenses that are not covered, including any charges that are more than the allowable charge (*see page I-2*).

Class I Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Calendar Year Deductibles		
Calendar Year Deductibles	$100/person $200/family	$500/person
Annual Out-of-Pocket Limits		
For Network Medical Care	$1,000/person	n/a
Preventive Healthcare Services—*see page D-3* *for age/frequency information*		
Well Baby Care— *for children under age 6 only*	$15 copay/visit	Not covered
Routine Pap Smear	$0	Not covered
Routine Mammograms		
Prostate Exam		

Commencement of Legal Action
Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted.

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

Class I Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Routine Physical Exam	$0	Not covered
Colonoscopy		
Immunizations		
Office Visits		
Primary Care Provider (PCP) Office Visit	$10 copay/visit	50% after deductible
Specialist Visit — *when a PCP follows the specialist referral rules (see page C-3)*		
Specialist Visit — *when a PCP does not follow the specialist referral rules (see page C-3)*	$20 copay/visit	
Mental Health/Substance Abuse Office Visits	$10 copay/visit	
Routine Podiatry— *up to $25 per visit, and $500 per person each year*	$0	Not covered
Non-Routine Podiatry	10% after deductible	
Chiropractic Care (not including chiropractic x-rays)— *up to $25 per visit, and $600 per person each year*	$0	
X-Rays for Chiropractic Care— *up to $400 per person each year*	10% after deductible	
Urgent and Emergency Care		
Urgent Care Center	$20 copay/visit	50% after deductible
Hospital Emergency Room for Emergency Care— *copay waived if admitted*	$50 copay/visit, then 10%	$50 copay/visit, then 10%

Class I Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Hospital Emergency Room for Non-emergency Care	$50 copay/visit, then 50% after deductible	50% after deductible
Professional Ambulance Services	10% after deductible	10% after deductible
Outpatient Services		
Laboratory Services and Radiology	$0	50%
Diagnostic Imaging (MRI, MRA, CT Scans)	10% after deductible	50% after deductible
Outpatient Surgery		
Physical, Speech, and Occupational Therapy— *up to 30 visits per person per year (combined)*		
Habilitative Therapy for Children with Autism Spectrum Disorder — *for treatment starting before June 1, 2018; certain other limits apply (see page D-7)*	$10/day of treatment	50% after deductible
Diabetes Education	$0	Not covered
Nutritional Counseling — *up to $200 per person per year*		
Inpatient Treatment		
Inpatient Hospitalization	10% after deductible	50% after deductible
Inpatient Hospitalization for Mental Health/Substance Abuse Treatment *(including residential treatment)*		
Skilled Nursing Facility — *up to 60 total days per person each year; no more than 30 non-network days*	10% after deductible	50% after deductible

Class I Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Other Services and Supplies		
Home Healthcare Services — *up to 60 total visits per person each year; no more than 30 non-network visits*	10% after deductible	50% after deductible
Hospice Care		
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment		
Durable Medical Equipment		
Travel and Lodging— *see page D-8 for information*	Reimburse 100% up to $250/day and $10,000/episode	
Medical Foods— *see page D-8 for information*	Reimburse 100%	
Other Covered Expenses	10% after deductible	50% after deductible
Prescription Drug Benefits		
Generic Drugs on the Formulary	$3	Not covered
Brand Name Drugs on the Formulary	$12	Not covered
Brand Name Drugs Not on the Formulary	$27	Not covered

Summary of Dental Benefits—What the Plan Pays	
Maximum Benefit Payable Each Calendar Year	$1,000/person *Maximum benefit does not apply to the following services for persons under age 19: dental exams, routine x-rays, routine cleanings, fluoride, or sealants*
Calendar Year Deductible	None

Summary of Dental Benefits—What the Plan Pays	
Description of Common Dental Care	**Maximum Benefit Payable—Plan pays 100% up to:**
Periodic Oral Exam	$17
Routine Cleaning (Prophylaxis)	$51 - adults $36 - children
Routine X-ray Services	$75 - complete set $35 - bitewings
Amalgam Restorative Services	$65 - 1 tooth surface $85 - 2 tooth surfaces
One Surface Metallic Inlay	$220
Crowns	$315 - resin with high noble metal $337 - porcelain fused to high noble metal
Anterior Root Canal	$188
Oral Surgery— *includes local anesthesia*	$40 - single tooth $75 - erupted tooth $113 - impacted, partially bony tooth
Complete Upper Dentures	$438
Fixed Bridgework	$320 - pontic case high noble metal $330 - pontic porcelain fused to high noble metal

Vision Care Benefits—for Class I & II Employees Only What the Plan Pays	
Vision Care Services and Supplies— *available every 24 months*	Plan pays 100% up to $200 per person every 24 months *Maximum benefit does not apply to the following services for persons under age 19: eye exams or eyeglass lenses*

Life and Accidental Death & Dismemberment (AD&D) Benefit What the Plan Pays	
Life Insurance—Active Employees	$10,000
Life Insurance—Retirees	$1,000

Life and Accidental Death & Dismemberment (AD&D) Benefit *What the Plan Pays*	
AD&D Insurance *(full amount)*—**Active Employees**	$5,000

Short-Term Disability Benefit—for Class I Employees Only *What the Plan Pays*	
Weekly Amount	$150
Maximum Length of Benefit	13 weeks
When Benefits Start:	
Disabled because of Accident	1st day
Disabled because of Sickness (*including pregnancy*)	8th day

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

Class II Medical Benefits

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

This section shows what you pay for your care (called your "cost-sharing"). You pay any copays, deductibles, your coinsurance share, any amounts over a maximum benefit, and any expenses that are not covered, including any charges that are more than the allowable charge (*see page I-2*).

Class II Medical Benefits—What You Pay

	Network Provider	Non-Network Provider
Calendar Year Deductibles		
Calendar Year Deductibles	$250/person	$500/person
Annual Out-of-Pocket Limits		
For Network Medical Care	$2,500/person	n/a
Preventive Healthcare Services—*see page D-3* *for age/frequency information*		
Well-Baby Care— *for children under age 6 only*	$15 copay/visit	Not covered
Routine Pap Smear	$0	Not covered
Routine Mammograms		
Prostate Exam		
Colonoscopy		
Immunizations		

Commencement of Legal Action
Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted.

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

Class II Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Office Visits		
Primary Care Provider (PCP) Office Visit	$10 copay/visit	50% after deductible
Specialist Visit — *when a PCP follows the specialist referral rules (see page C-3)*	$10 copay/visit	50% after deductible
Specialist Visit — *when a PCP does not follow the specialist referral rules (see page C-3)*	$20 copay/visit	50% after deductible
Mental Health/Substance Abuse Office Visits	$10 copay/visit	50% after deductible
Routine Podiatry— *up to $25 per visit, and $500 per person each year*	20%	Not covered
Non-Routine Podiatry	20% after deductible	Not covered
Chiropractic Care (not including chiropractic x-rays)— *up to $25 per visit, and $600 per person each year*	20%	Not covered
X-Rays for Chiropractic Care— *up to $400 per person each year*	20% after deductible	Not covered
Urgent and Emergency Care		
Urgent Care Center	$20 copay/visit	50% after deductible
Hospital Emergency Room for Emergency Care— *copay waived if admitted*	$50 copay/visit, then 20%	$50 copay/visit, then 20%
Hospital Emergency Room for Non-emergency Care	$50 copay/visit, then 50%	50% after deductible
Professional Ambulance Services	20% after deductible	20% after deductible

Class II Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Outpatient Services		
Laboratory Services and Radiology	20%	50%
Diagnostic Imaging (MRI, MRA, CT Scans)	20% after deductible	50% after deductible
Outpatient Surgery		
Physical, Speech, and Occupational Therapy— *up to 30 visits per person per year (combined)*		
Habilitative Therapy for Children with Autism Spectrum Disorder — *for treatment starting before June 1, 2018; certain other limits apply (see page D-7)*	$10/day of treatment	50% after deductible
Diabetes Education	$0	Not covered
Nutritional Counseling — *up to $200 per person per year*		
Inpatient Treatment		
Inpatient Hospitalization	20% after deductible	50% after deductible
Inpatient Hospitalization for Mental Health/Substance Abuse Treatment *(including residential treatment)*		
Skilled Nursing Facility — *up to 60 total days per person each year; no more than 30 non-network days*		
Other Services and Supplies		
Home Healthcare Services — *up to 60 total visits per person each year; no more than 30 non-network visits*	20% after deductible	50% after deductible

Class II Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Hospice Care	20% after deductible	50% after deductible
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment		
Durable Medical Equipment		
Travel and Lodging— *see page D-8 for information*	Reimburse 100% up to $250/day and $10,000/episode	
Medical Foods— *see page D-8 for information*	Reimburse 100%	
Other Covered Expenses	20% after deductible	50% after deductible
Prescription Drug Benefits		
Generic Drugs on the Formulary	$3	Not covered
Preferred Brand Name Drugs on the Formulary	$12	
Brand Name Drugs Not on the Formulary	$27	

Summary of Dental Benefits—What the Plan Pays	
Maximum Benefit Payable Each Calendar Year	$1,000/person *Maximum benefit does not apply to the following services for persons under age 19: dental exams, routine x-rays, routine cleanings, fluoride, or sealants*
Calendar Year Deductible	None
Description of Common Dental Care	**Maximum Benefit Payable—Plan pays 100% up to:**
Periodic Oral Exam	$17

Summary of Dental Benefits—What the Plan Pays	
Routine Cleaning (Prophylaxis)	$51 - adults $36 - children
Routine X-ray Services	$75 - complete set $35 - bitewings
Amalgam Restorative Services	$65 - 1 tooth surface $85 - 2 tooth surfaces
One Surface Metallic Inlay	$220
Crowns	$315 - resin with high noble metal $337 - porcelain fused to high noble metal
Anterior Root Canal	$188
Oral Surgery— *includes local anesthesia*	$40 - single tooth $75 - erupted tooth $113 - impacted, partially bony tooth
Complete Upper Dentures	$438
Fixed Bridgework	$320 - pontic case high noble metal $330 - pontic porcelain fused to high noble metal

Vision Care Benefits—for Class I & II Employees Only *What the Plan Pays*	
Vision Care Services and Supplies— *available every 24 months*	Plan pays 100% up to $200 per person every 24 months *Maximum benefit does not apply to the following services for persons under age 19: eye exams or eyeglass lenses*

Life and Accidental Death & Dismemberment (AD&D) Benefit *What the Plan Pays*	
Life Insurance—Active Employees	$10,000
AD&D Insurance *(full amount)*—**Active Employees**	$5,000

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

Class III Medical Benefits

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

This section shows what you pay for your care (called your "cost-sharing"). You pay any copays, deductibles, your coinsurance share, any amounts over a maximum benefit, and any expenses that are not covered, including any charges that are more than the allowable charge (*see page I-2*).

Class III Medical Benefits—What You Pay

	Network Provider	Non-Network Provider
Calendar Year Deductibles		
Calendar Year Deductibles	$100/person $200/family	$500/person
Annual Out-of-Pocket Limits		
For Network Medical Care	$1,000/person	n/a
Preventive Healthcare Services—*see page D-3 for age/frequency information*		
Well-Baby Care— *for children under age 6 only*	$15 copay/visit	Not covered
Routine Pap Smear	$0	Not covered
Routine Mammograms		
Prostate Exam		
Routine Physical Exam		
Colonoscopy		
Immunizations		

Class III Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Office Visits		
Primary Care Provider (PCP) Office Visit	$10 copay/visit	50% after deductible
Specialist Visit — *when a PCP follows the specialist referral rules (see page C-3)*		
Specialist Visit — *when a PCP does not follow the specialist referral rules (see page C-3)*	$20 copay/visit	
Mental Health/Substance Abuse Office Visits	$10 copay/visit	
Routine Podiatry— *up to $25 per visit, and $500 per person each year*	$0	Not covered
Non-Routine Podiatry	10% after deductible	
Chiropractic Care (not including chiropractic x-rays)— *up to $25 per visit, and $600 per person each year*	$0	
X-Rays for Chiropractic Care— *up to $400 per person each year*	10% after deductible	

Commencement of Legal Action
Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted.

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

Class III Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Urgent and Emergency Care		
Urgent Care Center	$20 copay/visit	50% after deductible
Hospital Emergency Room for Emergency Care— *copay waived if admitted*	$50 copay/visit, then 10%	$50 copay/visit, then 10%
Hospital Emergency Room for Non-emergency Care	$50 copay/visit, then 50% after deductible	50% after deductible
Professional Ambulance Services	10% after deductible	10% after deductible
Outpatient Services		
Laboratory Services and Radiology	$0	50%
Diagnostic Imaging (MRI, MRA, CT Scans)	10% after deductible	50% after deductible
Outpatient Surgery		
Physical, Speech, and Occupational Therapy— *up to 30 visits per person per year (combined)*		
Habilitative Therapy for Children with Autism Spectrum Disorder — *for treatment starting before June 1, 2018; certain other limits apply (see page D-7)*	$10/day of treatment	50% after deductible
Diabetes Education	$0	Not covered
Nutritional Counseling — *up to $200 per person per year*		

Class III Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Inpatient Treatment		
Inpatient Hospitalization	10% after deductible	50% after deductible
Inpatient Hospitalization for Mental Health/Substance Abuse Treatment *(including residential treatment)*		
Skilled Nursing Facility — *up to 60 total days per person each year; no more than 30 non-network days*		
Other Services and Supplies		
Home Healthcare Services — *up to 60 total visits per person each year; no more than 30 non-network visits*	10% after deductible	50% after deductible
Hospice Care		
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment		
Durable Medical Equipment		
Travel and Lodging— *see page D-8 for information*	Reimburse 100% up to $250/day and $10,000/episode	
Medical Foods— *see page D-8 for information*	Reimburse 100%	
Other Covered Expenses	10% after deductible	50% after deductible
Prescription Drug Benefits		
Generic Drugs on the Formulary	$3	Not covered
Brand Name Drugs on the Formulary	$12	Not covered
Brand Name Drugs Not on the Formulary	$27	Not covered

Life and Accidental Death & Dismemberment (AD&D) Benefit What the Plan Pays	
Life Insurance—Active Employees	$10,000
AD&D Insurance *(full amount)*—**Active Employees**	$5,000

Care Coordinators

Learn when you should call your Care Coordinators:

- To save money on your specialist office visit by using the specialist referral program.
- To get prior authorization for your care.
- To sign up for the case management program.

