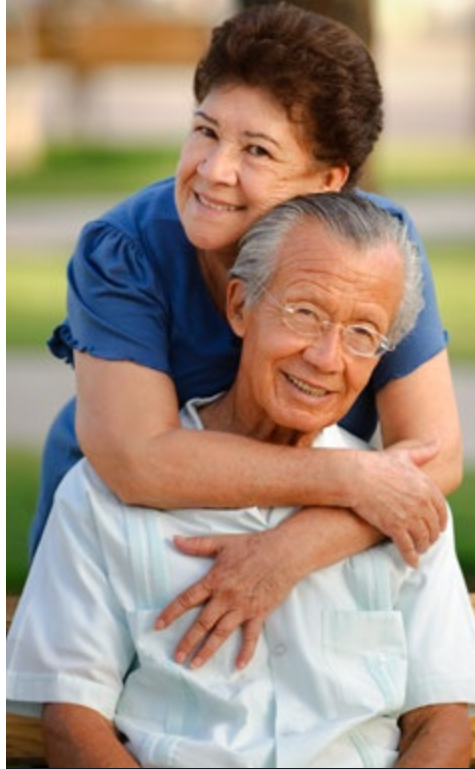




Plan 173 Retirees

UNITE HERE Staff

**UNITE
HERE!**
Staff



Summary Plan Description
Your Health and Welfare Benefits

UNITE HERE HEALTH

Summary Plan Description UNITE HERE Staff - Retirees Plan 173

Effective October 2016

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

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Using this book

Learn:

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

Please take some time to review this book.

If you have dependents, share this information with them. 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. The Fund serves participants working for employers in the hospitality industry. It is governed by a Board of Trustees made up of an equal number of union and employer trustees.

Your Plan, UNITE HERE Staff Retirees (Plan Unit 173), is part of the Fund. Plan 173 has been adopted by the Trustees to pay for medical and other health and welfare benefits through the Fund. Other SPDs explain the benefits for other Plans.

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 them. 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. You can get more information about different topics by carefully reading each section. A summary of the topics is shown at the start of each section. When you have questions, you should always contact your Care Coordinators at **(866) 686-0003**. Your Care Coordinators can help you understand 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. You can find more information about a specific benefit in the applicable section. For example, you can get more information about your medical benefits in the section titled "Medical Benefits" (*see page D-1*). If you want to know more about your life insurance benefits, read the section titled "Life insurance benefits" (*see page D-37*).

Remember, this SPD may describe benefits that do not apply to you.

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.

What are my benefit options?

The benefits described in this SPD explain the terms of all the benefit options available under Plan 173. However, the agreement with your former employer determines which benefit options you have. For example, if you are not eligible for medical benefits under Plan 173 Retirees, the part of this SPD that describes medical benefits will not apply you and your dependents. If you are not eligible for dental benefits, the part of the SPD that explains dental benefits does not apply to you.

The benefits you elect apply to both you and your enrolled dependents. You cannot elect coverage for your dependents only. You must elect coverage for yourself in order to elect coverage for your dependents. Dependents are not eligible for life insurance benefits. When you have questions about your benefit options, contact your Care Coordinators at **(866) 686-0003**.

How can I get help?

A

Care Coordinators (866) 686-0003

Call your Care Coordinators:

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

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

This booklet contains a summary in English of your plan rights and benefits under UNITE HERE HEALTH. If you have difficulty understanding any part of this booklet, you can visit or contact UNITE HERE HEALTH's headquarters at 711 N. Commons, Aurora, IL 60504. Office hours are from 8:30 a.m. to 4:30 p.m. Monday through Friday. You may also call UNITE HERE HEALTH at (866) 686-0003 for assistance. If you are in the Medicare supplement option, please call UNITE HER HEALTH at (855) 321-4373.

Este folleto contiene un resumen en inglés de los derechos y beneficios de su plan bajo UNITE HERE HEALTH. Si usted tiene alguna dificultad para comprender cualquier parte de éste folleto, puede visitar o contactar la oficina central de UNITE HERE HEALTH en 711 N. Commons, Aurora, IL 60504. El horario de oficina es de 8:30 AM a 4:40 PM de Lunes a Viernes. También puede llamar a UNITE HERE HEALTH al (866) 686-0003 para asistencia. Si usted está en la opción suplementaria de Medicare, por favor llamar a UNITE HERE HEALTH al (855) 321-4373.

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.
- ▶ How to join the Better Living program to manage your chronic health condition.

How do I get the most from my benefits?

Get a primary care provider

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

Make sure you or your PCP calls your Care Coordinators before your first visit to a specialist. **You can save \$10 if you call the Care Coordinators before you see a specialist** (see page C-3).

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

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

Get preventive healthcare

Your Plan pays 100% for certain types of preventive healthcare (See page D-7). 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.

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.

You pay \$20 for a visit to a network urgent care center. You pay 20% of all covered expenses if you get non-emergency care in a network emergency room.

- ✓ 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 questions about your benefits, help you understand your medical treatment plan, help you contact a nurse, help coordinate your care, and answer other questions for you. See page C-1 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-1 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 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).

Here is a sample medical claim to show how using a network provider usually saves you money.

Outpatient surgery in an ambulatory surgical facility		
	Network Provider	Non-Network Provider
A. Total charge	\$10,000	\$20,000
B. Network discount	-\$5,000	n/a
C. Allowable charge (See page I-2)	\$5,000	\$5,000
What you pay		
D. Amount over allowable charge	\$0 ($A - B - C = \0)	\$15,000 ($A - C = \$15,000$)
E. Deductible	\$200	\$400
F. Your cost sharing (copay or coinsurance)	\$0 (0% of C)	\$2,000 (40% of C = \$2,000)
Your total payment	\$200 ($D + E + F = \200)	\$17,400 ($D + E + F = \$17,400$)

Network benefits will be applied to:

- All emergency medical treatment, including non-network emergency treatment.
- Treatment provided by non-network doctors who specialize in emergency medicine, radiology, anesthesiology, or pathology.
- In-hospital consultations with non-network providers.

How do I get the most from my benefits?

- Non-network providers if there is no network provider available in that specialty.

In all of these cases, the allowable charge will be based on whether or not the provider is in the network. **You still pay the difference between the allowable charge and what the non-network provider charges.**

Easier claims filing with a network provider

If you use a network provider, the provider will usually file a claim for you. You generally don't have to fill out a claim form or submit your receipts.

If you choose a non-network provider, you may have to pay the entire cost of your care yourself. The non-network provider may or may not file a claim for you. If you have to pay the entire cost of your care yourself, you can file a claim to get paid back for this Plan's share of your covered expenses. *See page H-2* for more information about filing claims.

How do I stay in the network?

- Blue Cross Blue Shield of Illinois provides access to a national network of doctors, hospitals, and other healthcare providers. Your network is the Participating Provider Organization (PPO) network.
- Hospitality Rx provides access to a national network of participating pharmacies that you must use in order to get benefits for prescription drugs. Not all pharmacies are in the network. For example, **Walgreens is in your network. CVS and Wal-Mart are not in your network.**
- Davis Vision provides access to a national network of vision care providers. Use any participating Davis Vision provider to stay in the network.
- Delta Dental provides access to a national network of dental care providers. Network dentists are in the Delta Dental PPO Network. You can also save money by using a dentist in the Delta Dental Premier Network.

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

If you are in the Medicare supplement plan, please call UNITE HERE HEALTH at (855) 321-4373.

Join Better Living!

Is your chronic health condition taking over your life? Change your daily routine with the Better Living Program. The Better Living program is a free program that meets once a week for 6 weeks. Each meeting lasts just 2½ hours.

Join the program, and you will learn how to:

- Eat well.
- Manage your prescription drug.
- Deal with isolation and depression.
- Control your pain.
- Meet your goals.
- Fight fatigue and frustration.
- Start an exercise program.
- Manage stress and relax.
- Solve problems.
- Communicate better.
- Use your healthcare plan.
- Explore new treatments.