The Care Coordinator program is designed to help make sure you and your dependents get the right care in the right setting. **You pay nothing to use the Care Coordinator program**. This program helps make sure you don't get unnecessary medical care and helps you manage complex or long-term medical conditions. The Care Coordinator program includes mandatory prior authorization of certain types of care. It also includes specialist care referral, case management, and chronic condition programs.

A team of **(888) 437-3480** or Care Coordinators works with you to help you find a provider, answer questions about your benefits and eligibility, understand your treatment plan, and coordinate your healthcare and the information flow between your providers.

To reach your Care Coordinators, call toll-free:
(866) 686-0003
8:30 a.m. to 10:00 p.m. (Eastern time zone)

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

Choosing a PCP

You should choose a primary care provider (PCP) for yourself and for each of your dependents. You can all have the same PCP, or you can each choose different PCPs. For children, you may designate a pediatrician as your child's PCP. You have the right to designate any PCP, whether the provider participates in the network or not, who is available to accept you or your family members. Remember, you save money if you use a network PCP.

Contact your Care Coordinators at **(866) 686-0003** to choose a PCP. You can change your PCP at any time. If you don't have a PCP, your Care Coordinators can help you find one.

A **primary care provider** (PCP) is defined as a provider who has completed the necessary training to practice in the following fields:

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

Specialist referral program/reduced specialist copay

- ✓ Your PCP should call your Care Coordinators if you need to see a specialist. However, it is up to you to make sure your Care Coordinators are contacted before you go to a specialist in order to pay the lower specialist copay. You can always contact your Care Coordinators to see if your PCP has provided the referral.

- ✓ You do not need a referral for: preventive care, acupuncture, chiropractic care, mental health/substance abuse treatment, routine podiatry, and physical, occupational, or speech therapy (but you may need prior authorization - *see page C-4*).

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

Your Care Coordinators will send you a letter telling you when your referral to the specialist has been received. Referrals are generally valid for one year for unlimited visits to the specialist. Your PCP will tell you if your referral isn't for a full year. If you need specialist care after a year, ask your PCP to contact your Care Coordinators again.

- If your PCP contacts your Care Coordinators about the network specialist visit, your copay will be $10. Any PCP can make this referral, including a non-network PCP.
- If your PCP does not contact your Care Coordinators before you see a network specialist, your copay will be $20. Your copay will **NOT** be reduced to $10 if your PCP calls after the specialist visit. However, if your PCP contacts the Care Coordinators before your next specialist visit, your copay for that visit will only be $10.
- If you choose a non-network specialist, you pay 50% (after you pay your deductible) of the allowable charges for the visit. The Care Coordinators can still coordinate your care, so be sure you call before going to the specialist.

Although an OB/GYN (or other provider specializing in obstetrics or gynecology) is only considered a PCP if you are pregnant, the $10 PCP copay applies to each network office visit to an OB/GYN. Your Care Coordinators can help coordinate your care between the OB/GYN and your PCP.

You do not need prior authorization from your Care Coordinators in order to access obstetrical or gynecological care from a network healthcare provider who specializes in obstetrics or gynecology. The healthcare provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For help finding network healthcare providers who specialize in obstetrics or gynecology, contact your Care Coordinators at **(866) 686-0003**.

Get prior authorization for medical and surgical treatment

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

Care Coordinators
toll-free: **(866) 686-0003**

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

When to call your Care Coordinators

You or your healthcare provider should call your Care Coordinators any time you plan to get care other than in your PCP's office, or before getting any of the following:

- Any inpatient admission, including to a skilled nursing facility or for hospice care
- Outpatient surgery (other than surgery performed in a provider's office)
- Durable medical equipment rentals or purchases of $500 or more
- Orthotics or prosthetics if they cost more than $500
- Home healthcare
- Hospice care
- Oncology services, including but not limited to radiation therapy and chemotherapy
- Dialysis
- Genetic testing
- The following diagnostic imaging procedures:
  - MRA or MRI (magnetic resonance imaging or magnetic resonance angiography)
  - PET scan or PET-CT scan (positron emission tomography scintiscan or integrated positron emission tomography and computed tomography scan)
- Partial hospitalization programs (PHP) and intensive outpatient programs (IOP)
- Physical, speech, or occupational therapy

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

The list of services or supplies for which you should call your Care Coordinators changes from time to time. Call your Care Coordinators to get the most up-to-date information.

You should contact your Care Coordinators at least three business days before receiving any of the above types of services and supplies. If you need emergency care, you should contact your Care Coordinators as soon as possible, but no later than the next following business day. No prior authorization is required if you are receiving treatment in an emergency room or are in observation in the hospital. You should also call as soon as you have confirmed your pregnancy.

If you are hospitalized because you are having a baby, you must call your Care Coordinators if your stay will be longer than 48 hours for normal childbirth, or 96 hours for a Cesarean section. However, you should contact your Care Coordinators before a maternity admission, preferably at least 30 days prior to your expected delivery date.

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

See page H-5 for information about when your Care Coordinators must respond to your request for prior authorization and information about how to appeal a prior authorization denial.

Case management program

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

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

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

The case manager may recommend treatments, services, or supplies that are medically appropriate but are more cost-effective than the treatment proposed by your healthcare provider. UNITE HERE HEALTH, at its discretion and in its sole authority, may approve coverage for those alternatives, even if the treatment, service, or supply would not normally be covered.

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

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

Chronic condition management program

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

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

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

Medical benefits

Learn about your medical benefits:

- How to use your medical benefits.
- What you pay for medical healthcare.
- How the out-of-pocket limits protect you from large out-of-pocket expenses.
- What types of medical healthcare are covered.
- What types of medical healthcare are not covered.

Network Providers

Benefits are paid based on whether you use a network provider or a non-network provider. To find a network provider, contact:

Blue Cross and Blue Shield of Illinois (BCBSIL)—PPO Network
toll-free: **(800) 810-BLUE (2583)**
www.bcbsil.com
(Go to the Provider finder, and select the "Participating Provider Organization (PPO)" network)

See page A-9 for more information about how staying in the network can help you save money.

What you pay

You must pay any cost share (such as copays, coinsurance, or deductibles) for your share of covered expenses. You must also pay any expenses that are not covered expenses (*see page D-8* for information about what's not covered), including any amounts over the allowable charge when you use non-network providers, or charges once a maximum benefit or limitation has been met.

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

Deductibles

- **Classes I and III—Calendar year deductibles** of $100 per person and $200 per family apply each calendar year to your covered expenses provided by *network providers* before this Plan pays benefits. A $500 deductible per person applies each calendar year to your covered expenses provided by non-network providers before this Plan pays benefits. (There is no family deductible for non-network providers.)
- **Class II—A calendar year deductible** of $250 per person applies each calendar year to your covered expenses provided by *network providers* before this Plan pays benefits. A $500 deductible per person applies each calendar year to your covered expenses provided by non-network providers before this Plan pays benefits.

Amounts you pay for prescription drugs, vision care, or dental care will not apply toward the deductibles. In addition, the deductibles do not apply to certain medical benefits. See the applicable Summary of Benefits to learn which services require the deductible and which services are covered before you satisfy the deductible.

Any allowable charges applied to your calendar year deductibles during the last three months of the year will carry over and apply to your calendar year deductible in the next year. For example, if in December, you pay $50 out-of-pocket toward your network calendar year deductible, your network calendar year deductible for the next year will be $50 (Classes I & III) or $200 (Class II).

Copays

The copay covers your cost sharing for all of the healthcare you receive at the time of the service. For example, if you go to the emergency room of a network hospital, the $50 copay applies to all of the medical care you get and providers you see during the emergency room visit.

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

Out-of-Pocket limit for covered network expenses

Your out-of-pocket coinsurance and deductibles for most network covered expenses for your medical care is limited to $1,000 per person for Classes I & III, and $2,500 for Class II, each calendar year. Once your out-of-pocket costs for covered expenses meet these limits, the Plan will usually pay 100% for your covered expenses for medical care during the rest of that calendar year. However, the following costs you pay out-of-pocket do not apply to your out-of-pocket limits, and the Plan won't pay 100% for these charges even if you have met the out-of-pocket limit:

- Copayments.
- Amounts you pay out of pocket for prescription drug expenses under the section titled "Prescription drug benefits."
- The 50% coinsurance you pay for non-network services.
- Amounts over any maximum benefit.

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

What's covered

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

- **The following preventive healthcare services,** but only if provided by a network provider:
  - Routine well-baby exams for children up to age 6.
  - Immunizations, when performed according to the guidelines established by the American Academy of Pediatrics or the American Academy of Family Practitioners.
  - Cervical cancer screening (pap smears) once every 36 months for just the pap smear, or once every 60 months if both a pap smear and human papillomavirus screening are done together. Cervical cancer screenings are only covered for women from age 21 to age 65 who have a cervix.
  - Routine mammogram screenings for women are covered once every 12 months for

women ages 40 through 74. Routine mammograms if you are under 40, or older than 75, may be covered if you are at high-risk for breast cancer.

- Routine PSA (prostate-specific antigen) screening tests for men are covered once every 12 months for men age 40 through 69.
- Routine colonoscopies are covered for men and women age 50 and older, once every 10 years. If you are at high risk for colorectal cancer, colonoscopies will be covered once every 24 months. (You are at high risk for colorectal cancer if either you or someone in your immediate family have or had colorectal cancer.)
- ***For Classes I & III employees and dependents only***: one routine physical exam, once each calendar year, including a doctor's office visit, blood test, EKG, and chest x-ray.

- **Professional services** of a healthcare provider.
- **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)**.**
- **Injectable medications**, including immunizations provided by a healthcare provider.
- Treatment of **mental health conditions and substance abuse**, including inpatient and residential treatment, outpatient care, partial hospitalization, intensive outpatient care, and ambulatory detoxification.
- **Acupuncture services**.
- The following **podiatric care** when provided by a network provider**:**
  - **Routine podiatric care**, subject to the maximum benefits shown on the Schedule of Benefits.
  - **Surgical services** of a podiatrist**.**

  Non-network podiatric care is not covered.
- **Chiropractic care,** including chiropractic x-rays, when provided by a network provider, subject to the maximum benefits shown on the Schedule of Benefits.
- **Outpatient services** in a clinic or urgent care center.
- Hospital **emergency room** services.
- Transportation by a **professional ambulance service** to an area medical facility that is able to provide the required treatment.

  If you have no control over whether the ambulance was called, for example when the ambulance is called by a healthcare professional, employer, law enforcement, school, etc., the

ambulance will be considered medically necessary. Contact your Care Coordinators if you had no control over an ambulance being called.

- **Ambulatory surgical facility services**, including general supplies, anesthesia, drugs, and operating and recovery rooms. If you have multiple surgeries, covered expenses are limited to charges for the primary surgery.
- **Radiology**.
- **Laboratory services**.
- **Diagnostic imaging**, including but not limited to MRIs, MRAs, CT scans, PET scans.
- **Radium** or radioactive isotope therapy.
- **Hospital charges** for room and board, and other inpatient or outpatient services. The Plan's benefits for a private room will be limited to the semi-private room rate. Hospital charges include intensive care unit accommodations, and routine nursery charges for a covered newborn child.
- **Pregnancy** and pregnancy-related conditions for employees and spouses, including childbirth, miscarriage, and abortions. No benefits are payable for pregnancy or pregnancy-related conditions for a dependent child.

  Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or a newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
- **Mastectomies**, including reconstruction of the breast upon which the mastectomy is performed, surgery and reconstruction on the other breast to produce a symmetrical appearance, breast implants, and treatment of physical complications resulting from a mastectomy, including swollen lymph glands.
- **Medical services for organ transplants** if the following rules are all met:
  - The transplant must be covered by Medicare, including meeting Medicare's clinical, facility, and provider requirements.
  - You must use any case management program recommended by the Fund or its representative.
  - You must get prior authorization for the transplant.

- Donor expenses for your transplant are only covered if the donor has no other coverage.
- Transplant coverage does not include your expenses if you are giving an organ instead of getting an organ.

- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- **Skilled nursing facility care**, subject to the limits shown on the benefits summary, as long as you are under the care of a doctor, and are confined as a regular bed patient.
- **Blood and blood plasma,** and their administration.
- **Oxygen,** and its administration, and rental equipment.
- **Home healthcare services**, subject to the maximum benefits shown on the summary of benefits. Home health care services include home intravenous therapy, medical supplies, prescription drugs and medications, nursing services by a registered graduate nurse or licensed practical nurse, services by a licensed therapist for physical, occupational, and speech therapy. General housekeeping services or custodial care is not covered.
- **Hospice** services and supplies authorized by a doctor for a person whose life expectancy is six months or less, as follows:
  - Hospice room and board, while the person is an inpatient.
  - Other hospice services furnished by a hospice or hospice team comprised of a doctor and a registered nurse and may include one or more of the following: licensed social worker, a clergyman/counselor, volunteers, a clinical psychologist, a physical therapist, or an occupational therapist.
  - Counseling services provided by members of a hospice team.
  - Home health aid services.
- **Anesthesia**, and its administration.
- **Durable medical equipment**, and supplies, for all non-disposable devices or items prescribed by a healthcare provider, such as wheelchairs, hospital-type beds, respirators and associated support systems, infusion pumps, home dialysis equipment, monitoring devices, home traction units, and other similar medical equipment or devices.
  - Rental fees are covered if the DME can only be rented, and the purchase price is covered if the DME can only be bought.
  - However, if DME can be either rented or bought, and if the rental fees for the course of treatment are likely to be more than the equipment's purchase price, benefits may be limited to the equipment's purchase price.
  - If DME is bought, costs for repair or maintenance are also covered.

- **Habilitative therapy** for children with autism spectrum disorder (only for treatment that begins on or before May 31, 2018). *You must get prior authorization for habilitative therapy before the Plan pays benefits.* Benefits are limited to 30 hours per person each week, and to a total of 36 months. "Habilitative therapy" includes applied behavioral analysis (ABA) therapy and similar types of treatment. It does not include physical, speech, or occupational therapy.
  - Your child must be at least 2 years old, but no more than 8 years old.
  - Your child must have a diagnosis of autism spectrum disorder, and have a prorated mental age of at least 11 months.
  - The provider supervising the habilitative therapy must be certified by the Behavioral Analyst Certification Board (BACB) as a Board Certified Behavior Analyst or Board Certified Behavior Analyst Doctorate.
  - The person providing the habilitative therapy must be certified by the BACB as a Board Certified Assistant Behavioral Analyst or Registered Behavioral Technician.
  - Benefits will only be paid for services supplemental to any therapy for which your child is eligible through his or her school or school district. No benefits will be paid for therapy provided through the school or school district.
  - The habilitative therapy and treatment plan must get prior authorization from the Fund before treatment begins. The treatment notes and treatment plan must be reviewed by the Fund at least twice a year, and must show that:
    - Your child is demonstrating improvement.
    - You are trained to, and do, participate in the habilitative therapy.
    - You follow the treatment plan.
  - *No Plan benefits will be paid for a course of habilitative therapy that starts on or after June 1, 2018.*
- Outpatient rehabilitation services for **physical, speech, and occupational therapy** when provided by a licensed therapist, and subject to the maximum benefits show on the summary of benefits.
- Network professional services of a licensed **Certified Diabetes Educator** for the care, monitoring, or treatment of diabetes. Non-network expenses are not covered**.**
- Network professional services of a licensed **Registered Dietitian,** subject to the maximum benefit per shown on the summary of benefits. Non-network expenses are not covered.
- **Repair of sound natural teeth** and their supporting structures, if the covered expenses are the result of an injury. Treatment must be received while you are covered under the Fund. You may have additional dental coverage under your dental benefits—see the applicable dental benefit section.

- **Sterilization procedures**.
- **Surgical supplies and surgical dressings**, including artificial limbs and eyes, and casts, splints, and trusses.
- **Orthotics and prosthetics.**
- Treatment of **tumors, cysts and lesions** not considered a dental procedure.
- Oral surgery for the **removal of bony impacted teeth.**
- **Medical foods** if you have an inborn error of metabolism (IEM). You must get prior authorization for your medical food costs before the Plan will reimburse you. The Plan will reimburse 100% of your costs for medical foods. To be reimbursed, the medical food must be: (1) ordered by and used under the supervision of a healthcare provider; (2) the primary source of your nutrition; and (3) labeled and used for dietary management of your IEM.
- Reimbursement for **travel, lodging, and meal costs** for transportation to get certain treatment more than 50 miles away from your home (as long as you travel within the United States). You must get prior authorization for these expenses before the Plan will reimburse you. Covered expenses only include travel, lodging and meal costs related to: (1) transplants, (2) cancer-related treatments, and (3) congenital heart defect care. The following rules apply:
  - The travel, lodging, and meal costs of one other person traveling with you will also be covered. (Two other people will be covered if the patient is a minor child.)
  - Reimbursement is limited to $10,000 per episode of care for you and your traveling companion(s) combined. This includes up to $250 each day for lodging and meal costs.
  - You must provide the Plan with your original receipts.
  - You must participate in any case management programs required by the Fund.
  - You cannot get reimbursed for expenses related to your participation in a clinical trial, or for an organ transplant if you are donating an organ instead of getting an organ.
  - The Fund may prearrange or prepay certain travel or lodging costs. More details about the benefit are available upon request.

What's not covered

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

- Prescription drugs and medications, other than those used where they are dispensed. Prescription drugs may be covered under the prescription drug benefit shown *on page D-11*.

- Services or supplies provided by a non-network providers if the services or supplies are not covered when provided by a non-network provider.
- Alveolar ridge augmentation or implant procedures, whether of natural or artificial materials, to stabilize or otherwise alter natural or artificial teeth.
- Dental extractions or dental services for or in connection with routine care of the teeth and supporting oral tissues, or restorative services to replace natural teeth lost as a result of injury.

  However, charges made by a hospital or other facility for dental procedures covered under the dental benefit provisions (see the dental benefits sections), will be covered if the procedure requires the patient to be treated in an institutional setting to safely receive the care. For example, if you suffer from a medical or behavioral condition, such as autism or Alzheimer's, that severely limits your ability to cooperate with the dentist providing the care, charges made by a hospital or other facility will be considered a covered expense. Benefits for other types of dental care may be covered under the dental benefit (*see page D-19*).
- Treatment of temporomandibular joint (TMJ) disorders, craniofacial disorders, or orthognathic disorders, unless prior authorized by the Fund.
- Surgery to modify jaw relationships including, but not limited to, osteoplasty and genioplasty procedures. However, Le Fort-type operations are covered when primarily to repair birth defects of the mouth, conditions of the mid-face (over or under development of facial features), or damage caused by injury.
- Birth control devices.
- Eye refractions and eyeglasses. However, certain eye care may be covered for Class I and II employees under the vision benefits (*See page D-27*).

Prescription drug benefits

Learn:

- What you pay for your covered prescription drugs.
- What types of prescription drugs are covered.
- How the safety and cost containment programs help save you money and help protect your health.
- How much of a prescription drug you can get at one time.
- What the mail-order pharmacy is and how to use it.
- What the specialty order pharmacy is and when you must use it.
- What types of prescription drugs are not covered.

Benefits are only paid if you buy your prescription drugs at a pharmacy that participates in the network, **like Walgreens and CVS**. ***Not all retail pharmacies are in your pharmacy network.***

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

Important Phone Numbers	
If you want to	**Call**
Find a network pharmacy	**Care Coordinators** **(866) 686-0003**
Get prior authorization for prescription drugs	**WellDyne** **(844) 813-3860**
Get a free glucometer	**One Touch** (LifeScan products) **(888) 883-7091** *use order number 739WDRX01* **TruMetrix** (Trividia Health products) **(866) 788-9618**
Order from the mail-order pharmacy	**WellDyneRx Home Delivery** (through Hospitality Rx) **(844) 813-3860**
Order from the specialty pharmacy	**Walgreens Specialty Pharmacy** **(877) 647-5807**

What you pay

You must pay the applicable amount shown below for each fill of a prescription drug. You must also pay any expenses that are not considered covered expenses (***see page D-17*** for information about what's not covered).

Prescription Drugs under the EPO option	Your Cost for Each Fill or Refill	
	Retail (*up to a 34-day supply*)	**Mail Order** (*up to a 60-day supply*)
Generic Drugs	$3	$3
Brand Name Drugs on the Formulary	$12	$12
Brand Name Drugs NOT on the Formulary	$27	$27

Preferred brand name drugs and supplies are safe, effective, high-quality drugs and supplies. You pay less for these brand name drugs than you do for non-preferred brand name drugs. Prescription drugs and supplies may be added to or removed from the list of preferred drugs from time to time. Contact WellDyne at **(844) 813-3860** if you or your healthcare provider has questions about which prescription drugs and supplies are on the list of preferred drugs.

You must use the specialty pharmacy to get specialty and biosimilar prescription drugs. ***See page D-16*** for more information about the specialty pharmacy.

Generic prescription drug policy for retail pharmacies

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

The generic prescription drug policy does not apply to certain prescription drugs that need to be closely monitored, or if very small changes in the dose could be harmful. The prescription drugs that are not subject to the generic prescription drug policy change from time to time. You can get up-to-date information by calling WellDyne at **(844) 813-3860**. This rule will also not apply if the prior authorization program makes an exception to the rule. Your healthcare provider will need to get prior approval for this exception to apply to your prescription drugs.

If you have an exception to the generic prescription drug policy, you will still have to pay the applicable brand name drug copay ($12 for brand name drugs on the formulary, and $27 for brand name drugs not on the formulary).

What's covered

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

- FDA-approved prescription drugs which can legally be purchased only with a written prescription from a healthcare provider. This includes oral and injectable contraceptives and drugs mixed to order by a pharmacist, as long as at least one part of the mixed-to-order drug is an FDA-approved prescription drug.
- The following diabetic supplies: insulin, diabetic test strips, control solution for glucometers, disposable syringes and needles, and lancets.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control when provided by a network pharmacist. The Plan will pay 100% of the cost, including the cost of administration. Immunizations for children may be subject to age restrictions imposed by state or federal law.
- The following single-source formulary vitamins: ferrous sulfate, vitamin D,

cyanocobalamin, vitamin K, potassium chloride, bicarbonate, phosphate, calcium acetate, niacin, and Galzin (zinc).

Free glucometers

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

(888) 883-7091 for **OneTouch (LifeScan)** products
or visit www.OneTouch.orderpoints.com
use order number 739WDRX01

(866) 788-9618 for **TrueMetrix (Trividia Health)** products

If you don't want one of the Fund's free glucometers, you have to pay the full cost of the glucometer. (You may submit a claim to the Fund for the glucometer, but the Fund may not reimburse you for the full amount.)

Safety and cost containment programs for prescription drugs

The Fund provides extra protection through several safety and cost containment programs. These programs may change from time to time, and the prescription drugs or types of prescription drugs that are part of these programs may also change from time to time. You and your healthcare provider can always get the most current information by contacting WellDyne at **(844) 813-3860** or visiting www.hospitalityrx.org.

Safety and cost containment programs help make sure you and your family get the most effective and appropriate care. These programs look at whether a prescription drug is safe for you to take. For example, some prescription drugs cannot be taken together. Safety programs help make sure you are not taking two prescription drugs in a combination that could harm you.

The programs also can help make sure your money is not wasted on prescription drugs that do not work for you. For example, some prescription drugs cause serious side effects in some patients. By limiting your prescription to a limited number of pills, you can make sure the prescription drug is safe for you to take before you pay for a large supply of pills you will have to throw away if you get serious side effects.

See page H-8 for information about appealing a denial for prior authorization or appealing a denial of prescription drug benefits.

Prior authorization

If your healthcare provider prescribes certain drugs, he or she will need to provide your medical records to show that the prescription drug is clinically appropriate for your medical situation. The list of prescription drugs that require prior authorization changes from time to time. Call WellDyne at **(844) 813-3860** for a list of drugs on the prior authorization list, or to get prior authorization for a drug.

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

Step therapy

In many cases, effective lower-cost alternatives are available for certain prescription drugs. A step therapy program will ask you to try generic or lower cost versions of a prescription drug before approving coverage for a higher cost brand name drug. If the first level prescription drug does not work for you, or causes serious side effects, you are "stepped up" to another drug option.

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

The list of prescription drugs that require step therapy changes from time to time. Contact WellDyne at **(844) 813-3860** with questions about which prescription drugs require prior authorization.

Case management

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

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

Fill and refill limits

Quantity limits

Each prescription fill or refill is limited to the lesser of a 34-day supply or the amount prescribed by your healthcare provider. (You will be able to get refills if your provider prescribes more than a 34-day supply.) However:

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

You generally cannot refill a prescription until you have used most of your prescription, but in

some cases, you may be able to refill a prescription sooner than is usually allowed. For example, you may get an early refill if:

- You show you plan to be out of the country when you would run out of a prescription drug.
- Your prescription is lost or stolen.
- You accidentally use too much of a drug. The Fund may approve an early refill once for each drug under this rule (during your lifetime, not each year).

An early refill is subject to the quantity limits explained above, **plus** the refill quantity will not exceed the time for which you are eligible for benefits. The Fund may apply a surcharge of up to $50 (or, if less, the cost of the drug) in addition to the applicable copay after the first early refill of a drug each year. You may also have to participate in the case management program.

Contact WellDyne at **(844) 813-3860** if you need an early refill of a drug.

Exceptions to the standard quantity limits

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

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

Mail-order pharmacy

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

You can order from Hospitality Rx's mail-order pharmacy by mail, by phone, or on the internet.