Workshop leaders

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

Support along the way

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

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

Summary of benefits

Summary of benefits

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

Medical and Prescription Drug Benefits for Non-Medicare Eligibles		
<p>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 go to an urgent care center instead of a hospital emergency room for non-emergency care.</p> <p>This section shows what you pay for your care (called your “cost-sharing”). You must pay your copays, deductibles, coinsurance shares, amounts over a maximum benefit, and expenses that are not covered, including charges that are more than the allowable charge (<i>see page I-2</i>).</p> <p>If you are Medicare eligible, <i>see page D-42</i> for information about your medical benefits.</p>		
Calendar Year Deductibles	\$200 per person \$600 per family	\$400 per person \$800 per family
Lifetime Maximum Benefit per Person	\$1,000,000	

Medical benefits	BCBS PPO Network	Non-Network
Basic Inpatient and Outpatient Benefits		
Inpatient Hospitalization	\$0 (after deductible)	40% (after deductible)
Inpatient Hospitalization for Mental Health/ Substance Abuse Treatment	\$0 (after deductible)	40% (after deductible)
Hospital Outpatient Services	\$0 (after deductible)	40% (after deductible)
Diagnostic Services	\$0 (after deductible)	40% (after deductible)
Routine Mammography — frequency limits apply (See page D-7)	\$0 (after deductible)	Not covered
Ambulatory Surgical Services	\$0 (after deductible)	40% (after deductible)
Skilled Nursing Facility — up to 70 total days per person each year	\$0 (after deductible)	40% (after deductible)
Home Healthcare Services — up to 200 total visits per person each year	\$0 (after deductible)	40% (after deductible)
Hospice Care — up to 210 total lifetime visits per person	\$0 (after deductible)	40% (after deductible)
Hospital Emergency Room — Emergency medical treatment (See page I-4)	0% (after deductible)	0% (after deductible)
Hospital Emergency Room — Non-emergency medical treatment	20% (after deductible)	60% (after deductible)
Medical and Surgical Benefit		
Preventive Care		
Well Baby Care — for children up to 18 months of age	\$0	Not covered
Immunizations	\$20 copay/visit	Not covered

B

B-2

Summary of benefits

Medical benefits	BCBS PPO Network	Non-Network
Routine Colonoscopy — <i>frequency limits apply (See page D-7)</i>	\$0	Not covered
Routine PSA Tests — <i>frequency limits apply (on page D-7)</i>	\$0	Not covered
Preventive Exam — <i>one per person each year</i>	\$0	Not covered
Office Visits		
Primary Care Provider (PCP) Office Visit	\$10 copay/visit	40% (after deductible)
Specialist Visit — <i>when a PCP follows the specialist referral rules (See page C-3)</i>	\$10 copay/visit	40% (after deductible)
Specialist Visit — <i>when a PCP does not follow the specialist referral rules (See page C-3)</i>	\$20 copay/visit	40% (after deductible)
Mental Health/Substance Abuse Office Visit	\$20 copay/visit	40% (after deductible)
Chiropractic Services	\$20 copay/visit	40% (after deductible)
Routine Podiatric Services	\$20 copay/visit	40% (after deductible)
Urgent and Non-Facility Emergency Care		
Urgent Care Center	\$20 copay/visit	40% (after deductible)
Doctor Services in a Hospital Emergency Room for Non-Emergency Treatment	20% (after deductible)	20% (after deductible)
Professional Ambulance Services	First \$50 in charges – \$0 After first \$150 in charges – 40% (after deductible)	
Other Services and Supplies		
Inpatient Professional Services	\$0	20% (after deductible)
Certified Diabetes Educator — <i>up to \$200 maximum per person each year</i>	\$0	Not covered
Registered Dietitian — <i>up to \$200 maximum per person each year</i>	\$0	Not covered
Outpatient Mental Health or Substance Abuse Services	\$20 copay/visit	40% (after deductible)
Speech Therapy and Physical Therapy — <i>Speech therapy for children limited to \$2,500 per person each year</i>	\$0 (after deductible)	40% (after deductible)
Non-Replaced Blood and Blood Plasma — <i>After the cost of the first pint</i>	25%	
Second Surgical Opinion	\$0	\$0
Anesthesia	\$0	\$0
Durable Medical Equipment	\$0 (after deductible)	40% (after deductible)

B

B-3

Summary of benefits

Medical benefits	BCBS PPO Network	Non-Network
Habilitative Therapy for Children with Autism Spectrum Disorder — <i>only for treatment starting before June 1, 2018; certain other limits apply (see page D-9)</i>	\$10 copay/day	40% (after deductible)
Medical Foods for Inborn Metabolic Errors	The Plan will reimburse you 100%, up to \$2,500 per person each year	
All Other Covered Expenses	\$0	40% (after deductible)

Prescription drug benefits	Your Cost for Each Fill or Refill	
	Retail (up to a 10-day supply)	Mail Order (up to a 60-day supply)
Annual Maximum Benefit Payable per Family:		
Families with at least one person who is age 65 (or who turns age 65 during the year)	\$12,500	
Families without no one either age 65 or turning age 65 during the year	\$7,500	
Generic Prescription Drugs	\$3	\$15
Brand Name Prescription Drugs	\$10	\$30
Specialty Prescription Drugs	25% up to \$35 total copay per fill or refill	

Medicare supplement coverage	
Medicare supplement benefits apply to eligible retirees and spouses who are age 65 or older and eligible for Medicare, and dependent children eligible for Medicare. <i>See page D-42</i> for more information about Medicare supplement benefits.	
Annual Maximum Benefit per Person	\$25,000
Lifetime Maximum Benefit per Person	\$50,000
Calendar Year Deductible	\$150 per person

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.

Summary of benefits

B

Dental benefits - Only available to certain grandfathered retirees (and their dependents)		
Description of Services	Delta Dental PPO Dentists and Delta Dental Premier Dentists	Non-Network Dentists
Calendar Year Deductible	\$25 per person; \$100 per family	
Maximum Benefits	\$2,000 per person every calendar year	
Dental (Non-Orthodontic) Services	\$500 per child per lifetime	
Orthodontic Services		
What You Pay for Your Covered Dental Care		
Diagnostic and Preventive Services	\$0	\$0
Emergency Palliative Services	\$0	\$0
Minor Restorative Services	20% (after deductible)	20% (after deductible)
Major Restorative Services	20% (after deductible)	20% (after deductible)
Prosthodontic Services	20% (after deductible)	20% (after deductible)
Orthodontic Services (for children under age 19 only)	40%	40%

Vision benefits - Not applicable if you are Medicare-eligible	
	<i>Maximum benefit</i>
For retirees and spouses	\$75 every 24 months
For dependent children age 19 and older	\$75 every 24 months
For dependent children under age 19	\$75 every 12 months

Life Insurance Benefit (Retirees Only) - Only available to certain grandfathered individuals	
What the Plan Pays	
Life Insurance	\$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.

Care Coordinators

*This section does not apply to you if you are covered under the Medicare supplement benefit.
See page D-42 for more information about your Medicare supplement benefit.*

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 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.

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

- ✓ You or your PCP should call your Care Coordinators if you need to see a specialist. However, it is up to you to make sure your Care Coordinators are contacted before you go to a specialist 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, chiropractic care, mental health/substance abuse treatment, routine podiatry, physical, or speech therapy.

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 was approved, and how many visits are approved or how long the approval lasts (such as 6 months). You do not need another referral for that type of specialist until you use all of the pre-approved visits, or until after the approved period of time. If you still need specialist care, ask your PCP to contact your Care Coordinators again.

- If your PCP contacts your Care Coordinators about the network specialist visit, your copay will be \$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 20% of the allowable charges for the visit. The Care Coordinators can still coordinate your care, even if you choose a non-network 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.

Get prior authorization for medical and surgical treatment

You or your doctor must call your Care Coordinators before you get any of the types of care listed below. If your doctor does not get prior authorization before you receive these types of care, your claim may be denied. Your Care Coordinators will ask your doctor for more information to decide whether the claim should be re-processed and paid. Making sure your Care Coordinators are

Care Coordinators

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 doctor should call your Care Coordinators any time you plan to get care other than in your PCP's office. You should also make sure you or your doctor contacts your Care Coordinators before any of the following:

- Any inpatient admission, including to a skilled nursing facility.
- Outpatient surgery (other than surgery performed in a provider's office).
- Durable medical equipment rentals or purchases of \$500 or more. This includes breast pumps costing \$500 or more.
- Home healthcare.
- Hospice care.
- Oncology services, including but not limited to radiation therapy and chemotherapy.
- Dialysis.
- Genetic testing.
- The following diagnostic imaging procedures:
 - ▶ MRA or MRI (magnetic resonance imaging or magnetic resonance angiography).
 - ▶ PET scan or PET-CT scan (positron emission tomography scintiscan or integrated positron emission tomography and computed tomography scan).
- 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-6 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 doctor 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 doctor 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 doctor. 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.

Care Coordinators

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

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

Chronic condition management program

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

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

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

Medical benefits

Learn:

- ▶ What you pay for healthcare.
- ▶ How your lifetime maximum benefit works.
- ▶ What types of medical healthcare are covered.
- ▶ What types of medical healthcare are not covered.

Medical benefits

This section does not apply to you if you are Medicare-eligible. See page D-42 for information about Medicare supplement benefits.

Certain grandfathered retirees and dependents are not eligible for these medical benefits.

Types of medical benefits

Your medical benefits are split into two categories:

- Basic inpatient and outpatient benefits
- Medical and surgical benefits

The deductibles apply to both types of medical benefits. However, the deductibles will not apply to certain types of medical and surgical benefits. The deductibles do apply to all of your basic inpatient and outpatient benefits.

The lifetime maximum benefit *only applies to medical and surgical covered expenses.*

Network providers

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

**In California, only Blue Cross providers are network providers;
Blue Shield providers are not in your network.**

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

What you pay

You must pay your cost share (such as deductibles, copays, and coinsurance) for your covered expenses. You must also pay any expenses that are not covered expenses (see page D-12 for information about excluded expenses), including any amounts over the allowable charge, or charges once a maximum benefit or limitation has been met.

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

Deductibles

There are two deductibles:

- **Network calendar year deductibles** of \$200 per person and \$600 per family apply each calendar year to your covered expenses provided by *network providers* before this Plan pays benefits.
- **Non-network calendar year deductibles** of \$400 per person and \$800 per family apply each calendar year to your covered expenses provided by *non-network providers* before this Plan pays benefits.

Each deductible only applies once each year. Once you have paid your deductible (sometimes called “satisfying your deductible”), you do not have to make any more payments toward your deductible for the rest of that year.