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

Specialty pharmacy

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

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

Walgreens Specialty Pharmacy
(877) 647-5807

What's not covered

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

- Prescription drugs that have not been approved by the FDA. However, the Fund may cover prescription drugs not approved by the FDA in certain situations. You or your healthcare professional may ask for an exception through the Fund's prior authorization program.
- Specialty prescription drugs, other than those used to treat HIV/AIDS, if you do not use the specialty pharmacy.
- Experimental or investigational drugs.
- Fertility drugs.
- Prescriptions or refills in amounts over the quantity limits (*see page D-15*).
- Non-sedating antihistamines or histamine receptor blockers.
- Over-the-counter proton pump inhibitors.
- Birth control devices and implants.
- Diagnostics (drugs used to help in the process of diagnosing certain medical conditions) or biologicals (preparations made from living organisms or their products and used as a diagnostic, preventive, or therapeutic agent).
- Vitamins, dietary supplements, or dietary aids, except those specifically listed as a covered expense.
- New-to-market prescription drugs until the Fund or its representative has reviewed and approved the prescription drug.
- High-cost "me too" drugs, unless the Fund or its representative approves the drug for purchase. "Me-too" drugs usually have only very small differences in how they work, but

are considered "new" drugs with no generic equivalent. Often, the manufacturer charges high prices for these drugs even though there are other drugs available that work just as well for a lower cost. You can find out if a "me too" drug is covered by contacting your Care Coordinators.

- Drugs that require review under a safety or cost containment program (such as a drug that requires prior authorization, or a drug subject to the step therapy program) if that safety or cost containment program is not followed, or does not approve the drug.
- Drugs, medications, or supplies that are not for an FDA-approved indication, that are not covered under the Plan's or Plan's designee's claims processing guidelines or any other internal rule, including but not limited to any national guidelines used by the medical community.
- Glucometers, other than those the Fund gives to you for free. You may be able to get a glucometer through the medical benefit if you do not want one of the free ones, but you will usually have to pay part or all of the cost.
- Rogaine and other drugs to prevent hair loss.
- Drugs or medications used, consumed or administered at the place where dispensed, other than immunizations. (These drugs may be covered under your medical benefits. *See page D-3*.)
- Diagnostics or biologicals.
- Drugs used for cosmetic reasons.
- Human growth hormone, except to treat emaciation due to AIDS.
- Drugs or other covered supplies not purchased from a network pharmacy.
- Medical foods (medical foods may be covered under the medical benefit—*see page D-8*).

Dental benefits

Learn:

- How to use your dental benefits.
- What the Plan pays for your dental care.
- What types of dental care are covered.
- What types of dental care are not covered.

This benefit is not available to Class III employees or dependents.

Summary of Dental Benefits—What the Plan Pays	
Maximum Benefit Payable Each Calendar Year	$1,000/person *Maximum benefit does not apply to the following services for persons under age 19: dental exams, routine x-rays, routine cleanings, fluoride, or sealants*
Calendar Year Deductible	None
Description of Common Dental Care	**Maximum Benefit Payable—Plan pays 100% up to:**
Periodic Oral Exam	$17
Routine Cleaning (Prophylaxis)	$51 - adults $36 - children
Routine X-ray Services	$75 - complete set $35 - bitewings
Amalgam Restorative Services	$65 - 1 tooth surface $85 - 2 tooth surfaces
One Surface Metallic Inlay	$220
Crowns	$315 - resin with high noble metal $337 - porcelain fused to high noble metal
Anterior Root Canal	$188
Oral Surgery— *includes local anesthesia*	$40 - single tooth $75 - erupted tooth $113 - impacted, partially bony tooth
Complete Upper Dentures	$438
Fixed Bridgework	$320 - pontic case high noble metal $330 - pontic porcelain fused to high noble metal

The above table summarizes the maximum benefit payable for the most common types of dental procedures. Call your Care Coordinators to get a complete listing of the maximum benefits by dental procedure.

You can use any licensed dentist you want to get your dental care. You don't have to worry about

finding a network dentist—there is no network. Instead, the Plan pays 100% of your covered dental expenses, subject to the maximum benefit for each procedure, regardless of which dentist you use.

What the Plan pays

The Plan pays 100% up of covered expenses provided by a dentist, up to the scheduled maximum benefit. The Plan pays up to $1,000 per person each calendar year. However, this annual maximum does not apply to the following types of dental care for persons under age 19: dental exams, routine x-rays, routine cleanings, fluoride, or sealants.

If multiple procedures are performed at the same site, Plan benefits are limited to the most inclusive service, plus pro-rated amounts for other, associated services.

The Plan will prorate covered services provided by quadrant as follows:

- Benefits for treatment involving 1 or 2 teeth in a quadrant will be limited to 1/3 of the quadrant allowance.
- Benefits for treatment involving three or four teeth in a quadrant will be limited to 1/2 of the quadrant allowance.
- Benefits for treatment involving five or more teeth in a quadrant will equal 100% of the quadrant allowance.

A covered dental expense is considered incurred on the date that:

- The final impression is taken for dentures and partials.
- The involved teeth are prepared for fixed bridgework, crown, inlays, and onlays.
- The pulp chamber is opened for root canal therapy.
- Any other service is rendered.

A temporary dental service is considered part of the final service, not a separate service.

What you pay

A maximum benefit applies to each covered expense. You pay any billed charges that are more than what the Plan pays for that covered expense. You also have to pay for any dental care that isn't covered, including dental care you get more often than is covered, or dental care once you reach your maximum benefit for dental care during a year.

What's covered

There may be limits on how often certain services and supplies are covered. If the amount of time in any limitation has not passed since the service or supply was last provided, you may have to pay the entire cost. You can always contact your Care Coordinators to find out the last time you got benefits for a certain service or supply.

- **Diagnostic and preventive services and procedures**, including but not limited to exams and cleanings.
  - Routine cleanings (prophylaxis). These types of cleanings are limited to 2 each year if you are age 19 or older. (No frequency limit applies to routine cleanings for people under age 19.)
  - X-rays. Full-mouth or (panoramic) x-rays for persons age 19 and older are limited to 1 set every 36 consecutive months. (No frequency limit applies to x-rays for people under age 19.)
  - Topical application of fluoride for persons under age 19 only.
  - Sealants for children under age 16.
- **Emergency palliative care** to temporarily relieve pain and discomfort.
- **Diagnostic x-rays** to diagnose a specific condition.
- **Restorative services**, including but not limited to inlays, onlays, crowns, and labial veneers.
- **Endodontic services and procedures** to treat teeth with diseased or damaged nerves.
- **Periodontic services** to treat diseases of the gums and supporting structures of the teeth.
  - Root planing and scaling is covered once every 18 months per quadrant.
  - Periodontal surgery of any type is considered a covered service once every 36 months per quadrant. Periodontal surgeries subject to this limit include but are not limited to gingivectomies, gingivoplasties, gingival curettage, gingival flap procedures, mucogingival surgeries, osseous surgeries, osseous grafts, pedicle grafts, free tissue grafts, etc.
  - Full mouth debridement to remove extensive plaque and tartar is limited to once in a 24-month period.
- **Prosthodontics**, and repairs to prosthodontics (such as relining and rebasing).
  - Denture relining must be performed more than 6 months after you get the denture.
  - Relines are limited to once every 12 consecutive months.
- **Oral surgery**, extractions, and other surgical procedures.

What's not covered

See page E-2 for a list of this Plan's general exclusions and limitations. In addition to that list, the following types of dental care are not covered under the dental benefit:

- Treatment in progress before coverage begins, but only to the extent charges for such treatment are incurred before coverage begins.
- Replacement of a lost or stolen dental appliance, duplicate dentures, or charges for the replacement of an existing bridge or partial denture which is or can be made satisfactory.
- Replacement of a prosthesis (other than a crown necessitated for restorative purposes only) installed while you were covered by the Plan and being replaced within five years after the initial installation, unless:
  - Replacement is made necessary by the initial placement of an opposing full prosthesis or the extraction of natural teeth,
  - The prosthesis is a temporary prosthesis and is being replaced by a permanent prosthesis, or
  - The prosthesis, while in your mouth, is damaged beyond repair by an injury occurring while covered by the Plan.
- Labial veneers if the tooth or teeth can be reasonably restored with composite materials.
- Procedures used to change vertical dimension.
- Cast inlays or non-abutment crowns, unless the tooth cannot be restored with amalgam or composite materials.
- Treatment of temporomandibular joint dysfunction (TMJ), cranio-facial pain disorders, or orthognathic surgery; however, charges for night guards are covered.
- Dental implants and all attachments to implants, including posts, crowns, retainers, and other devices.
- Setting fractures or dislocations, or treatment of malignancies, cysts, or neoplasms over 1.25 cm., unless a benefit is listed in the Plan's schedule of dental benefits.
- Placement of bone grafts or extra-oral substances in the treatment of periodontal disease.
- Orthodontic services and supplies.
- Fixed prostheses on:
  - Periodontically compromised teeth with significant bone loss, unless certified by a independent periodontist that the recommended treatment is appropriate and the prognosis for the affected tooth or teeth is good, or

- Endodontically compromised teeth, unless it is certified by an independent endodontist that needed therapy is complete and that prognosis for the affected tooth or teeth is good.

- Fissure sealants for covered persons age 16 or older.
- Topical fluoride for anyone age 19 or older.
- Congenital or developmental malformations unless for dental care otherwise covered.
- Services that are primarily cosmetic in nature.
- Conditions caused by atomic explosion.
- Customization of dental prostheses, including but not limited to personalized, elaborate, or precision attachment dentures, bridges, or specialized techniques.
- Drugs of any kind.
- Services for which benefits may be payable under the medical benefits (*see page D-3*).
- Services or supplies which will not have a satisfactory result, or that are not necessary for your dental health.

Pre-determination of benefits

You or your dentist may contact UNITE HERE HEALTH before treatment starts for any non-emergency services your dentist expects to cost more than $250. Your dentist can get treatment pre-determination by sending examination and treatment records to UNITE HERE HEALTH along with an itemized estimate of the cost of the recommended treatment. UNITE HERE HEALTH will let you and your dentist know how much the Plan will pay for the suggested treatment. Through predetermination, you will know before treatment starts how much of the bill you will be required to pay.

✓ Pre-determination does not guarantee eligibility for benefits under the Plan.

Alternate course of treatment

If your dentist submits a pre-treatment plan, and UNITE HERE HEALTH determines that an alternate method of treatment would be at least as effective, but less costly, the Plan may pay benefits based on the alternate method, as long as the alternate treatment is both:

- Commonly used in the treatment of the existing condition, as determined by UNITE HERE HEALTH or its designee.

- Recognized by the dental profession to be appropriate in accordance with accepted nation-wide standards of dental practice.

Benefits after coverage ends

If coverage ends while dental treatment is in progress, benefits will be extended for the services shown below until the end of the month following the month coverage ends.

Coverage will only be extended for the following services:

- Amalgam restorations, if a temporary medicated filling has been placed before coverage ends.
- Minor adjustments to prosthetic devices placed before coverage ends.
- A crown, fixed bridgework, or inlay if the tooth had final preparation and the impressions were taken before coverage ends.
- A denture, if the final impressions were taken before coverage ends.
- Endodontic treatment, including root canal work, if the tooth was opened before coverage ends.

Vision benefits

Learn:

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

Vision benefits are payable for Class I and II employees only. No vision benefits are payable for any dependent, or for Class III employees.

Vision Care Benefits—for Class I and II Employees Only *What the Plan Pays*	
Vision Care Services and Supplies— *available every 24 months*	Plan pays 100% up to $200 per person every 24 months *Maximum benefit does not apply to the following services for persons under age 19: eye exams or eyeglass lenses*

What the Plan pays

The Plan pays up to $200 per employee for all covered services during a 24-month period, measured from the first day of the month in which the applicable allowable charges are incurred for covered expenses. For example, if covered expenses are first furnished September 20, 2017, the 24-month benefit period would begin again September 1, 2019.

The $200 benefit maximum does not apply to the following vision care covered expenses for persons under age 19: eye examinations or eyeglass lenses. However, the Plan will cover each of these services only once every 12 months.

What's covered

- Complete vision examinations, limited to 1 every 12 months.
- Single vision, bi-focal, or tri-focal eyeglass lenses, limited to 1 every 12 months.
- Aphakic lenses, limited to 1 every 12 months.
- Contact lenses.
- Frames.

What's not covered

See page E-2 for a list of this Plan's general exclusions and limitations. In addition to that list, the following types of vision care are not covered under the vision benefit:

- Vision care obtain or supplies ordered before your coverage begins.
- Sunglasses or coated lenses.
- Replacement of lost, broken, or stolen frames or lenses.

- Orthoptics or visual training.
- Aids for subnormal vision.
- Anti-reflective coatings or tinted eyeglass lenses with a tint higher than #2.
- Duplicate or spare eyeglasses, lenses, or frames.
- Visual analysis that doesn't include eye refraction.
- Services and supplies the Plan covers under the medical benefits.

Short-Term disability benefit

Learn:

- How the Plan determines your short-term disability benefit.
- What isn't covered under the short-term disability benefit.

This benefit is available for Class I employees only. No short-term disability benefits are payable for dependents or Class II or III employees.

Short-Term disability benefits are designed to provide benefits as the result of a disability caused by a non-occupational injury or sickness. To be entitled to benefits, you must be eligible when disability begins. No benefits are available for any period of continuous disability beginning:

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

You are considered disabled if you are prevented by injury or sickness from engaging in the normal activities of your job. You must submit a completed application for benefits and a doctor's statement establishing total disability before benefits can begin. Contact your Care Coordinators for the required forms.

What the Plan pays

The Plan pays a weekly benefit of $150 for as long as you are disabled – up to 13 weeks during any 1 period of disability. The Plan provides a daily benefit of 1/7 of your weekly rate for periods of disability less than 7 days.

Benefits begin on:

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

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

Multiple periods of disability

Periods of disability due to the same cause will be treated as 1 period of disability unless you have returned to work for at least 2 weeks.

Periods of disability due to unrelated causes will be treated as 1 period of disability unless you have returned to work for at least 1 day.

What's not covered

No short-term disability benefits are provided under any of the conditions or circumstances listed in the general exclusions and limitations section (*see page E-2*).

Life and AD&D benefits

Learn:

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

Life and AD&D benefits are for employees only. Dependents are not eligible for life and AD&D benefits.

Event	Benefit	Who Gets
Life Insurance—Active Employees	$10,000	Your beneficiary
AD&D Insurance *(full amount)*—**Active Employees**	$5,000	You (or your beneficiary if you die)

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

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

The terms of the certificate are summarized below. If there is a conflict between this summary and the certificate of insurance, the certificate governs. You may request a copy of the certificate of insurance by contacting Dearborn National.

Retiree death benefit

The amount of the retiree death benefit is $1,000 and is solely provided by UNITE HERE HEALTH, not Dearborn National. This section does not apply to the retiree death benefit. To qualify for retiree death benefits, you must:

- Be at least 62 when you retire.
- Have at least 30 years of credited service when you retire.
- Begin receiving pension benefits under the National Retirement Fund, formerly known as the H.E.R.E.I.U. Pension Plan, upon retirement.
- Not be entitled to life insurance benefits as an active UNITE HERE HEALTH Plan participant when you die.

Call your Care Coordinators when you have questions about retiree death benefits or for help filing a claim.

Life insurance benefit

Your life insurance benefit is shown in the table on the previous page and will be paid to your beneficiary(ies) if you die while you are eligible for coverage or within the 31-day period immediately following the date coverage ends.

Continuation if you become totally disabled

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

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

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

You must provide a completed application for benefits plus a doctor's statement establishing your total disability. The form and the doctor's statement must be provided to UNITE HERE HEALTH within 12 months of the start of your total disability. (Forms are available from the Fund.)

UNITE HERE HEALTH must approve this statement and your disability form. You must also provide a written doctor's statement every 12 months, or as often as may be reasonably required based on the nature of the total disability. During the first two years of your disability, UNITE HERE HEALTH has the right to have you examined by a doctor of its choice as often as reasonably required. After two years, examinations may not be more frequent than once a year.

Converting to individual life insurance coverage

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

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

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

Terminal Illness Benefit

If you have a terminal illness, your life insurance pays a cash lump sum equal to 75% of the death benefit in force on the day proof of terminal illness is accepted. The remaining 25% of your death benefit will be paid to your named beneficiaries after your death. "Terminal illness" means an illness so severe that you have a life expectancy of 24 months or less.

Accidental death & dismemberment insurance benefit

If you die or suffer a covered loss within 365 days of an accident that happens while you are eligible for coverage, AD&D benefits will be paid as shown below. However, the total amount payable for all losses resulting from one accident is $1,000.

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

AD&D exclusions

AD&D benefits do not cover losses caused by:

- Any disease, or infirmity of mind or body, and any medical or surgical treatment thereof.
- Any infection, except an infection of an accidental injury.
- Any intentionally self-inflicted injury.
- Suicide or attempted suicide while sane or insane.
- Losses caused while you are under the influence of narcotics or other controlled substances, gas or fumes.
- A direct result of your intoxication.
- Your active participation in a riot.
- War or an act of war while serving in the military, if you die while in the military or within 6 months after your service in the military.

See your certificate for complete details.

Additional accidental death & dismemberment insurance benefits

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

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

- **Transportation Benefit**—If you die more than 75 miles from your home, your additional AD&D coverage pays up to $5,000 to transport your remains to a mortuary.

Naming a beneficiary

Your beneficiary is the person or persons you want Dearborn National to pay if you die. Beneficiary designation forms are available on www.uhh.org or by calling your Care Coordinators at **(866) 86-0003**. You can name anyone you want and you can change beneficiaries at any time. You can name anyone you want and you can change beneficiaries at any time. However, beneficiary designations will only become effective when a completed form is received.

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

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

Additional services

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

- **Beneficiary Resource Services**—Beneficiary Resource Services is available to beneficiaries of an insured person who dies, and to participants who qualify for the terminal illness benefit. The program combines grief and financial counseling, funeral planning, and legal support provided by Bensinger, DuPont & Associates, a nationwide organization utilizing qualified and accessible grief counselors and legal and financial consultants. Services are provided via telephone, face-to-face contact, and referrals to local support resources. Free online will preparation is also included. Call **(800) 769-9187** for more information or go to www.beneficiaryresource.com and enter the username: Dearborn National.

- **Travel Resource Services**—Europ Assistance USA, Inc. provides 24-hour emergency medical and related services for short-term travel more than 100 miles from home. Services include: assistance with finding a doctor, medically necessary transportation, and replacement of medications or eyeglasses. Other non-medical related travel services are also available. Europ Assistance USA, Inc. arranges and/or pays for certain covered services up to the program maximum. While in the US or Canada, call **(877) 715-2593** for more information. From other locations, call **(202) 659-7807**.

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

General exclusions and limitations

Learn:

- The types of care not covered by the Plan.

General exclusions and limitations

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

- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a healthcare provider.
- Any injury, sickness, or dental or vision treatment which arises out of or in the course of any occupation or employment, or for which you have gotten or are entitled to get benefits under a workers' compensation or occupational disease law, whether or not you have applied or been approved for such benefits.
- Any treatment, services, or supplies:
  - For which no charge is made.
  - For which you, your spouse or your child is not required to pay.
  - Which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish, or municipal hospital when there is no legal requirement to pay for such treatment, services, or supplies.
- Any 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 charge which is more than the Plan's allowable charge (*see page I-2*).
- Treatment, services, or supplies not recommended or approved by your healthcare provider, or not medically necessary in treating the injury or sickness as defined by UNITE HERE HEALTH (*see page I-5*).
- Any expense or charge for failure to appear for an appointment as scheduled, or charge for completion of claim forms, or finance charges.
- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault.
- Any treatment, services, or supplies provided by an individual who is related by blood or marriage to you, your spouse, or your child, or who normally lives in your home.
- Any dental treatment of teeth or their supporting structures, or services or supplies associated with such treatment, unless specifically stated as covered.
- Hearing aids, hearing exams, or the fitting of hearing aids.

- Cosmetic, plastic, or reconstructive surgery, unless that surgery is either: (1) to treat an injury, or (2) breast reconstruction following a mastectomy.
- Any elective procedure (other than sterilization or abortion, or as otherwise specifically stated as covered) that is not for the correction or cure of a bodily injury or sickness.
- Confinement in an institution that is primarily a place of rest, a place for the aged, or a nursing home.
- Routine physical examinations (unless specifically stated as covered); or medical certificates required for employment.
- Procedures to reverse a voluntary sterilization.
- Any smoking cessation treatment, drug, or device to help you stop smoking or using tobacco.
- Preventive medicine, unless specifically covered under the Plan.
- Any expense greater than any maximum benefit, or any expense incurred before eligibility for coverage begins or after eligibility terminates, unless specifically provided for under this Plan.
- Sex transformation for any reason.
- Supplies or equipment for personal hygiene, comfort or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, tanning bed or water bed, televisions, cosmetics, guest trays, magazines, and bed or cots for family members or other guests. This exclusion does not apply to equipment or items that meet the Plan's requirements for durable medical equipment.
- Home construction for any reason.
- Any charges incurred for education or training, unless specifically stated as covered.
- Any charges incurred while you are confined in a hospital, home, or other facility or institution (or a part of such facility) which are primarily for education, training, or custodial care.
- Birth control devices, fertility medication, or drugs or vitamins prescribed for dietary purposes.
- Any treatment, services or supplies for or in connection with the pregnancy or pregnancy-related condition of a dependent child.
- Weight loss programs or treatment, except to treat morbid obesity if the program is under the direct supervision of a healthcare provider, or as specifically stated as covered (for example, diabetes education, or nutrition counseling).
- Experimental treatment (*see page I-4*), or treatment that is not in accordance with

generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH.

- Any treatment, services, or supplies purchased or provided outside of the United States (or its Territories), unless for a medical emergency. The decision of the Trustees in determining whether an emergency existed will be final.
- Hospital charges for personal comfort items, including but not limited to telephone, television, cosmetics, guest trays, magazines, and beds or cots for family members or other guests.
- Eye refractions and eyeglasses, except as specifically covered under the vision benefit (*see page D-28*).
- Orthoptics, vision training, subnormal vision aids, or tonography (a test measuring pressure in the eye).
- Psychological testing for the purpose of evaluating covered dependent children for school-related problems.
- Charges for shoe inserts and similar devices.
- Growth hormones, unless otherwise stated as covered.
- Services performed by a social worker, unless otherwise specifically covered by the Plan.
- Treatment for or in connection with infertility, other than for diagnostic services, including but not limited to in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and fertility drugs and medications of any kind.
- Any treatment, service, or supply that is denied or not covered because prior authorization was not obtained when prior authorization is required as a condition of coverage.
- A service or item that is not covered under the Plan's claims processing guidelines or any other internal rule, guideline, protocol or similar criterion that the Plan relies upon.
- Charges or claims incurred as a result, in whole or in part, of fraud, false information, or misrepresentation.

Coordination of benefits

Learn:

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

These coordination of benefits provisions only apply to medical benefits, the vision benefits, and the dental benefits. If you have questions about how your benefits are coordinated, contact your Care Coordinators.

No coordination of benefits applies to prescription drug benefits, short-term disability benefits, or life and AD&D benefits.

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

This Plan coordinates benefits with the following types of plans:

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

The Fund will not coordinate benefits with health maintenance organizations (HMOs) or reimburse an HMO for services provided. The Fund will also not coordinate with an individual policy.

Which plan pays first

The first step in coordinating benefits is to determine which plan pays first (the primary plan) and which plan pays second (the secondary plan). If the Fund is primary, it will pay its full benefits. However, if the Fund is secondary, the benefits it would have paid will be used to supplement the benefits provided under the other plan, up to 100% of allowable expenses.

Order of payment

The general rules that determine which plan pays first are summarized below.

- Plans that do not contain COB provisions always pay before those that do.
- Plans that have COB and cover a person as an employee always pay before plans that cover the person as a dependent.
- Plans that have COB and that covers a person (or dependent of such person) who is laid off, retired, or enrolled in continuation coverage offered in accordance with federal or state law will be secondary to active coverage, including self-paid coverage. Continuation coverage

offered in accordance with federal or state law, such as COBRA, will be secondary to any non-continuation coverage, subject to the rule for military or government plans, below.

- Generally, military or government coverage will be secondary to all other coverage.
- With respect to plans that have COB and cover dependent children under age 18 whose parents are not separated, plans that cover the parent whose birthday falls earlier in a year pay before plans covering the parent whose birthday falls later in that year.
- With respect to plans that have COB and cover dependent children under age 18 whose parents are separated or divorced:
  - Plans covering the parent whose financial responsibility for the child's healthcare expenses is established by court order pay first.
  - If there is no court order establishing financial responsibility, the plan covering the parent with custody pays first.
  - If the parent with custody has remarried and the child is covered as a dependent under the plan of the stepparent, the order of payment is as follows:
    - The plan of the parent with custody.
    - The plan of the stepparent with custody.
    - The plan of the parent without custody.
- With respect to plans that have COB and cover adult dependent children age 18 and older under both parents' plans, regardless of whether these parents are separated or divorced, or not separated or divorced, the plan that covers the parent whose birthday falls earlier in a year pays before the plan covering the parent whose birthday falls later in the year, unless a court order requires a different order.
- With respect to plans that have COB and cover adult dependent children age 18 and older under one or more parents' plan and also under the dependent child's spouse's plan, the plan that has covered the dependent child the longest will pay first.

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

COB and prior authorization

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

Special rules for Medicare

I am an active employee

Generally, the Plan pays primary to Medicare for you and your dependents. However, there is an exception if you or your dependent has end-stage renal disease (see below).

If you are also enrolled in Medicare, Medicare will pay secondary. This means Medicare may pay for some of your expenses after the Plan pays its benefits.

I am an active employee, but I have, or my dependent has, end-stage renal disease (ESRD)

For the first 30 months you (or your dependent) are eligible for Medicare because of ESRD, the Plan pays primary, and Medicare pays secondary.

Medicare will pay primary for people with ESRD, regardless of their age, beginning 30 months after you become eligible for Medicare because of ESRD. The Plan pays secondary, whether or not you (or your dependent) have enrolled in Medicare.

Your ESRD Medicare coverage will usually end, and the Plan's normal coordination rules will apply again:

- 12 months after the month you stop dialysis treatments; or
- 36 months after the month you have a kidney transplant.

If you (or your dependent) have ESRD, you should enroll in Medicare to avoid getting billed for things Medicare will cover.

I have COBRA coverage or retiree coverage

If you and your dependents have COBRA coverage or retiree coverage, and you (or your dependent) are eligible for Medicare, the Plan pays secondary to Medicare whether or not you (or your dependent) enroll in Medicare. The Plan won't pay amounts that can be paid by Medicare.