Amounts you pay for your network calendar year deductible do not apply to your non-network calendar year deductible, and vice versa.

The calendar year deductibles do not apply to covered expenses for the following medical and surgical benefits:

- Network services for:
 - Preventive care.
 - Office visits.
 - Chiropractic or podiatric services.
 - Outpatient mental health or substance abuse services.
 - Clinic or urgent care facility services.
 - Certified diabetes educator or registered dietitian services.
 - Non-replaced blood and blood plasma.
 - Second or third surgical opinions.
 - The first \$50 charged per trip for professional ambulance transportation.
- The following non-network services:
 - Anesthesiology.
 - Non-replaced blood and blood plasma.
 - Second or third surgical opinions.
 - The first \$50 charged per trip for professional ambulance transportation.

Medical benefits

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 \$100 out-of-pocket toward your network calendar year deductible, your network calendar year deductible for the next year will be \$100 (\$200 total - \$100 from December).

See page I-3 for more information about what a deductible is.

Copays

The copay covers all healthcare you receive at the time of the service. For example, you only pay one office visit copay for all healthcare you receive during that office visit.

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

Lifetime maximum benefit for medical and surgical benefits

The Plan will pay up to \$1,000,000 per person for your covered expenses for medical and surgical benefits during your lifetime for network and non-network covered expenses combined. Once the Plan has paid \$1,000,000 in total medical benefits on your behalf, the Plan will not pay any additional amount for your medical and surgical benefits.

However, every calendar year, the Plan will automatically restore some of your lifetime maximum benefit. Restoration of your lifetime maximum benefit starts the first day of the calendar year after you have been covered under Plan 173 (Retirees) for at least 12 months. The amount of your lifetime maximum benefit that will be restored is the lesser of:

- The amount of the medical and surgical benefits paid on your behalf during the prior calendar year; OR
- \$5,000

For example, suppose you have been covered under Plan 173 (Retirees) for two years. The Plan paid \$4,000 in benefits for you during the past year. On January 1, the amount of Plan benefits paid toward your lifetime maximum benefit is reduced by \$4,000.

The lifetime maximum benefit does not apply to covered expenses for basic inpatient and outpatient benefits.

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 doctor.

Basic inpatient and outpatient benefits

- **Hospital charges** for room and board, and other inpatient or outpatient services, up to 365 days for all confinements not separated by 90 or more days. The Plan's benefits for a private room will be limited to the semi-private room rate.
 - ▶ The following outpatient charges actually administered by the hospital are also covered:
 - Emergency medical treatment for injury or sickness.
 - Surgery.
 - Chemotherapy for the treatment of malignant disease, other than oral chemotherapy or subcutaneous or intramuscular injection of drugs.
 - Radiation therapy.
 - Diagnostic services (such as MRIs and PET scans).
 - Mammography when indicated by the person's health history.
 - Routine mammography, every 1-2 years if you are age 40 through age 74. Routine mammograms for women under 40, or older than 75, may be covered if you are at high-risk for breast cancer. Routine mammography is covered only if you use a network provider.
 - ▶ Preadmission testing associated with scheduled inpatient or outpatient surgery at the hospital where the tests are performed;
- **Ambulatory surgical facility services**, including general supplies, anesthesia, drugs, and operating and recovery rooms. If you have multiple surgeries, covered expenses are limited to charges for the primary surgery. However, professional services for surgical procedures that would normally be performed in a provider's office are not covered.
- **Skilled nursing facility care**, limited to a total of 70 days per person each year for network and non-network care combined. The skilled nursing facility care must meet all of the following rules:
 - ▶ It must start within 14 days of a hospitalization of at least 3 days.
 - ▶ It must be under the care of a healthcare professional.
 - ▶ You must be a regular bed patient.
 - ▶ Your healthcare professional must certify that skilled nursing facility confinement is necessary because of the same injury or sickness treated during the immediately preceding hospitalization.
- **Preadmission testing** for scheduled inpatient or outpatient surgery at the hospital where the tests are performed.

Medical benefits

- **Home healthcare services**, limited to a total of 200 visits per person each year for network and non-network services combined up to a combined network/non-network maximum of 200 home care visits each calendar year, if visits begin within 7 days after a preceding hospitalization, or up to a combined network/non-network maximum of 40 visits each calendar year, if there is no preceding hospitalization. General housekeeping services or custodial care is not covered.
 - ▶ The following services will be covered regardless of whether they are furnished by network or non-network providers:
 - Part-time professional nursing services by an RN or LPN.
 - Part-time home health aide services. Four hours equals one home healthcare visit.
 - Physical, occupational, or speech therapy.
 - Medical supplies, prescription drugs, and laboratory services.
 - ▶ The following services are covered only if furnished by network providers:
 - Medical social work services.
 - X-ray and EKG services.
 - Professional ambulance or ambulette transportation to a hospital.
- **Hospice services and supplies** if you are terminally ill, limited to 210 total lifetime visits per person for network and non-network services combined. The services must be authorized by a doctor. Covered hospice care includes:
 - ▶ Outpatient care in your home.
 - ▶ Inpatient care in a hospital, including a designated hospice unit.
 - ▶ Intermittent nursing or home healthcare.
 - ▶ Physical, occupational, or speech therapy.
 - ▶ Respiratory therapy and equipment.
 - ▶ Nutritional services.
 - ▶ Office visits.
 - ▶ Laboratory tests and x-rays.
 - ▶ Chemotherapy/radiation therapy for symptom control.
 - ▶ Prescription drugs.
 - ▶ Rental of medical equipment.

- ▶ Medical/surgical supplies.
- ▶ Professional ambulance or ambulette transportation between home and hospital or hospice.
- ▶ Social services, including up to five visits for bereavement counseling for your family, either before or after your death.

Medical and surgical benefits

- The following **preventive healthcare services** when a network provider is used. Non-network expenses are not covered.
 - ▶ **One routine gynecological exam** each year if you are female and at least age 16.
 - ▶ **Cervical cancer screening** (pap smears) are covered 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.
 - ▶ **Routine mammograms** for women are covered every 1-2 years if you are age 40 through age 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 tests** for men are covered every 12 months for men age 40 through 69.
 - ▶ One **routine physical examination** not otherwise covered above, limited to one such examination every year, conducted in the doctor's office.
 - ▶ **Well baby examinations** for children up to 18 months of age.
 - ▶ **Routine immunizations and flu shots** provided in accordance with the guidelines established by the American Academy of Pediatrics and the American Academy of Family Practitioners.
 - ▶ **Routine outpatient colonoscopies**, when performed as follows:
 - Once every 10 years beginning at age 50, if you are of average risk for colon cancer.
 - Once every two years if your treating physician diagnosis you as high risk for colon cancer because of medical history of immediate family members.
- **Professional medical and surgical services of a doctor.**
- Treatment of **mental health conditions**, including:
 - ▶ Inpatient care
 - ▶ Outpatient care. Services include treatment is provided by psychiatric nurses, Master's degreed social workers, licensed clinical professional counselors, and clinical psychologists.

Medical benefits

- Treatment of **substance abuse**, including:
 - Inpatient care.
 - Outpatient care. Services include treatment provided by licensed chemical dependency therapists, Master's degreed social workers, and clinical psychologists.
- **Chiropractic care**.
- **Podiatric care**, including routine podiatric services and podiatric surgery.
- **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, if a healthcare professional, employer, law enforcement, school, etc., calls the ambulance, your ambulance transportation will be considered medically necessary. Contact your Care Coordinators if you had no control over an ambulance being called.
- **Radiology**, including but not limited to x-rays, ultrasounds, and fetal monitoring.
- **Laboratory services**.
- **Diagnostic imaging**, including but not limited to MRIs, MRAs, CT scans, PET scans, and cardiac testing.
- **Pregnancy** and pregnancy-related conditions, including childbirth, miscarriage, or abortion.
- **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.
 - The Fund or its representative must get prior authorization for the transplant.
 - Donor expenses for your transplant are only covered if the donor has no other coverage.
 - Transplant coverage does not include your expenses if you are giving an organ instead of getting an organ.

- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- Network professional services of a network **certified diabetic educator**, limited to \$200 per person each year. Non-network expenses are not covered.
- Network professional services of a network **registered dietitian**, limited to \$200 per person each year. Non-network expenses are not covered.
- Unreplaced **blood and blood plasma** and their administration.
- **Anesthesia** and its administration.
- **Durable medical equipment**, including supplies, for all non-disposable devices or items prescribed by a doctor, such as wheelchairs, hospital-type beds, respirators and associated support systems, infusion pumps, home dialysis equipment, monitoring devices, home traction units, and other similar medical equipment or devices. Non-network DME is not covered.
 - ▶ Rental fees are covered if the DME can only be rented. 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.
- **Second and third surgical opinions.**
- **Habilitative therapy** for children with autism spectrum disorder (only for treatment that begins between June 1, 2015 and May 31, 2018). *You must get prior authorization for habilitative therapy before the Plan pays benefits.* Benefits are limited to 30 hours per person each week, and to a total of 36 months, for network and non-network services combined. "Habilitative therapy" includes applied behavioral analysis (ABA) therapy and similar types of treatment. It does not include physical, speech, or occupational therapy.
 - ▶ Your child must be at least 2 years old, but no more than 8 years old.
 - ▶ Your child must have a diagnosis of autism spectrum disorder, and have a prorated mental age of at least 11 months.
 - ▶ The provider supervising the habilitative therapy must be certified by the Behavioral Analyst Certification Board (BACB) as a Board Certified Behavior Analyst or Board Certified Behavior Analyst Doctorate (or similar licensing body).
 - ▶ The person providing the habilitative therapy must be certified by the BACB as a Board Certified Assistant Behavioral Analyst or Registered Behavioral Technician (or similar licensing body).