If you have retiree or COBRA coverage, and you do not enroll in both Medicare Part A (Hospital Benefits) and Part B (Doctor's Benefits) when you are 65, you will have to pay 100% of the costs that Medicare would have paid.

How to get help with Medicare

Get help enrolling in Medicare, or get answers about Medicare, by:

- Calling **(800) 772-1213**
- Going online to www.SocialSecurity.gov
- Contacting your local Social Security office

If you and your spouse are both employees under this Plan

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

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

Subrogation

Learn:

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

The Plan's right to recover payments

When injury is caused by someone else

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

Typical examples include injuries sustained:

- In a motor vehicle or public transportation accident.
- By medical malpractice.
- By products liability.
- On someone's property.

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

Statement of facts and repayment agreement

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

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

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

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

Settling your claim

Before you settle your claim with a third party, you or your attorney should contact UNITE

HERE HEALTH to obtain the total amount of medical bills paid. Upon settlement, UNITE HERE HEALTH is entitled to reimbursement for the amount of the benefits it has paid or the full amount of the settlement or other recovery you or a dependent receive, whatever is less.

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

If the Plan unknowingly pays benefits resulting from an injury caused by an individual who may have financial responsibility for any medical expenses associated with that injury, your acceptance of those benefits is considered your agreement to abide by the Plan's subrogation rule, including the terms outlined in the Repayment Agreement.

Although UNITE HERE HEALTH expects full reimbursement, there may be times when full recovery is not possible. The Trustees may reduce the amount you must repay if special circumstances exist, such as the need to replace lost wages, ongoing disability, or similar considerations.

When your claim settles, if you believe the amount UNITE HERE HEALTH is entitled to should be reduced, send your written request to:

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

Eligibility for coverage

Learn:

- Who is eligible for coverage (who is considered a dependent).
- How you enroll yourself and your dependents.
- What your benefit options are.
- When and how you become eligible for coverage.
- How you stay eligible for coverage.

You establish and maintain eligibility by working for an employer required 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. You may also have to satisfy other rules or eligibility requirements before your employer is required to contribute on your behalf. Any hours you work during a waiting period or before you meet all of the eligibility criteria before your employer is required to begin making contributions for you do not count toward establishing your eligibility under UNITE HERE HEALTH. If you have questions about when your employer will begin making contributions for you, talk to your employer or union representative.

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

The Trustees may change or amend eligibility rules at any time.

Who is eligible for coverage

The Plan provides three levels of health care benefits depending on your employment classification and the level of employer contribution required by your Collective Bargaining Agreement.

- **Class I Benefits**
- **Class II Benefits** (apply only to wait-staff and bartenders (extra employees))
- **Class III Benefits**

Employees

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

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

If you are required to make any payment toward the cost of providing coverage for you and your family, you must arrange with your employer to make those payments by payroll deduction. If your employer does not permit payroll deductions, you must submit any payment owed to UNITE HERE HEALTH. Payments are due by the 15th day of the month *prior to* the coverage month for which you are making a self payment.

UNITE HERE HEALTH
P.O. Box 6557
Aurora, IL 60598-0557

Dependents

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

You can add dependents after your coverage starts. See "Dependent coverage" starting *on page G-7* and "Special enrollment periods" starting *on page G-10* for more information.

Who your dependents are

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

- Your legal **spouse**.
- Your **children** who are under age 26, including any of the following:
  - Biological children.
  - Step-children.
  - Adopted children or children placed with you for adoption, if you are legally responsible for supporting the children until the adoption is finalized.
  - Children for whom you are the legal guardian or for whom you have sole custody under a state domestic relations law.
  - Children entitled to coverage under a Qualified Medical Child Support Order.
    - ✓ 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 the Fund.

If your child is age 26 or older and disabled, his or her coverage may be continued under the Plan. In order to continue coverage, the child must have been diagnosed with a physical or mental handicap, must not be able to support himself or herself, and must continue to depend on you for support. Coverage for a child with a disability will continue as long as all of the following rules are met:

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

You must provide proof of the mental or physical handicap within 30 days after the date coverage would end because the child becomes age 26. The Fund may also require you to provide proof of the handicap periodically. Contact the Fund for more information on how to continue coverage for a child with a serious handicap.

Enrollment requirements

Employees

You or your employer must provide the Fund with any required information before benefits will be paid on your behalf. This may include providing a signed enrollment form that authorizes payroll deductions for your share of your dependents' cost of coverage, if applicable.

Dependents

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

In order to enroll your dependents, you must provide information about them when you enroll. You must provide the requested information during your initial enrollment period. UNITE HERE HEALTH will tell you when this information is due.

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

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

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

When your coverage begins (initial eligibility)

Your coverage begins at 12:01 a.m. on the coverage period corresponding to the work period for which you establish initial eligibility. The terms of your employer's CBA determines when your employer must make contributions for your work, and when you establish initial eligibility.

For purposes of establishing initial eligibility:

Work period means the two-calendar-month period for which you must meet the eligibility requirements each month of the work period:

- **If your employer's CBA requires flat-rate monthly contributions**: Your work period is any 2 consecutive months for which your employer must make monthly contributions to UNITE HERE HEALTH on your behalf.
- **If your employer's CBA requires hourly contributions:** Your work period is any 2 consecutive months for which your employer must make a contribution to UNITE HERE HEALTH on your behalf and:
  - You are credited with at least 1 hour in each of the 2 months
  - Your contributions for the 2 months total at least:
    - For Class I and Class III employees: 160 hours
    - For Class II employees: 64 hours for wait-staff and 32 hours for bartenders

Lag period means the 2-calendar-month period between the end of a work period and the beginning of the corresponding coverage period.

Coverage period means the calendar month for which you get coverage because you met the eligibility rules in the corresponding work period.

Example: Establishing Initial Eligibility		
Work Period	**Lag Period**	**Coverage Period**
July, August	September, October	November

Suppose you work the required hours, or get flat-rate contributions, during each of July and August. Your coverage begins November 1, and continues through the entire month of November.

Continuing eligibility

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

For purposes of continuing eligibility:

Work period means a calendar during which you meet the eligibility requirements described in your CBA:

- **If your employer's CBA requires flat-rate contributions:** Your work period is any month for which your employer must make a monthly contributions to UNITE HERE HEALTH on your behalf.
- **If your employer's CBA requires hourly contributions:** Your work period is any month for which your employer must make a contribution to UNITE HERE HEALTH on your behalf and during which you are credited with at least:
  - For Class I and Class III employees: 80 hours
  - For Class II employees:
    - 32 hours for wait-staff
    - 16 hours for bartenders

Lag period means the 2-calendar-month period between the end of a work period and the beginning of the corresponding coverage period.

Coverage period means the calendar month during which you get coverage because you met the eligibility rules in the corresponding work period.

Example: Continuing Eligibility		
Work Month	**Lag Period**	**Coverage Period**
September	October, November	December
October	November, December	January
November	December, January	February

You have already become eligible. Suppose your employer is required to contribute on your behalf for September. If you meet the continuing eligibility rule described above, your coverage continues during December. Contributions in the amounts described above for October continues your coverage for January, and so on.

Dependent coverage

✓ **If you are a Class I employee**, your CBA determines whether or not you must contribute towards the cost of your dependents' coverage.

✓ **If you are a Class II or Class III employee**, you must contribute towards the cost of your dependents' coverage.

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

You must enroll each dependent according to the Plan's enrollment rules. No benefits of any kind will be provided for your dependents until they are properly enrolled.

Your dependents will remain covered as long as you remain eligible.

If your employer pays the entire cost of your dependents' coverage

Coverage for your dependents begins on the later of the date you become eligible for coverage under the Plan or on the date you get your first dependent.

If you get a new dependent, you must enroll him or her within 60 days. See "Special enrollment periods" starting *on page G-10* for more information about when coverage starts. If you don't enroll your new dependent within 60 days, you will usually have to wait until the next open or special enrollment period to enroll the dependent.

However, you may be able to enroll a previously unenrolled dependent outside open or special enrollment periods if your CBA provides for automatic dependent coverage. Contact your Care Coordinators at **(866) 686-0003** for more information about how to enroll a dependent, and when your dependents' coverage starts.

If you pay part or all of the cost of your dependents' coverage

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.

- Your dependents' coverage will start on the date your coverage starts ***as long as*** you submit the required enrollment material within 30 days after the date you become eligible for dependent coverage, ***and*** make an initial payment to the Fund equal to 3 monthly payments.
- If you don't make this initial 3-month payment:
  - **If you are a Class I employee:** Your dependents' coverage will begin on the 1st day of the third month following the month of your first payroll deduction. (For example, if your payroll deductions start in July, your dependents' coverage will start October 1.)

- **If you are a Class II or Class III employee**: Your dependents' coverage will begin on the 1st day of the 3rd month following the month in which you make your 1st monthly payment to the Fund, as long as you make the payment by the 15th of the month before the month for which coverage is to begin. (For example, if you make your first payment to the Fund on July 10th, your dependents' coverage will start October 1.)

If you don't enroll your dependents when you first become eligible, you will have to wait until the next open or special enrollment period to add dependents (*on page G-10*).

However, if you pay a composite rate for your share of your dependents' coverage (meaning you pay the same amount no matter how many dependents you have), you may be able to enroll a previously unenrolled dependent outside open or special enrollment periods. Contact your Care Coordinators at **(866) 686-0003** for more information about how to enroll a dependent, and when your dependents' coverage starts

Disability credit hours to continue eligibility

Class II employees are not entitled to disability credit hours.

If you are a Class I or III employee, you can continue eligibility while totally disabled if you meet all of the following rules. You must have:

- Established initial eligibility.
- Become totally disabled for at least 15 days because of injury or sickness, including pregnancy.
- Been actively working during the month you became totally disabled.
- Been credited with at least 80 hours of work during the work period immediately preceding the one in which total disability begins.

If you qualify, you will be credited with up to 80 disability credit hours for each work period you are totally disabled. If your employer's CBA requires a flat-rate contribution, you get disability credit hours in an amount necessary to maintain eligibility for each work period you are totally disabled.

Hours you actually work during the work period in which your total disability begins and the work period during which your total disability ends will be subtracted from the amount of disability credit hours you could otherwise get.

You can continue you coverage with disability credit hours for up to 12 consecutive work periods (12 months).

You are considered disabled if you are prevented by injury or sickness from engaging in the normal activities of your job. You must submit, at your own expense, a completed application for benefits and a doctor's statement establishing total disability before benefits can begin. The required claim forms are available by contacting your Care Coordinators.

Self-payments

Self-payments for continuing eligibility

✓ All self-payments must be postmarked no later than the 15th day of the month immediately preceding the coverage period for which continued coverage is intended.

You can make self-payments only if you lose eligibility as the result of:

- Temporary lay-off
- Approved leaves of absence
- Reduction in hours
- Approved vacation time off

The work period for which you are making a self-payment must immediately follow one for which you were credited with at least the minimum number of hours of work to maintain eligibility or for which your employer is required to make a flat-rate contribution on your behalf.

- If your employer's CBA requires *flat-rate contributions*, the amount of self-payment is the same as the flat-rate contribution the employer must pay under the terms of the CBA.
- If your employer's CBA requires c*ontributions on an hourly basis,* the amount of the self-payment is:
  - **For Class I and III employees:** Your employer's hourly rate times the difference between 80 hours and your actual hours credited for that work period.
  - **For Class II employees:** The difference between 40 hours and your actual hours credited for that work period.

Self-payments can only be made for up to 12 consecutive months. Self-payments cannot be made after your employment terminates.

Self-payments during remodeling or restoration

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

Self-payments during a strike

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

- Your CBA has expired.

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

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

Enrollment periods

Open enrollment periods

Open enrollment periods take place as designated by the Plan. They provide you with the opportunity to enroll your dependents for coverage if you didn't when you first became eligible to do so. You must submit the required enrollment material and arrange to make any required payments.

- **If you are a Class I employee:** Coverage for your dependents will begin on the 1st day of the 3rd month following the month in which your first payroll deduction is made.
- **If you are a Class II or Class III employee:** Coverage for your dependents will begin on the 1st day of the 2nd month following the annual enrollment period. The required monthly payment must be made by the 15th of the month before the month in which coverage is to begin.

Special enrollment periods

In a few special circumstances, you do not need to wait for the open enrollment period to add dependents. You qualify for a special enrollment period by contacting the Fund within 60 days after any of the following events:

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

or Child Health Insurance Program to help pay for the cost of UNITE HERE HEALTH's dependent coverage.

When dependent coverage starts after a special enrollment period

As long as you notify the Fund within 60 days of one of the above events, and properly enroll your dependent, your dependents coverage will begin as follows:

- **If your employer pays the entire cost of your dependents' coverage:** Your dependents' coverage will begin on:
  - The 1st of the month following the date you got married or the other coverage terminates; or
  - The date a child is born, adopted, or placed with you for adoption, or the date a child comes to the United States to take up residence with you, a dependent loses eligibility for Medicaid or Child Health Insurance Program benefits, or you or a dependent becomes eligible for state financial assistance under a Medicaid or Child Health Insurance Program.
- **If you pay for part or all of your dependent's coverage:** You have 2 choices for when your dependent coverage begins.
  - ***Option 1:*** As long as you either: 1) make the number of self-payments required from the date of the special enrollment through the month in which your first payroll deductions are made, or, 2) make 3 monthly payments to the Fund no later than the 15th day of the month immediately following the date of the special enrollment event, your dependents' coverage will take effect on:
    - The 1st day of the month following the date you got married or the other coverage terminates.
    - The date a child is born, adopted, or placed with you for adoption, or the date a child comes to the United States to take up residence with you, a dependent loses eligibility for Medicaid or Child Health Insurance Program benefits, or you or a dependent becomes eligible for state financial assistance under a Medicaid or Child Health Insurance Program.
  - ***Option 2:*** If you don't make either of the initial payments described in option 1 above, your dependents' coverage will start:
    - **For Class I employees:** The 1st day of the 3rd month following the month in which your first payroll deduction is made.
    - **For Class II & III employees:** The 1st day of the 3rd month following the month in which the event occurs, as long as you make the required monthly payment by the 15th day of the month before the month during which coverage begins.

Call your Care Coordinators at **(866) 686-0003** for help understanding when your dependents' coverage begins.

If you do not notify the Fund within 60 days of a special enrollment period, you will usually have to wait until the next open enrollment or special enrollment period to add dependents. ***See page G-7*** for more information about enrolling dependents.

Termination of coverage

Learn:

- When your coverage and your dependents' coverage ends.

Your and your dependents' coverage continues as long as you maintain your eligibility as described *on page G-5*. However, your coverage ends if one of the events described below happens. If your coverage terminates, you may be eligible to make self-payments to continue your coverage (called COBRA continuation coverage). *See page G-22*.

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

When employee coverage ends

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

- The date the Plan is terminated.
- The last day of the coverage period for which you were last credited with the minimum work requirements requiring your employer to make contributions on your behalf during the corresponding work period.
- The last day of the coverage period for which you last made a timely self-payment, if allowed to do so.

When dependent coverage ends

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

- The date the Plan is terminated.
- Your (the employee's) coverage ends.
- The dependent enters any branch of the uniformed services.
- The last day of the month in which your dependent no longer meets the Plan's definition of a dependent (*see page G-2*).
- The last day of the month for which you last made a timely self-payment for dependent coverage, if required.

The effect of severely delinquent employer contributions

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

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

Special termination rules

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

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

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

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

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

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

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

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

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

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

Certificate of creditable coverage

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

Contact your Care Coordinators when you have questions about certificates of creditable coverage.

Reestablishing eligibility

Learn:

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

Portability

If you are covered by one UNITE HERE HEALTH Plan Unit when your employment ends but you start working for an employer participating in another UNITE HERE HEALTH Plan Unit within 90 days of your termination of employment with the original employer, you will become eligible under the new Plan Unit on the first day of the month for which your new employer is required to make contributions on your behalf.

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

Family and Medical Leave Act (FMLA)

✓ Your eligibility will be continued during your leave of absence under the Family and Medical Leave Act (FMLA).

If you are making contributions for your dependents coverage when leave begins, you can continue dependent coverage during your leave by making any required payments. If you stop making payments, dependent coverage will start again on the first day of the month for which your employer must make a contribution on your behalf after you return to work, provided you immediately resume making self-payments for your dependents' coverage.

The effect of uniformed service

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

- You provide your employer with advance notice of your absence, whenever possible.
- Your cumulative length of absence for "eligible service" is not more than 5 years.
- You report or submit an application for re-employment within the following time limits:
  - For service of less than 31 days or for an absence of any length to determine your

fitness for uniformed service, you must report by the first regularly scheduled work period after the completion of service PLUS a reasonable allowance for time and travel (8 hours).

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

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

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

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

If your dependents lose eligibility due to your leave of absence governed by the Uniformed Services Employment and Reemployment Rights Act (USERRA), your dependents' coverage will be reinstated at the same time your coverage starts again, provided you start making any required self-payments for your dependents' coverage when you return to covered employment.

Reestablishing eligibility lost for other reasons

Reestablishing eligibility for employees

If you lose eligibility, and your loss of eligibility is less than 12 months, you can reestablish your eligibility by satisfying the Plan's continuing eligibility rules (*page G-5*). If your loss of eligibility lasts for 12 months or more you must again satisfy the Plan's initial eligibility rules.

Reestablishing eligibility for dependents

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 the earliest of:

- A special enrollment period (*see page G-10*)
- The next open enrollment period following the termination of dependent coverage (*see page G-10*)

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 USERRA, you will be able to reestablish dependent coverage as follows:

- **If you make self-payments by payroll deduction:** the first day of the third month following the month in which your payroll deductions are resumed, as long as your payroll deductions are resumed no later than the month immediately following you reestablishment your eligibility.
- **If you make self-payments to the Fund:** the first day of the month immediately following the month in which your restarts self-payments are postmarked no later than the 15th day of the month, as long as your self-payments are resumed by the month immediately following the annual enrollment period.

COBRA continuation coverage

Learn:

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

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

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

Who can elect COBRA continuation coverage?

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

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

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

What is a qualifying event?

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

- Your death.
- Your loss of eligibility due to:
  - Termination of your employment (except for gross misconduct).
  - A reduction in your work hours below the minimum required to maintain eligibility.
- The last day of a leave of absence under FMLA if you don't return to work at the end of that leave.
- Divorce or legal separation from your spouse.
- A child no longer meeting the Plan's definition of dependent (*see page G-2*).
- Your coverage under Medicare. (Medicare coverage means you are eligible to receive coverage under Medicare; you have applied or enrolled for that coverage, if an application is necessary; and your Medicare coverage is effective.)
- Your employer withdraws from UNITE HERE HEALTH.

What coverage can be continued?

By electing COBRA continuation coverage, you have the same benefit options and can continue the same healthcare coverage available to other employees who have not had a qualifying event. In addition to medical benefits, COBRA continuation coverage includes medical/prescription drug benefits, vision benefits, and dental benefits. **Life and AD&D and short-term disability benefits cannot be continued under COBRA.** However, you may be able to convert your life insurance to an individual policy. Contact your Care Coordinators for more information.

How long can coverage be continued?

The maximum period of time for which you can continue your coverage under COBRA depends upon the type of qualifying event and when it occurs:

- Coverage can be continued for up to 18 months from the date coverage would have otherwise ended, when:
  - Your employment ends.
  - Your work hours are reduced below the minimum required to maintain eligibility.
  - You fail to make voluntary self-payments.
  - Your ability to make self-payments ends.
  - You fail to return to employment from a leave of absence under FMLA.
  - Your employer withdraws from UNITE HERE HEALTH.

  However, you may be able to continue coverage for yourself and your dependents for up to an additional 11 months, for a total of 29 months. The Social Security Administration must determine that you or a covered dependent are disabled according to the terms of the Social Security Act of 1965 (as amended) any time during the first 60 days of continuation coverage.
- Up to 36 months from the date coverage would have originally ended for all other qualifying events (*see page G-22*), as long as those qualifying events would have resulted in a loss of coverage despite the occurrence of any previous qualifying event.

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

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

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

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

Notifying UNITE HERE HEALTH when qualifying events occur

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

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

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

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

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

If you don't use UNITE HERE HEALTH's forms to provide the required notice, you must submit information describing the qualifying event, including your name, Social Security number, address, telephone number, date of birth, and your relationship to the qualified beneficiary, to UNITE HERE HEALTH in writing. Be sure you sign and date your submission.

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

- For divorce or legal separation: 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 or legal separation agreement.

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

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

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

Election and payment deadlines

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

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

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

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

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

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

- UNITE HERE HEALTH must receive the first payment within 45 days after the date it receives your election form. The first payment must equal the premiums due from the date coverage ended until the end of the month in which payment is being made. This means that your first payment may be for more than one month of COBRA continuation coverage.
- After the first payment, additional payments are due on the first day of each month for which coverage is to be continued. To continue coverage, each monthly payment must be postmarked no later than 30 days after the payment is due.

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

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

Termination of COBRA continuation coverage

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

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

- The end of the month for which a premium was last paid, if you or your dependents do not pay any required premium when due.
- The date the Plan terminates.
- The date Medicare coverage becomes effective if it begins after the person's election of COBRA (Medicare coverage means you are entitled to coverage under Medicare; you have applied or enrolled for that coverage, if application is necessary; and your Medicare coverage is effective).
- The date the Plan's eligibility requirements are once again satisfied.
- The end of the month occurring 30 days after the date disability under the Social Security Act ends, if that date occurs after the first 18 months of continuation coverage have expired.
- The date coverage begins under any other group health plan.

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

To get more information

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

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

Claim filing and appeal provisions

Learn:

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

Filing a benefit claim

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

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

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

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

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

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

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112

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

Hospitality Rx
UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

All other claims
All life or AD&D claims, short-term disability claims, dental claims, or vision claims, or any claims denied because you are not eligible, should be mailed to UNITE HERE HEALTH.

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

If you are filing a claim for life or AD&D benefits, after you have contacted the Fund about an employee's death or dismemberment, Dearborn National will contact you to complete the claim filing process.

Deadlines for filing a benefit claim

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

Deadline for filing a claim	
Type of claim	**Deadline to file**
Life insurance	Within a reasonable amount of time
AD&D insurance	• Written *notice* must be received within 31 days of loss (or as soon as possible). • Written *proof* of loss must be received within 90 days of loss (or as soon as possible). Other deadlines may apply to your additional AD&D insurance benefits—your insurance certificate provides more information.
All other claims (including healthcare, prescription drug, dental, vision, and short-term disability claims)	18 months following the date the claim was incurred

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

Individuals who may file a benefit claim

You, a healthcare provider (under certain circumstances), or an authorized representative acting for you may file a claim for benefits under the Plan.

Who is an authorized representative?
You may give someone else the authority to act for you to file a claim for benefits or appeal a claim denial. If you would like someone else (called an "authorized representative") to act for you, you and the person you want to be your authorized representative must complete and sign a form acceptable to the Fund and submit it to:

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

In the case of an urgent care/emergency treatment claim, a healthcare provider with knowledge of your medical condition may act as your authorized representative.

If UNITE HERE HEALTH determines that you are incompetent or otherwise not able to pick an authorized representative to act for you, any of the following people may be recognized as your authorized representative without the appropriate form:

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

Your authorized representative may act for you until the earlier of the following dates:

- The date you tell UNITE HERE HEALTH, either verbally or in writing, that you no longer want the authorized representative to act for you.
- The date a final decision on your appeal is issued.

Determination of claims

Post-service healthcare claims not involving concurrent care decisions
You will be notified of the decision within a reasonable period of time appropriate to your medical circumstances, but no later than 30 days after getting your claim. In general, benefits for medical/surgical services will be paid to the provider of those services.

This 30-day period may be extended for up to an additional 15 days if necessary for matters beyond the Plan's control. If a 15-day extension is required, you will be notified before the end of the original 30-day period. You will also be notified why the extension is needed, and when a decision is expected. If this extension is needed because you do not submit the information needed, you have 60 days from the date you are told more information is needed to submit it. You will be told what additional information you must provide. If you do not provide the required infor-

mation within 60 days, your claim will be denied, and any benefits otherwise payable will not be paid.

Concurrent care decisions
If your ongoing course of treatment has been approved, any decision to reduce or terminate the benefits payable for that course of treatment is considered a denial of your claim. (If the Plan is amended or terminated, the reduction or termination of benefits is not a denial).

For example, if you are approved for a 30-day stay in a skilled nursing facility, but your records on day 20 of your stay show that you only need to stay a total of 25 days, the approval for your skilled nursing facility stay may be changed from 30 days to 25 days. The final 5 days of your original 30-day stay will not be covered, and are considered a denial of your claim.

If your concurrent care claim are denied, you will be notified of the decision in time for you to appeal the denial before your benefit is reduced or terminated.

Your request that your approved course of treatment to be extended is also considered a concurrent care claim. If your request for an extension of your course of treatment is an urgent care/emergency treatment claim, a decision regarding your request will be made as soon as possible, taking into account your medical circumstances. You will be notified of the decision (whether a denial or not) no later than 24 hours after receipt of your claim.

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

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

Rules for prior authorization of benefits

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

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

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

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

If you don't follow the rules for requesting prior authorization, you will be given notice how to file such a request. This notice will be provided within 5 days (24 hours in case of an urgent care claim) of the failure.

Special rules for decisions involving urgent concurrent care

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

If your request is not made more than 24 hours in advance, the decision must be made no later than 72 hours after your request is received. If the request for an extension of the prescribed period is not a request involving urgent care, the request will be treated as a new request to have benefits prior authorized and will be decided subject to the rules for a new request.

If a request for prior authorization is denied

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

Appealing a benefit prior authorization denial

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

If a benefit claim is denied

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

Life and AD&D claims

You can file an appeal within 60 days of Dearborn National's decision. Dearborn National will generally respond to your appeal within 60 days (but may request a 60-day extension). If you need

help filing a claim or appeal, or have questions about how Dearborn National's claim and appeal process works, contact Dearborn National.