- ▶ 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.*
- **Medical foods** if you have an inborn error of metabolism (IEM). *You must get prior authorization for your medical food costs before the Fund will reimburse you.* The Fund will reimburse 100% of your costs for medical foods, up to a total of \$2,500 per person each year. To be reimbursed, the medical food must be:
 - ▶ Ordered by and used under the supervision of a doctor.
 - ▶ The primary source of your nutrition
 - ▶ Labeled and used for dietary management of your IEM.
- Outpatient rehabilitation services for **physical therapy** provided by a licensed physical therapist.
- Outpatient rehabilitation services for **occupational therapy** provided by a licensed occupational therapist.
- Outpatient **speech therapy services** when provided by a licensed speech therapist:
 - ▶ For adults, only speech therapy to restore speech lost as the result of injury or sickness is covered.
 - ▶ For dependent children, speech therapy, up to \$2,500 each year for network and non-network services combined, is only covered to:
 - Screen, detect, and treat autism spectrum disorders.
 - Restore or improve speech for speech-language and developmental delay disorders caused by a non-chronic sickness, intra-uterine trauma, hearing loss, difficulty swallowing, or acute sickness or injury.
 - Treat a speech delay associated with a specific disease, injury, or congenital defect, such as cleft lip and palate.

- **Radiation therapy.**
- **Chemotherapy.**
- **Oxygen** and rental equipment for its administration.
- **Repair of sound natural teeth** and their supporting structures, if the covered expenses are the result of an injury. Treatment must be received while you are covered under the Fund and within six months of the injury. You may have additional dental coverage under your dental benefits, if applicable—see the dental benefits sections.
- **Sterilization procedures** for retirees, spouses, and female dependent children.
- **Nursing services** performed by a registered graduate nurse (RN) or licensed practical nurse (LPN) and other specialized services performed by registered graduate nurses with the following certifications:
 - ▶ Certified Registered Nurse Anesthetist (CRNA).
 - ▶ Nurse Practitioner (NP).
 - ▶ Clinical Nurse Specialist (CNS).
 - ▶ Certified Nurse Midwife (CNM).
- **Services of Certified Registered Nurse First Assistants (CRNFAs).**
- **Surgical supplies and dressings**, including casts, splints, prostheses, braces, crutches, and trusses.
- **Orthotics and prosthetics.**
- **Birth control devices.**
- Treatment of **tumors, cysts and lesions** not considered a dental procedure.
- Oral surgery for the **removal of bony impacted teeth.**
- **Allergy treatments**, including extracts.
- **Transgender healthcare services** in accordance with the Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders (6th version).
- **Administration of injectable medications**, including immunizations, that would otherwise be a covered expense, if such medication is administered by a pharmacist.

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:

Basic inpatient and outpatient benefits

- Blood and blood plasma when replacement is available.
- Professional charges for or in connection with confinement in a hospital or skilled nursing facility. (These charges may be covered under the medical and surgical benefits.)
- Charges for a private room.
- Inpatient care primarily for custodial purposes, long-term care, or care during the non-acute stages of a sickness.
- Inpatient admissions primarily for diagnostic studies or physical therapy.
- Outpatient surgery performed in an ambulatory surgical center that would normally be performed in a doctor's office.
- Occupational therapy, except as specifically stated as covered.
- 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 section), 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-25).

Medical and surgical benefits

- Ambulatory surgical facility fees for procedures normally performed in a provider's office.
- Prescription drugs and medications, other than those used where they are dispensed. Prescription drugs may be covered under the prescription drug benefit shown on page D-15.
- Cosmetic, plastic, or reconstructive surgery, unless that surgery is either: (1) to treat an accidental injury, and the surgery is performed within 24 months after the accident, or (2) breast reconstruction following a mastectomy.
- Procedures to reverse a voluntary sterilization.

- 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 section), 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-25*).

- Treatment of temporomandibular joint (TMJ) disorders, craniofacial disorders or orthognathic disorders.
- Surgery to modify jaw relationships including, but not limited to, osteoplasty and genioplasty procedures. However, Le Fort-type operations are covered when primarily to repair birth defects of the mouth, conditions of the mid-face (over or under development of facial features), or damage caused by accidental injury.
- Private duty nursing care.
- Acupuncture.
- Supplies or equipment for personal hygiene, comfort, or convenience including but not limited to air conditioning, humidifier, physical fitness and exercise equipment, tanning beds, or water beds.
- Eye or hearing exams, except as specifically stated as covered, or unless the exam is for the diagnosis or treatment of an accidental bodily injury or an illness. However, eye exams may be covered under the vision benefits (*See page D-33*).
- Eye refractions, eyeglasses, or contact lenses. However, these expenses may be covered under the vision benefits (*See page D-33*).
- Hearing aids.

Prescription drug benefits

Learn:

- ▶ What you pay for your covered prescription drugs.
- ▶ How your annual maximum family benefit works.
- ▶ What the generic substitution rule is.
- ▶ 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.

Prescription drug benefits

Certain grandfathered retirees and dependents are not eligible for these prescription drug benefits.

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

If you use a pharmacy not in your network, like CVS or Wal-Mart, 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:	At:
Find a network pharmacy	Care Coordinators	(866) 686-0003
Get prior authorization for prescription drugs	Hospitality Rx	(866) 686-0003
Get a free glucometer	One Touch (LifeScan products) True Test (Nipro products)	(800) 227-8862 (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-21* for information about excluded expenses), including any amounts over the allowable charge.

You must use the specialty pharmacy to get specialty and biosimilar prescription drugs. *See page D-21* for more information about the specialty pharmacy.

Prescription drug benefits

Prescription drug benefits	Your Cost for Each Fill or Refill	
	Retail (up to a 10-day supply)	Mail Order (up to a 60-day supply)
Annual Maximum Benefit Payable per Family:		
Families with at least one person who is age 65 (or who turns age 65 during the year)		\$12,500
Families without no one either age 65 or turning age 65 during the year		\$7,500
Generic Prescription Drugs	\$3	\$15
Brand Name Prescription Drugs	\$10	\$30
Specialty Prescription Drugs	25% up to \$35 total copay per fill or refill	

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.

Annual maximum benefit

The Plan will 100%, after you pay any applicable copay, for your family's prescription drugs, up to the annual maximum benefit. Once the Plan has paid the annual maximum benefit for your family's prescription drugs during a calendar year, the Plan will not pay for any more prescription drugs for anyone in your family during the rest of that calendar year.

The annual maximum benefit for your family's prescription drugs are:

- \$12,500 for all family members combined—if at least one person in your family is age 65 or will turn age 65 during the calendar year.
- \$7,500 for all family members combined—if no one in your family is age 65 (or turns age 65) during that calendar year.

Generic prescription drug policy for retail pharmacies

If you or your provider chooses a brand name prescription drug when you could get a generic equivalent instead, you pay the difference in cost between the brand name prescription drug and the generic equivalent. For example, if the brand name prescription drug costs \$80 at retail, and

Prescription drug benefits

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 your Care Coordinators. This rule will also not apply if the prior authorization program makes an exception. Your doctor 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 preferred or non-preferred brand name drug copay.

This rule does not apply to the mail order pharmacy—brand name drugs with generic equivalents are not covered under the mail order pharmacy.

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 doctor. This includes oral and injectable contraceptives, vitamins, 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.
- Insulin, diabetic test strips, and 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.
- Effective January 1, 2017: the following single-source 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:

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

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

If you don't want one of the 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 usually will 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 doctor can always get the most current information by contacting your Care Coordinators at (866) 686-0003 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 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 larger supply of pills you will have to throw away if you get serious side effects.

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

Prior authorization

If you have a prescription for certain drugs, your doctor will need to provide your medical records to show that the prescription drug is clinically appropriate for your situation. The list of prescription drugs that require prior authorization changes from time to time. Call (866) 686-0003 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 that 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 asks you to try over-the-counter, generic, or preferred formulary versions of prescription drugs first. If the first level of prescription drugs does not work for you, or causes serious side effects, you are “stepped up” to the next level of prescription drugs.

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

The list of prescription drugs that require step therapy changes from time to time. Contact your Care Coordinators at (866) 686-0003 with questions about which prescription drugs require prior authorization.

Prescription drug benefits

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 to the case managers if they contact you!

Fill and refill limits

Quantity limits

- Prescriptions purchased through a network retail pharmacy are limited to a 10-day supply, unless the prescription is a prepackaged medication only sold in quantities greater than a 10-day supply. Only two fills of the same drug will be filled during a 180-day period.
- If you use the mail-order pharmacy, you can usually 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.

If you get a covered prescription drug that can only be filled with a 90-day supply, you will pay two times the applicable mail order copay if you fill it through the mail order pharmacy.