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

Appealing claim denials (other than life and AD&D claims)

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

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

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

First level of appeal

All appeals for medical/surgical or mental health/substance abuse benefit claims that are denied by your Care Coordinators (prior authorization denials or extensions of treatment beyond limits previously approved) must be sent within 12 months of your receipt of the claim denial to:

Care Coordinators by Quantum Health
17450 Huntington Park Drive, Suite 100
Columbus, OH 43235
Fax: **(877) 498-3681**

Second level of appeal

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

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

Two levels of appeals for prescription drug claim denials made by Hospitality Rx

First level of appeal

If a prescription drug claim, including a prior authorization claim, is denied, the claim has two levels of appeals. The first appeal of a prescription drug claim denial must be sent within 180 days of your receipt of Hospitality Rx's denial to:

UNITE HERE HEALTH
Attn: Hospitality Rx
711 N. Commons Drive
Aurora, IL 60504-4197

Second level of appeal

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

The Appeals Subcommittee
UNITE HERE HEALTH
711 N. Commons Drive
Aurora, Illinois 60504-4197

One level of appeal for most other claims

If you disagree with all or any part of a dental claim denial, vision claim denial, short-term disability benefits, life or AD&D denial, or healthcare claim denial, and you wish to appeal the decision, you must follow the steps in this section. (See the preceding sections to learn how to appeal a prior authorization denial by the Care Coordinators or appeal a prescription drug denial.)

You must submit an appeal within 12 months of the date you receive notice of the claim denial to:

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

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

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

Appeals involving urgent care claims

If you are appealing a denial of benefits that qualifies as a request for emergency treatment/urgent care, you can orally request an expedited (accelerated) appeal of the denial by calling:

- **(630) 699-4372** for urgent healthcare appeals.
- **(844) 813-3860** for urgent prescription drug appeals.

All necessary information may be sent by telephone, facsimile or any other available reasonably effective method.

Appeals under the sole authority of the plan administrator

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

- UNITE HERE HEALTH's refusal to accept self-payments made after the due date.
- Late COBRA payments and applications to continue coverage under the COBRA provisions.
- Late applications, including late applications to enroll for dependent coverage.

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

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

Review of appeals

During review of your appeal, you or your authorized representative are entitled to:

- Upon request, examine and obtain copies, free of charge, of all Plan documents, records and other information that affect your claim.
- Submit written comments, documents, records, and other information relating to your claim.
- Information identifying the medical or vocational experts whose opinion was obtained on behalf of UNITE HERE HEALTH in connection with the denial of your claim. You are entitled to this information even if this information was not relied on when your appeal was denied.
- Designate someone to act as your authorized representative (*see page I-2* for details).

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

- UNITE HERE HEALTH will not defer to the initial denial of your claim.

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

Notice of the decision on your appeal

You will be notified of the decision on your appeal within the following time frames, counted from the reviewing entity's receipt of your appeal:

	Emergency Treatment/ Urgent Care	Prior Authorization	All Other Healthcare Claims
Subject to one level of appeal	As soon as possible not later than 72 hours	Within a reasonable time period, but not later than 30 days	Within a reasonable time period, but not later than 60 days
Subject to two levels of appeal	As soon as possible but not later than 72 hours for both levels of appeal combined	Within a reasonable time period, but not later than 15 days for each level of appeal	Within a reasonable time period, but not later than 30 days for each level of appeal

If your claim is denied on appeal based on a medical necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances will be provided free of charge upon request.

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

Non-assignment of claims

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

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

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

Commencement of legal action

Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted.

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

Definitions

Learn:

- A summary definition of some of the terms this Plan uses.

Allowable charges

An **allowable charge** is the amount of charges for covered treatments, services, or supplies that this Plan uses to calculate the benefits it pays for a claim. If you choose a non-network provider, the provider may charge more than the **allowable charge**. You must pay this difference between the actual charges and the **allowable charges**. Any charges that are more than the **allowable charge** are not covered. Benefits are not payable for charges that are more than the **allowable charge.**

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

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

Copay or copayment

A fixed amount (for example, $20) you pay for a covered health care service. You usually have to pay your **copay** to the provider at the time you get health care. The amount can vary by the type of covered health care service. Usually, once you have paid your **copay**, this Plan pays the rest of the covered expenses. For example, each time you go to an emergency room for emergency treatment, a $50 **copay** applies.

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

Coinsurance

Your share of the costs of a covered expense, calculated as a percent (for example, 10% or 20%) of the allowable charge for the service. You pay your **coinsurance** plus any deductibles or copays. For example, if your ambulance trip costs $1,000, your 10% **coinsurance** equals $100 (your 20% coinsurance if you are covered under Class II equals $200). The Fund pays the rest of the allowable charge.

Your **coinsurance** for your medical care counts toward your out-of-pocket limit.

Cosmetic or reconstructive surgery

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

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

Covered expense

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

Deductible

The amount you owe for covered expenses before the Fund begins paying benefits. For example, if you are in Class I or Class III, the Plan will not start paying benefits on your behalf until you meet your $100 individual **deductible** or $200 family **deductible** for network care. If you are in Class II, the Plan will not start paying benefits on your behalf until you meet your $250 individual **deductible for network care.**

Amounts you pay for medical care that is not a covered expense will not count toward your **deductible**. This includes but is not limited to, excluded services and supplies, charges that are more than the allowable charge, amounts over a benefit maximum or limit, and other charges for which no benefits are payable.

Durable medical equipment (DME)

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

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

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

Emergency medical treatment

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.

Experimental, investigational, or unproven (experimental or investigational)

Experimental, investigational, or unproven procedures or supplies are those procedures or supplies which are classified as such by agencies or subdivisions of the federal government, such as the Food and Drug Administration (FDA) or the Office of Health Technology Assessment of the Centers for Medicare & Medicaid Services (CMS); or according to CMS's Medicare Coverage Issues Manual. Procedures and supplies that are not provided in accordance with generally accepted medical practice, or that the medical community considers to be experimental or investigative will also meet the definition of **experimental, investigational, or unproven**, as does any treatment, service, and supply which does not constitute an effective treatment for the nature of the illness, injury or condition being treated as determined by the Trustees or their designee.

Healthcare professional, doctor

A doctor or healthcare professional is any of the following:

- A person licensed to practice medicine and surgery as a Doctor of Medicine or Osteopathy;
- A person licensed as a dentist, podiatrist, chiropractor or optometrist and who is practicing within the scope of his or her profession.
- With respect to mental health and substance abuse treatment, any person who is licensed to practice any of the branches of medicine and surgery by the state in which the person practices, as long as he or she is practicing within the scope of his or her license.
- A dentist if he or she is licensed to practice dentistry or perform oral surgery in the state in which he or she is practicing, as long as he or she practices within the scope of that license.
- Additional types of providers specifically listed as covered—for example a certified diabetes educator providing diabetes education.

A primary care provider (PCP) is defined as a doctor who has completed the necessary training and education to practice in the following fields:

- Family medicine.
- General practice.
- Internal medicine.

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

A specialist is a doctor who has received training and education in a particular medical specialty. A specialist is a provider who does not practice in one of the primary care fields described above.

A healthcare professional may also be a facility (such as a hospital or clinic) that provides treatment, services, or supplies.

Neither a doctor nor a healthcare professional is:

- You or your dependents.
- A person who normally lives in your home with you.
- A person related to you or your dependent by blood or marriage.

Injuries and sicknesses

Benefits are only paid for the treatment of **injuries** or **sicknesses** that are not related to employment (non-occupational **injuries** or **sicknesses**).

Sickness also includes mental health conditions and substance abuse, and for employees and spouses only, pregnancy and pregnancy-related conditions, including abortion. Voluntary sterilization procedures are considered a **sickness**.

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

Medically necessary

Medically necessary services, supplies, and treatment are:

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

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

The Board of Trustees has the sole authority to determine whether care and treatment is **medically necessary**, and whether care and treatment is experimental or investigational. In all cases, the Trustees' determination will be final and binding. However, determinations of **medical necessity** and whether or not a procedure is experimental or investigative are solely for the purpose of establishing what services or courses of treatment are covered by the Plan. All decisions regarding medical treatment are between you and your healthcare provider and should be based on all appropriate factors, only one of which is what benefits the Plan will pay.

Out-of-Pocket limit for network care and treatment

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

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

You can get more information about your **out-of-pocket limits** for medical care *on page D-3*.

Plan Document

The rules and regulations governing the Plan of benefits provided to eligible employees and dependents participating in Plan Unit 106 (Pittsburgh).

Other important information

Who pays for your benefits?

Employers participating in the Plan are required to make contributions for their employees. These contributions are controlled by the terms of the Collective Bargaining Agreements negotiated by your local union. Depending on your classification (***see page G-2***) and your Collective Bargaining Agreement, you may also be required to contribute towards the cost of dependent coverage. The Plan is supported by employer contributions and any required contributions you make.

What benefits are provided through insurance companies?

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

The Fund provides the life insurance and AD&D benefits on a fully insured basis. These benefits are funded and guaranteed under group policies underwritten by Dearborn National.

The Fund also contracts with other organizations to help administer certain benefits. Prescription drug benefits are administered by Hospitality Rx, LLC, a wholly owned subsidiary of UNITE HERE HEALTH. Specialist referral services, prior authorization and other utilization review services, case management and chronic condition management for the medical benefits are provided by Quantum Health through your Care Coordinators.

Interpretation of Plan provisions

For benefits provided on a fully insured basis, the insurer has the sole to make decisions about benefits and decide all questions or controversies of whatever character with respect to the insured policy

All other authority rests with the Board of Trustees. The Board of Trustees of UNITE HERE HEALTH has sole and exclusive authority to:

- Make the final decisions about applications for or entitlement to Plan benefits, including:
  - The exclusive discretion to increase, decrease, or otherwise change Plan provisions for the efficient administration of the Plan or to further the purposes of UNITE HERE HEALTH,
  - The right to obtain or provide information needed to coordinate benefit payments with other plans,
  - The right to obtain second medical or dental opinions or to have an autopsy performed when not forbidden by law;
- Interpret all Plan provisions and associated administrative rules and procedures;

- Authorize all payments under the Plan or recover any amounts in excess of the total amounts required by the Plan.

The Trustees' decisions are binding on all persons dealing with or claiming benefits from the Plan, unless determined to be arbitrary or capricious by a court of competent jurisdiction. Benefits under this Plan will be paid only if the Board of Trustees of UNITE HERE HEALTH, in their sole and exclusive discretion, decide that the applicant is entitled to them.

The Plan gives the Trustees full discretion and sole authority to make the final decision in all areas of Plan interpretation and administration, including eligibility for benefits, the level of benefits provided, and the meaning of all Plan language (including this Summary Plan Description). In the event of a between this Summary Plan Description and the Plan Document governing the Plan, the Plan Document will govern. The decision of the Trustees is final and binding on all those dealing with or claiming benefits under the Plan, and if challenged in court, the Plan intends for the Trustees' decision to be upheld unless it is determined to be arbitrary and capricious.

Amendment or termination of the Plan

The Trustees reserve the right to amend or terminate UNITE HERE HEALTH, either in whole or in part, at any time, in accordance with the Trust Agreement. For example, the Trustees may determine that UNITE HERE HEALTH can no longer carry out the purposes for which it was founded, and therefore should be terminated.

In accordance with the Trust Agreement, the Trustees also reserve the right to amend or terminate your Plan or any other Plan Unit, or to amend, terminate or suspend any benefit schedule under any Plan Unit at any time. Such termination or suspension, as well as, the termination, expiration, or discontinuance of any insurance policy under UNITE HERE HEALTH shall not necessarily constitute a termination of UNITE HERE HEALTH.

If UNITE HERE HEALTH is terminated, in whole or in part, or if your Plan, any other Plan Unit or any schedule of benefits is terminated or suspended, no employer, participant, beneficiary or other employee benefit plan will have any rights to any part of UNITE HERE HEALTH's assets. This means that no employer, plan or other person shall be entitled to a transfer of any of UNITE HERE HEALTH's assets on such termination or suspension. The Trustees may continue paying claims incurred before the termination of UNITE HERE HEALTH or any Plan Unit, as applicable, or take any other actions as authorized by the Trust Agreement. Payment of benefits for claims incurred before the termination of UNITE HERE HEALTH, any Plan Unit, or any schedule of benefits will depend on the financial condition of UNITE HERE HEALTH.

Your Plan and all other Plan Units in UNITE HERE HEALTH are all part of a single employee health plan funded by a single trust fund. No Plan Unit and no schedule of benefits shall be treated as a separate employee benefit plan or trust.

Free choice of provider

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

Providers are not agents or employees of UNITE HERE HEALTH, and the Fund 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

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

Employer and employee organizations

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

Plan administrator and agent for service of legal process

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

UNITE HERE HEALTH
Chief Executive Officer
711 North Commons Drive
Aurora, IL 60504
(630) 236-5100

Employer identification number

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

Plan number

The Plan number is 501.

Plan year

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

Remedies for fraud

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

Limited retroactive terminations of coverage allowed

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

If the Fund terminates coverage on a prospective basis, the prospective termination of coverage (termination scheduled to occur in the future) is not a rescission. The Fund may retroactively terminate coverage in any of the following circumstances, and the termination is not considered a rescission of coverage:

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

Your rights under ERISA

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

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

Receive information about your Plan and benefits

ERISA provides that all Plan participants shall be entitled to:

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

Continue group health Plan coverage

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

Prudent actions by Plan fiduciaries

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

Enforce your rights

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

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

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

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

Assistance with your questions

If you have any questions about your Plan, you should contact the Plan Administrator.

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

Important phone numbers and addresses

Care Coordinators by Quantum Health
7450 Huntington Park Drive,
Suite 100
Columbus, Ohio 43235
(866) 686-0003

Blue Cross and Blue Shield of Illinois Health Care Service Corporation
300 East Randolph Street
Chicago, IL 60601-5099
(800) 810-2583

Dearborn National
1020 31st Street
Downers Grove, IL 60515-5591
(800) 348-4512

Hospitality Rx
711 North Commons Drive
Aurora, IL 60540
(844) 484-4726

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