You generally cannot refill a prescription until you have used at least 75% of the supply, but in some cases, you may be able to refill a prescription sooner. For example, if you show you plan to be out of the country when you would run out of a prescription drug, the Fund may approve an early refill once for each drug each year. If your prescription is lost or stolen, you may also get an early refill once for each drug 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. If your lost or stolen drug is approved for an early refill, the Fund may apply a surcharge of up to \$50 (or, if less, the cost of the drug) in addition to the applicable copay.

Call your Care Coordinators if you will be out of the country when you would run out of a prescription drug, or if you have lost your prescription or had it stolen.

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 through the mail order pharmacy. 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 doctor can call for information about these quantity limits. Your doctor 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.

However, brand name drugs with generic equivalents are not covered expenses through the mail order pharmacy.

You can order from the 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 doctors who specialize in helping people with your condition. The specialty pharmacy staff can help make sure your prescription gets refilled on time, and 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.

Prescription drug benefits

- Fertility drugs.
- Birth control devices and implants.
- Prescriptions or refills in amounts over the quantity limits (*see page D-20*).
- Non-sedating antihistamines or histamine blockers.
- Over-the-counter proton pump inhibitors.
- Vitamins obtainable without the written prescription of a healthcare professional, or dietary aids or supplements. As of January 1, 2017, this exclusion will read: Vitamins, dietary supplements, or dietary aids, except those specifically listed as a covered.
- 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.
- Any drug or supply that is subject to a safety or cost containment program if that program is not followed, or if the program does not authorize the drug or supply.
- 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 benefits 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 it is dispensed, other than immunizations. (These drugs may be covered under your medical benefits. *See page D-4.*)
- Diagnostics or biologicals.
- Drugs used for cosmetic reasons.
- Weight control drugs, unless for the treatment of morbid obesity under the direct supervision of a doctor, and authorized in writing by the Fund.
- Human growth hormone, except to treat emaciation due to AIDS.

Prescription drug benefits

- 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-9*).
- With respect to the mail order pharmacy only: relenza and tamiflu.

Dental benefits

Learn:

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

Dental benefits

Dental benefits are only available to certain grandfathered retirees and their dependents who have retained dental coverage because of previous plan mergers. For more information about who is eligible for dental benefits, contact your Care Coordinators at (866) 686-0003.

UNITE HERE HEALTH has contracted with Delta Dental of Illinois (Delta Dental) to administer dental benefits for you and your dependents.

Dental benefits - Only available to certain grandfathered retirees (and their dependents)		
Description of Services	Delta Dental PPO Dentists and Delta Dental Premier Dentists	Non-Network Dentists
Calendar Year Deductible	\$25 per person; \$100 per family	
Maximum Benefits		
Dental (Non-Orthodontic) Services	\$2,000 per person every calendar year	
Orthodontic Services	\$500 per child per lifetime	
What You Pay for Your Covered Dental Care		
Diagnostic and Preventive Services	\$0	\$0
Emergency Palliative Services	\$0	\$0
Minor Restorative Services	20% (after deductible)	20% (after deductible)
Major Restorative Services	20% (after deductible)	20% (after deductible)
Prosthodontic Services	20% (after deductible)	20% (after deductible)
Orthodontic Services (for children under age 19 only)	40%	40%

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.

Network vs. non-network providers

Benefits are paid based on whether you get treatment from a network provider or a non-network provider. To locate a network provider near you, contact:

Delta Dental
 toll-free: (800) 323-1743
www.deltadentalil.com
 (you will have to create an account)

Delta Dental PPO Dentist or a Delta Dental Premier Dentist have contracted with Delta Dental to accept Delta Dental's contracted rates for dental care. If you use a Delta Dental PPO Dentist or a Delta Dental Premier Dentist, you can limit what you pay for your dental care. Dentists that do not contract with Delta Dental (non-network dentists) can bill you the difference between their billed charges and what the Fund will pay for the services (often called "balance billing"). If you use either a PPO Dentist or a Premier Dentist, the dentist will not balance bill you for your covered expenses. That means you usually will not have to pay anything for your covered dental care if you use a PPO or Premier Dentist, unless the Plan pays its maximum benefit.

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

What you pay

You must pay your cost share (such as deductibles, copays, and coinsurance) for your share of covered expenses. You must also pay any expenses that are not covered expenses (See page D-30 for information about excluded expenses), including any amounts over the allowable charge, or charges once a maximum benefit or limitation has been met.

Maximum benefits

Dental care maximum benefit for non-orthodontic care

The Plan pays up to \$2,000 per person each year for both network and non-network dental care combined. Once this Plan pays \$2,000 for your dental care during a year, no more benefits will be paid for your dental care for the rest of that year.

Orthodontic care maximum benefit

This Plan pays up to a lifetime maximum of \$500 per person for both network and non-network orthodontic care combined. Once the \$500 maximum is reached, no more benefits will be paid for your orthodontic care. Orthodontic care is only covered for dependent children under age 19.

Alternate course of treatment

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

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

What's covered

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

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

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

- **Diagnostic and preventive services** and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease, including exams, cleanings, and consultations with a non-treating dentist.
 - ▶ Prophylaxes (cleaning) and oral exams are limited to two every calendar year.
 - ▶ Bitewing x-rays are limited to two series every calendar year.
 - ▶ Full mouth x-rays (which include bitewing x-rays) is limited to one every 36 months. Panoramic or panographic x-rays (including bitewings) are considered a full mouth x-ray.
 - ▶ Topical application of fluoride if you are under age 19 are limited to two every calendar year.
 - ▶ Sealants to the first and second permanent molars are limited to one treatment per tooth. Sealants are covered only for dependent children under age 14.
 - ▶ Space maintainers for non-orthodontic treatment. Recementation of a space maintainer is limited to once each calendar year, and is covered only for dependent children under age 14.
- **Emergency palliative treatment** to temporarily relieve pain and discomfort.
- **Oral surgery services:** extractions and other surgical dental procedures furnished in a dentist's office, including pre- and post-operative care and anesthesia.
- **Endodontic services** (such as root canals) to treat teeth with diseased or damaged nerves.
 - ▶ Root canals on primary teeth will be limited to the benefits provided for a pulpotomy, unless x-rays show that there is no permanent successor tooth, and the primary tooth has sufficient intact root structure.
 - ▶ Resorbable filling is limited to once per tooth per lifetime.

- **Periodontic services** for the treatment of diseases and the gums and supporting structures of the teeth.
 - ▶ Full mouth debridement is limited to once per lifetime.
 - ▶ Surgical periodontal therapy is limited to once per quadrant in any 60-month period.
 - ▶ Periodontal maintenance is limited to two each calendar year.
- **Restorative services** to rebuild, repair, or reform the tissues of the teeth, such as restorations, crowns, and jackets:
 - ▶ Amalgam or resin restorations are limited to once per tooth surface every 12 months.
 - ▶ Sedative fillings are limited to once per tooth per lifetime.
 - ▶ Gold restorations are covered only when the tooth cannot be restored with another filling.
- **Prosthodontic services** that replace missing natural teeth, and repairs to prosthodontics:
 - ▶ Complete replacement of denture base materials or relines are limited to one every 24 months.
 - ▶ A fixed partial denture placed in a dental arch with three or more missing teeth will be limited to the benefits provided for removable dentures. Any additional appliance placed in the same arch within 60 months following the initial appliance is not covered.
 - ▶ Benefits will be limited to those for a removable partial denture, when a fixed partial denture and a removable partial denture are placed in the same arch.
 - ▶ When a porcelain/ceramic inlay is placed as an abutment, benefits will be limited to those for a cast metal inlay.
 - ▶ Benefits for pontics will be limited to the benefit for one pontic when the space between teeth created by a missing tooth is greater than the size of the original tooth.
 - ▶ Benefits for personalization of dentures, precision attachments, stress breakers, or specialized techniques will be limited to the benefits provided for conventional dentures.
- **Other services** listed below:
 - ▶ Consultations.
 - ▶ Labial veneers.
 - ▶ Therapeutic drug injections.
- **Orthodontic services** for children under age 19.

Dental benefits

- ▶ Benefits for specialized techniques, such as clear or invisalign braces, are limited to the benefits provided for conventional braces.

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 treatments, services, and supplies are not covered:

- Topically applied fluorides for persons age 19 or older.
- Pulp vitality tests billed in conjunction with any service other than emergency examinations or palliative treatment.
- Repair of space maintainers, or recementing by the same office within six months of initial placement.
- Fillings when crowns are allowed for the same teeth.
- Replacement of any cast restoration performed (crowns, onlays, ceramic restorations) with any type of cast restoration within 60 months of the initial placement of an existing restoration.
- Replacement of a stainless steel crown with any type of cast restoration by the same dental office within 24 months of the initial placement.
- A cast restoration lacking radiographic evidence of decay or missing tooth structure or restorations placed for any other purpose, including, but not limited to, cosmetic, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures.
- Crown build-up when radiographic evidence shows sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration.
- Repair of any component of a cast restoration.
- Recementing of inlays, onlays, partial coverage restorations, cast and prefabricated posts and cores and crowns by the same dental office within six months of the initial placement.
- Additional procedures to construct a new crown under an existing partial denture framework within six months of the initial placement.
- Sedative fillings placed on the same date as a permanent filling.
- Endodontic procedures performed in conjunction with complete removable prosthodontic appliances.
- Bone replacement grafts performed in conjunction with extractions or implants.
- Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions, or periadicular surgery/apicoectomy.

- Crown lengthening or gingivoplasty if not performed at least 4 weeks prior to crown preparation.
- Periodontal splinting to restore occlusion.
- Replacement of an existing prosthodontic appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontic appliance within 60 months after initial placement of an existing appliance.
- Fixed partial dentures, when a fixed partial denture and a removable partial are requested or placed in the same arch.
- Reline or rebase of an existing appliance within six months after initial placement.
- Fixed or removable prosthodontics for a person under age 16.
- Any prosthodontic appliance connected to an implant.
- Tissue conditioning.
- A pontic, when the toothless space between teeth is less than 50% of the size of the missing tooth.
- Mobilization of an erupted or malpositioned tooth to aid eruption or placement of a device to facilitate eruption of an impacted tooth performed in conjunction with other oral surgery.
- Services performed to correct developmental malformation, including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and congenitally missing teeth for persons other than newborn infants.
- Services for purely cosmetic purposes, including, but not limited to, tooth-colored veneers, bonding, porcelain restorations, and microabrasion.
- Services for anesthetists or anesthesiologists.
- Temporary procedures.
- Any procedure performed on a tooth when radiographs indicate less than 40% of the root is supported by bone.
- Services performed on second or third molars that do not have an opposing tooth.
- Services performed on primary teeth near exfoliation.
- Drugs or the administration of drugs, except for anesthesia and therapeutic drug injection.
- Procedures considered experimental or investigational by the American Dental Association, for which there is no procedure code, or which are not consistent with Current Dental Terminology coding and nomenclature.

Dental benefits

- Procedures that Delta Dental considers to be included in the fees for other procedures . (You will not be billed for such procedures.)
- The completion of claim forms and the submission of required information, not otherwise covered for the determination of benefits.
- Infection control procedures and fees associated with compliance with OSHA requirements.
- Missed appointments.
- Charges for services for inpatient or outpatient hospital treatment.
- Services or supplies for oral hygiene or plaque control programs.
- Services and supplies to correct harmful habits.
- Treatment for treatment of the temporomandibular joint (TMJ).
- Orthodontic services or supplies for any retiree or spouse, or for a child age 19 or older.

Predetermination of dental benefits

If your dentist recommends dental work that is estimated to cost \$250 or more, you can ask Delta Dental to help you determine how much the Plan will pay. This is a voluntary program to help you understand your costs before you have dental care. Delta Dental will help you and your dentist understand what the Plan will pay for your proposed care. By contacting Delta Dental in advance, you will have a better idea of what your share of the costs will be so you don't get surprise bills. If you take advantage of this program, Delta Dental will review your dentist's records and provide you and your dentist with an estimate of what you must pay, and what the Plan will pay.

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

Dental benefits after eligibility ends

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

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

Vision benefits

Learn:

- ▶ What you pay for your covered vision care.
- ▶ How your maximum benefit works.
- ▶ What types of vision care are covered.
- ▶ What types of vision care are not covered.

Vision benefits

Vision benefits are not available to retirees and their dependents who are eligible for Medicare.

Certain grandfathered retirees and their dependents are not eligible for vision benefits. For more information about who is eligible for vision benefits, contact your Care Coordinators at (866) 686-0003.

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

Vision benefits	
	Maximum benefit
For retirees and spouses	\$75 every 24 months
For dependent children age 19 and older	\$75 every 24 months
For dependent children under age 19	\$75 every 12 months

Network and non-network vision providers

Benefits are paid based on whether you get treatment from a network provider or a non-network provider.

To locate a network provider near you, contact:

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

If you choose a network provider, you may also get discounts on lenses, frames, and contacts that are not in the Davis Vision collection, or that cost more than any maximum allowance.

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

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.

What you pay

You pay for any expenses that are not covered, including costs that are more than any maximum allowance or benefit.

Discount fee schedule options through network providers

If you use a network provider, you can get certain discounts on your eye wear, upgrades, or other options. The network provider has agreed to charge you discounted rates to help you stretch your vision benefits.

Available upgrades and options include, but are not limited to, progressive lenses, scratch protection, anti-reflective and ultra anti-reflective, and ultraviolet coating, polycarbonate lenses, high index lenses, and polarized and photosensitive lenses. Get your questions about options answered by contacting Davis Vision, or by asking your network provider. Your cost for an upgrade depends on which upgrade(s) you pick.

Maximum benefit

This Plan only pays up to the maximum benefit or allowance shown in the table for your vision care (you pay any charges over the maximum benefit).

Your benefit period is measured from the first day of the month during which the covered expense is incurred. For example, if you (a retiree) get frames and lenses on July 15, 2017 the next 24-month benefit period during which you can get new lenses and frames would begin July 1, 2019.

What's covered

- Routine eye exams (including dilation when professionally indicated).
- Spectacle lenses, including single vision, bifocal, trifocal, or lenticular.
- Frames.
- Contact lenses (soft, daily-wear, disposable, or planned replacement) instead of glasses.
- Medically necessary contacts, with prior authorization from Davis Vision.

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 vision treatments, services, and supplies are not covered under the vision benefits:

- Medical treatment or eye disease or injury.
- Vision therapy.
- Non-prescription lenses.
- Any type of lenses, frames, services, supplies, or options that are not specifically listed as covered, or that are not covered under the Davis Vision contract.
- Two or more pairs of glasses instead of bifocals or trifocals.
- Contacts and eyeglasses during the same benefit period.
- Replacement of lost or broken lenses or frames before the beginning of a benefit period.
- Services not performed by licensed vision care professionals.

Life insurance benefits

Learn:

- ▶ What your life insurance benefit is.
- ▶ How to convert your life insurance to an individual policy if you lose coverage.
- ▶ How to tell the Fund who should get these benefits if you die.
- ▶ Additional benefits.

Life insurance benefits

Life insurance benefits are only available to certain grandfathered individuals. Dependents are not eligible for life insurance benefits.

Life Insurance Benefit (<i>Retirees Only</i>)	
What the Plan Pays	
Life Insurance	\$5,000

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

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

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

Life insurance benefit

Your life insurance benefit is shown in the table at the top of this 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.

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.

Converting to individual life insurance coverage

If your insurance coverage ends, you may be able to convert your group life coverage to an individual policy of whole life insurance. You must submit a completed application and the required premium to Dearborn National within 31 days after the date your coverage 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

Naming a beneficiary

Your beneficiary is the person or persons you want Dearborn National to pay if you die. Beneficiary designation forms are available from your Care Coordinators. You can also get a form from www.uhh.org. 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

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; they are made available through outside organizations that have contracted with Dearborn National. They have no relationship to the Fund or the benefits it provides.

- **Online Will Preparation**—Online will preparation gives you the ability to easily and quickly create a will, free of charge. These services are administered by ComPsych®, a major provider of global employee assistance programs.
- **Beneficiary Resource Services**—The Beneficiary Resource Services program is available to beneficiaries of an insured person who dies and to an insured person who qualifies for

Life insurance benefits

the Terminal Illness Benefit. The program combines grief, legal, and financial counseling provided by Bensinger, DuPont & Associates, a nationwide organization that uses masters degreed grief counselors, licensed attorneys, and Certified Consumer Credit Counselors. Services are provided via telephone, face-to-face contact, and referrals to local support resources.

- **Travel Resource Services**—Europ Assistance USA, Inc. provides 24-hour emergency medical and related services for short-term travel more than 100 miles from home. Services include: assistance with finding a doctor, medically necessary transportation, and replacement of medications or eyeglasses. Other travel services are also available. Europ Assistance USA, Inc. arranges and pays for covered services, up to the program maximum.

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

D

Medicare supplement benefit

Learn:

- ▶ What Medicare Part A supplemental benefits are paid.
- ▶ What Medicare Part B supplemental benefits are paid.
- ▶ What limited medical benefits are paid.
- ▶ What is not covered.

Medicare supplement benefit

If you are in the Medicare supplement option, please call UNITE HER HEALTH at (855) 321-4373 when you need help.

Medicare supplement benefits apply to eligible retirees and spouses who are age 65 or older and eligible for Medicare, and dependent children eligible for Medicare.

In general, under the Medicare supplement benefit, the Plan pays 100% of the Medicare Part A and Part B deductibles and the 20% coinsurance Medicare does not pay. Medicare supplement benefits also provide limited medical benefits for some of the services Medicare does not cover.

Supplemental benefits for Medicare Part A

If you need inpatient care, Medicare Part A helps pay up to 90 days of confinement in a Medicare-participating facility for each spell of illness. After you pay the Part A Deductible, Medicare pays 100% for all covered services for the first 60 days of confinement. For days 61 through 90, Medicare pays for all covered services except for a daily coinsurance amount.

If you are out of the hospital for at least 60 days in a row, and then go back in, a new spell of illness begins. Your 90 days of coverage starts over again, and you pay another deductible.

The Plan pays 100% for the following Medicare Part A covered services:

- The Medicare Part A deductible per spell of illness.
- Hospital confinement from the 91st day through the 455th day.
- The first three pints of blood not covered by Medicare.
- The daily coinsurance for skilled nursing facility confinement from the 21st day through the 100th day.
- Emergency hospital care when an individual is out of the country.

Supplemental benefits for Medicare Part B

Medicare Part B helps pay for doctor services and other services and supplies such as outpatient hospital care, outpatient physical therapy, and x-rays. Each calendar year, before Medicare Part B pays for covered services, you must pay a deductible. After you pay the Part B deductible, Medicare will generally pay 80% of covered charges for the remainder of the year.

The Plan pays 100% for the following Medicare Part B services:

- The annual Medicare Part B deductible.
- Medicare Part B coinsurance for the following:
 - Doctor office or hospital visits and services.
 - Chiropractic services.

- ▶ Outpatient physical, occupational, and speech therapy.
- ▶ Kidney dialysis.
- ▶ Medical supplies.
- ▶ Durable medical equipment.
- ▶ Prosthetic devices.
- ▶ Oxygen.
- ▶ Anesthesia.
- ▶ Non-routine podiatric services.
- ▶ Ambulance transportation.
- ▶ The following immunizations: annual flu shots; one-time hepatitis B inoculation for individuals at high risk; and one-time pneumococcal inoculation for all individuals, and a booster after 5 years for those at high risk.

Limited Medical Benefits

You pay \$150 each year (per person) before the Plan begins paying benefits. Once you have met your \$150 deductible, the Plan pays 80% of the first \$2,000 of covered expenses you incur during a calendar year, and you pay 20%. Then the Plan pays 100% of covered expenses (you pay nothing) for the rest of that calendar year. The Plan pays up to \$25,000 in limited medical benefits per person each year, and up to a lifetime maximum benefit of \$50,000 per person.

Covered expenses are limited to:

- One routine eye examination during a calendar year.
- Private duty nursing services at home and while hospitalized.
- Immunizations not covered under Medicare Part B.

What's Not Covered

Medicare Supplement Benefits will not be payable for the following:

- Amounts in excess of Medicare's allowable expense or maximum benefits.
- Reimbursement for or in connection with any coverage under Medicare Part C or Medicare Part D.
- Any services, supplies or charges excluded under the Plan's General Exclusions and Limitations (*See page E-1*).

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, prescription drug, dental, and vision benefits. No benefits will be paid under this 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 doctor.
- Any injury, sickness, or dental or vision treatment that arises out of or in the course of any occupation or employment, or for which you have gotten or are entitled to get benefits under a workers' compensation or occupational disease law, whether or not you have applied or been approved for such benefits.
- Any treatment, services, or supplies:
 - ▶ For which no charge is made.
 - ▶ For which you, your spouse or your child is not required to pay.
 - ▶ Which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish, or municipal hospital when there is no legal requirement to pay for such treatment, services, or supplies.
- Any charge which is more than the Plan's allowable charge (*see page I-2*).
- Treatment, services, or supplies not recommended or approved by your doctor, or not medically necessary in treating the injury or sickness as defined by UNITE HERE HEALTH (*see page I-5*).
- Experimental treatment (*see page I-4*), or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH.
- If prior authorization is required in order to get coverage, any treatment, service, or supply that is denied or not covered because prior authorization was not obtained.
- Preventive care, unless specifically stated as covered.
- Any expense or charge for failure to appear for an appointment as scheduled, or charge for completion of claim forms, or finance charges.
- Any treatment, services, or supplies provided by an individual who is related by blood or marriage to you, your spouse, or your child, or who normally lives in your home.
- Any treatment, services, or supplies purchased or provided outside of the United States (or its Territories), unless for a medical emergency. The decision of the Trustees in determining whether an emergency existed will be final.
- Any expense or charge by a rest home, old age home, or a nursing home.

General exclusions and limitations

- Any charges incurred while you are confined in a hospital, nursing home, or other facility or institution (or a part of such facility) which are primarily for education, training, or custodial care.
- Any treatment, services, or supplies for or in connection with the child of your dependent child, unless such child meets the definition of a dependent (*see page G-2*).
- Home construction for any reason.
- Hospital charges for personal comfort items, including but not limited to telephones, televisions, cosmetics, guest trays, magazines, and bed or cots for family members or other guests.
- Treatment for or in connection with infertility, including but not limited to fertility treatment with the goal of becoming pregnant (such as in vitro fertilization or other treatment intended to cause pregnancy).
- Weight loss programs or treatment, except to treat morbid obesity if the program is under the direct supervision of a doctor, or as specifically stated as covered.
- Any smoking cessation treatment, drug, or device to help you stop smoking or using tobacco.
- Any charges incurred for treatment, services, or supplies as a result of a declared or undeclared war or any act thereof; or any loss, expense or charge incurred while a person is on active duty or in training in the Armed Forces, National Guard, or Reserves of any state or any country.
- Any elective procedure (other than sterilization or abortion, or as otherwise specifically stated as covered) that is not for the correction or cure of a bodily injury or sickness.
- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault.
- Music therapy.
- Education or training, unless specifically stated as covered.
- 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.
- 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.

Coordination of benefits

Learn:

- ▶ How benefits are paid if you are covered under this Plan in addition to other plan(s).

Coordination of benefits

These coordination of benefits provisions only apply to medical benefits and dental benefits. However, the rules Delta Dental follows to coordinate dental benefits may be slightly different than described in this section. If you have questions about how your benefits are coordinated, contact your Care Coordinators.

No coordination of benefits applies to prescription drug benefits, vision benefits, or to Medicare supplement benefits.

If you or your dependents are covered under this Fund 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 trusted 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 also will 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 this Plan is primary, it will pay its full benefits. However, if this Plan is secondary, the benefits it would have paid will be used to supplement the benefits paid 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 cover a person as an active employee always pay before plans that cover the person as a retired or laid off employee.

- With respect to plans that have COB and cover dependent children under age 18 whose parents are not separated, plans that cover the parent whose birthday falls earlier in a year pay before plans covering the parent whose birthday falls later in that year.
- With respect to plans that have COB and cover dependent children under age 18 whose parents are separated or divorced:
 - ▶ Plans covering the parent whose financial responsibility for the child's healthcare expenses is established by court order pay first.
 - ▶ If there is no court order establishing financial responsibility, the plan covering the parent with custody pays first.
 - ▶ If the parent with custody has remarried and the child is covered as a dependent under the plan of the stepparent, the order of payment is as follows:
 - 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

If you are entitled to Medicare while covered by the Fund, Medicare is secondary to the Fund except as shown below:

- The Fund is primary for the first 30 months a person is eligible for and entitled to Medicare because of end-stage renal disease (ESRD).
- Medicare is primary with respect to any coverage under the Fund provided for you after employment ends (such as COBRA coverage - *see page G-10*).

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

If you and your spouse are both retirees under this Plan

This rule only applies to coordination of benefits for your medical benefits.

If both you and your spouse (or domestic partner) are covered as retirees 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 retirees under the Fund, or if you and your dependent child are both covered as retirees 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.

Subrogation

These rules do not apply to benefits provided under the Medicare supplement benefit.

The Plan's right to recover payments

When injury is caused by someone else

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

Typical examples include injuries sustained:

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

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

Statement of facts and repayment agreement

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

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

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

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

Settling your claim

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

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

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

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

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

Eligibility for coverage

Learn:

- ▶ Who is eligible for coverage (who is considered a dependent).
- ▶ How you enroll yourself and your dependents.
- ▶ How much your coverage costs.
- ▶ When your coverage starts.
- ▶ How you stay eligible for coverage.

Eligibility for coverage

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

Who is eligible for coverage

Retirees

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

- You complete at least 15 years of employment.
- You are at least age 55.
- You begin receiving Pension Benefits from the Consolidated Retirement Fund.

Survivors

If you are a survivor of an eligible retiree who had at least 15 years of employment, you are eligible for coverage if all of the following are met:

- You qualify for an immediate monthly survivor's benefit from the Consolidated Retirement Fund upon the death of the retiree.
- The retiree was covered under the applicable UNITE HERE Staff Health Benefits Plan.
- You were married to the deceased for at least five years at the time of retirement or death.

You must still pay for the cost of your coverage. The same rules that apply to retirees apply to you (See page G-4).

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 cannot add dependents after the date you become eligible for retiree coverage.

The only exception is that you can delay enrolling your spouse if he or she is eligible for Medicare and has employer-sponsored health insurance. In this case, you must enroll your spouse no later than 90 days after the date your spouse loses his or her employer-sponsored health insurance. Your spouse's coverage will begin on the first day of the month for which your share of the cost of spousal coverage is taken out of your monthly pension benefit. 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.

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 as long as such child is not covered under, or eligible to be covered, under another group health plan as an employee. A “child” is 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 your Care Coordinators.

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 the disabled child will continue as long as all of the following rules are met:

- You (the retiree) 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 your Care Coordinators for more information on how to continue coverage for a child with a serious handicap.

Eligibility for coverage

Enrollment requirements

Employees

Once you become eligible, your coverage is automatic. However, you still need to fill out and submit an enrollment form.

Dependents

Your dependents become eligible for coverage on the date you become eligible for retiree coverage. Only dependents enrolled for benefits on the date you retire are eligible for coverage. 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 your marriage certificate.
- A commemoration of your marriage from a generally recognized denomination of organized religion.
- A certified copy of a 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).
- A certificate of creditable coverage. This form of proof of dependent status will not be accepted as of January 1, 2017.
- 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.

Paying for Retiree Coverage

Retiree coverage is not free. You must contribute toward the cost of providing coverage, either for you or for you and your dependents. Your share is 50% of the cost of providing coverage. Your required contribution is deducted from your monthly pension benefit, but in no event will this amount exceed 50% of your gross monthly pension benefit.

The same contribution rules apply to survivors' coverage.

When your coverage begins

Retiree coverage begins on the first day of the month for which a deduction toward the cost of providing coverage is made from your monthly pension benefit.

Continuing eligibility

Your coverage continues as long as deductions toward the cost of providing coverage is made from your monthly pension benefit.

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*Plan 173
Retirees*

Termination of coverage

Learn:

- ▶ When your coverage and your dependents' coverage ends.

Termination of coverage

Situations that can cause termination of coverage are listed below. In some cases, you and your dependents can temporarily continue coverage beyond the date it would otherwise end by electing COBRA continuation coverage.

When Retiree Coverage Ends

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

- The Plan is terminated.
- You die.
- The first day of the month for which a deduction from the monthly pension benefit toward the cost of providing coverage is not made.

When Dependent Coverage Ends

A dependent's coverage ends on the earliest date any of the following occurs:

- The Plan is terminated.
- The retiree's death, unless the dependent qualifies for survivor coverage (*See page G-5*).
- The dependent child enters any branch of the uniformed services.
- The first day of the month immediately following the month in which a dependent child no longer meets the Plan's definition of dependent.
- The date the dependent child is eligible for other group health care coverage based on his or her status as an employee.
- The first day of the month for which a deduction from the monthly pension benefit toward the cost of providing coverage is not made.

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.

COBRA continuation coverage

Learn:

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

COBRA continuation coverage

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

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

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. A child born to you (the retiree), or placed for adoption with you, while you have COBRA continuation coverage is also a qualified beneficiary.

What is a qualifying event?

A qualifying event is any of the following events that 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 a 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 retirees who have not had a qualifying event. In addition to medical benefits, COBRA continuation coverage includes prescription drug benefits, vision benefits, and dental benefits (if applicable).

Life insurance 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-10*), as long as those qualifying events would have resulted in a loss of coverage despite the occurrence of any previous qualifying event.

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

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

COBRA continuation coverage

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

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

Notifying UNITE HERE HEALTH when qualifying events occur

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

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

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

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

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

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

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

- For divorce 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.

COBRA continuation coverage

- For a dependent child's loss of eligibility, the child's: name, Social Security number, address, telephone number, date of birth, 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, your: date of death, 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 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.

COBRA continuation coverage

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

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

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

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

Termination of COBRA continuation coverage

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

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

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

COBRA continuation coverage

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.

Claim filing and appeal provisions

Non-assignment of claims

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

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

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

Commencement of legal action

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

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.

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.

Claim filing and appeal provisions

- 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 insurance benefits 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:

UNITE HERE HEALTH

Attn: Hospitality Rx

P.O. Box 6020
Aurora, IL 60598-0020

Dental claims

Delta Dental PPO and Premier dentists usually will file dental claims for you. However, if you need to file a claim, for example because you used a non-network provider, you should send the claim to Delta Dental.

Delta Dental

P.O. Box 5402
Lisle, IL 60532

Claim filing and appeal provisions

Vision claims

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

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

Life insurance claims

To file a claim for benefits, send claim information to:

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

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

All other benefit claims

Claims for all other services or supplies, including services and supplies denied because you are not eligible, or claims denied for lack of prior authorization, and all claims for the Medicare supplement benefit should be mailed to:

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

Deadlines for filing a benefit claim

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

- **Life insurance**—within a reasonable amount of time
- **Dental claims**—written notice and proof of claim must be received within 90 days of the date the dental care was provided. Claims may be submitted for up to one year if the 90-day deadline cannot reasonably be met.
- **Vision claims**—365 days following the date the claim was incurred.
- **All other claims**, including medical and prescription drug claims and claims for the Medicare supplement benefit—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.

Claim filing and appeal provisions

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. Submit the form 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-

Claim filing and appeal provisions

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 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 insurance benefit claims

In general, you will be notified of the decision on your claim for life insurance 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.

Claim filing and appeal provisions

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).

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.

Claim filing and appeal provisions

Life insurance 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 insurance 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 retiree'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
7450 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

Claim filing and appeal provisions

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, Medicare supplement benefit denial, or healthcare claim denial, and you wish to appeal the decision, you must follow the steps in this section. (See page H-8 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..

Claim filing and appeal provisions

- The Appeals Subcommittee would have overturned the original benefit denial based on its standard practices and policies.

Appeals involving urgent care claims

If you are appealing a denial of benefits that qualifies as a request for emergency treatment/urgent care, you can orally request an expedited (accelerated) appeal of the denial by calling **(866) 686-0003**. All necessary information may be sent by telephone, fax 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 H-5 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.

Claim filing and appeal provisions

- 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:

	Emergency Treatment/ Urgent Care	Prior Authorization	All Other Healthcare Claims
Subject to one level of appeal	As soon as possible but 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 36 hours for each level of appeal	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 that 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.

H-12

*Plan 173
Retirees*

Definitions

Learn:

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

Call the Care Coordinators if you aren't sure what a word or phrase means.

Definitions

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, like the BCBSIL rate. 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 healthcare service. You usually have to pay your **copay** to the provider when you get healthcare. The amount can vary by the type of covered healthcare service. Usually, once you have paid your **copay**, this Plan pays the rest of the covered expenses. For example, each time you go to your network PCP, you only pay a \$10 **copay**.

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

Coinsurance

Your share of the costs of a covered expense, calculated as a percent (for example, 20%) of the allowable charge for the service. You pay your **coinsurance** plus any deductibles or copays. For example, if the allowable charge for non-emergency care provided in a network emergency room is \$1,000, your 20% **coinsurance** equals \$200. The Fund pays the rest of the allowable charge if you've met your deductible.

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-8).

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 certain covered expenses before the Fund begins paying benefits. For example, the Fund will not start paying network medical benefits on your behalf until you meet your \$200 individual network calendar year **deductible**. The Fund will not start paying non-network medical benefits on your behalf until you meet your \$400 individual non-network calendar year **deductible**.

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 the Plan does not pay benefits. You can get more information about your **deductibles** in the section titled “Medical benefits.”

Durable medical equipment

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.

Definitions

Emergency medical treatment

Emergency medical treatment means any services received due to or in connection with an unforeseen injury or sickness that needs surgical or medical attention, when in the absence of such care, you could reasonably be expected to suffer serious physical impairment or death.

Experimental, investigational, or unproven (experimental or investigational)

Experimental, investigational, or unproven procedures or supplies are those procedures or supplies 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 that 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** is person licensed to practice medicine and surgery as a Doctor of Medicine or Osteopathy, or a person licensed as a Dentist, Podiatrist, Chiropractor or Optometrist and who is practicing within the scope of his or her profession.

A **healthcare professional** may also include additional types of providers specifically listed as covered—for example a certified diabetes educator providing diabetes education, or a licensed clinical professional counselor for outpatient mental health treatment.

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 **dentist** may be a doctor 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.

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 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 doctor, 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.

Definitions

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 health-care provider and should be based on all appropriate factors, only one of which is what benefits the Plan will pay.

Plan Document

The rules and regulations governing the Plan of benefits provided to eligible retirees and dependents participating in Plan 173 Retirees (UNITE HERE Staff Retirees).

Other important information



Other important information

Who pays for your benefits?

In general, this Plan's benefits are provided by the money (contributions) employers participating in the Fund must contribute on behalf of eligible retirees under the terms of the agreements negotiated by your union.

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 Medicare supplement benefits (including the limited medical 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 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. Delta Dental of Illinois administers the dental benefits. Davis Vision administers the vision benefit. 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

All 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.

Other important information

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

The Plan gives the Trustees full discretion and sole authority to make the final decision in all areas of Plan interpretation and administration, including eligibility for benefits, the level of benefits provided, and the meaning of all Plan language (including this Summary Plan Description). In the event of a 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 intend to continue the Plan within the limits of the funds available to them. However, they reserve the right, in their sole discretion, to amend or terminate the Plan, in its entirety or in part, without prior notice.

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

Free choice of provider

The decision to use the services of particular hospitals, clinics, doctors, dentists, or other health-care providers is voluntary. 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.

Other important information

Type of Plan

UNITE HERE HEALTH is a welfare plan providing healthcare and other benefits, including life insurance and accidental death and dismemberment protection. UNITE HERE HEALTH 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. Copies are also available, 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. Copies are also available, 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 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
(630) 236-5100
711 North Commons Drive
Aurora, IL 60504

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.

Your rights under ERISA

Your rights under ERISA

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

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

Receive information about your Plan and benefits

ERISA provides that all Plan participants shall be entitled to:

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

Continue group health Plan coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce your rights

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

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

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

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

Assistance with your questions

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

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

Important phone numbers and addresses

Care Coordinators by Quantum Health
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

Delta Dental of Illinois (Delta Dental)
111 Shuman Blvd.
Naperville, IL 60563
(800) 323-1743

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

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

Hospitality Rx
P.O. Box 6020
Aurora, IL 60598-0020
(866) 686-0003

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