UNITE HERE HEALTH

Greater Boston Local 26 Health Plan

Plan Unit 108

Summary Plan Description

Your Health and Welfare Benefits

Your Fund is taking care of you during the national coronavirus emergency!

Until the end of the national coronavirus (COVID-19) emergency as declared by the Department of Health and Human Services, you will not pay any cost-sharing (copays, deductibles, or coinsurance) for:

- Medically appropriate COVID-19 testing that is ordered by a healthcare provider. ("Testing" includes both tests to determine if you currently have the virus, or if you have antibodies to the virus.) In addition, if the primary purpose is to get the testing, you will not pay any cost-sharing for items and services related to the test, including, for example, in-person or telehealth office visits, urgent care center visits, and emergency room visits. However, your normal cost-sharing applies to visits, items, and services (other than the COVID-19 test), if the primary purpose of your visit isn't to get or determine if you need to get a COVID-19 test.
- Medically necessary treatment of COVID-19. All other Plan rules remain in effect, including what's not covered. Remember, the Fund will not pay amounts over the allowable charge – if you use a non-network provider, you may have to pay those amounts even though you won't have to pay your cost-sharing.

When the Department of Health and Human Services declares the national emergency related to the coronavirus (COVID-19) has ended, the temporary special benefit changes your Fund made to support you and your family during the national emergency will also end. After the national emergency is over, the regular Plan rules (including what cost-sharing you must pay, network requirements, and what's not covered) apply to medically appropriate COVID-19 testing and medically necessary treatment of COVID-19.

Because of the pandemic, you generally have more time to do certain things, like file or appeal a claim, enroll your new dependent, or elect COBRA and make COBRA payments. Call us at **(800) 267-4325** for more information.

UNITE HERE HEALTH

Summary Plan Description

Greater Boston Local 26 Health Plan—Plan Unit 108

Effective October 1, 2020

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

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 call UNITE HERE HEALTH at (844) 267-4325 (TTY: (855) 386-3889 or (855) FUNDTTY) for assistance.

Este folleto contiene un resumen en inglés de los derechos y beneficios de su plan bajo UNITE HERE HEALTH. Si tiene dificultades para entender cualquier parte de este folleto, puede llamar a UNITE HERE HEALTH al (844) 267-4325 (teléfono de texto: (855) 386-3889 o (855) FUNDTTY) para asistencia.

本手冊提供您在 *under UNITE HERE HEALTH* 下的計劃權利和福利的繁體中文總結。如果理解本手冊的内容存在困難，您可以致電 *UNITE HERE HEALTH at (844) 267-4325* (*TTY: (855) 386-3889* 或 *(855) FUNDTTY*) 尋求協助。

Table of Contents

Using this book

Learn:

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

Please take some time to review this book.

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

What is UNITE HERE HEALTH?

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

Your coverage is being offered under Plan Unit 108 (Greater Boston Local 26 Health Plan), which has been adopted by the Trustees of UNITE HERE HEALTH to provide medical and other health and welfare benefits through the Fund. Other SPDs explain the benefits for other Plan Units.

What is this book and why is it important?

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

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

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

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

How do I use my SPD?

This SPD is broken into sections. 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 contact the Fund at **(844) 267-4325**. The Fund can help you understand your benefits.

Read your SPD for important information about what your benefits are, 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." If you want to know more about your life or AD&D benefits, read the section titled "Life and AD&D benefits."

Some terms are defined for you in the section titled "Definitions" starting *on page I-2*. The SPD will also explain what some commonly used terms mean. When you have questions about what certain words or terms mean, contact the Fund at **(844) 267-4325**.

How can I get help?

Call the Fund at **(844) 267-4325**:

- When you have questions about your benefits.
- When you have questions about your eligibility.
- When you have questions about payments for your share of the cost of coverage.
- To update your address.
- To report changes in your family status.
- To get forms or a new SPD.

You can also visit www.uhh.org to sign up for the member portal and get forms, an electronic copy of your SPD, and other important information.

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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.
- How to use network providers to save time and money.

Get a primary care provider

Generally, **the Plan only pays medical benefits if your care is provided by or referred by your primary care provider (PCP) in the Tufts EPO Select network**. *See pages D-2 to D-4* for exceptions and more information about selecting 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. Your PCP also helps you keep track of when you need preventive healthcare. *See page D-3* for more information about why you need a PCP.

✓ Call Tufts Health Plan (Tufts) at **(800) 462-0224** to register your PCP or get help finding a PCP.

Get preventive healthcare

Your Plan pays 100% for most types of preventive healthcare when you use your network PCP or get a referral for network care. 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. **Be sure to use your PCP or get a referral from your PCP.** The Plan won't pay for preventive healthcare if you don't.

See pages D-6, D-20, and *I-6* for more information about preventive healthcare.

Re-think emergency room care

Is it really an emergency? You can save money by going to your PCP for non-emergencies. If you can't get to your PCP, you can use a network free-standing urgent care center or limited service medical clinic (a walk-in clinic usually based in a retail store). You pay nothing out of pocket for these visits as long as you stay in the network. You pay a $100 copay for emergency room care. (*See page I-3* for the definition of "emergency.")

Some urgent care centers are open late in the evening. Call **(800) 462-0224** if you need help finding a network urgent care center.

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

Use network providers

✓ Generally no Plan benefits are payable for medical care, mental health/substance abuse care, alternative care, or prescription drugs if you choose a non-network provider.

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

How do I stay in the network?

- Tufts Health Plan (Tufts) provides access to the **EPO Select** network of doctors, hospitals, and other healthcare providers. Call Tufts at **(800) 462-0224** to find a network provider or visit www.tuftshealthplan.com/local26. If you (the employee) live outside of the Tufts EPO network area, see *page D-4* for details about your network.
- Modern Assistance Programs, Inc. (MAP) provides access to a network of doctors, clinicians, and other healthcare providers for mental health/substance abuse care and alternative care. Call **(800) 878-2004** or **(617) 774-0331** to find a **MAP** network provider.
- Hospitality Rx provides access to a select national network of participating pharmacies (called the WellDyne National network) that you must use in order to get benefits for prescription drugs. Not all pharmacies are in the network. Contact **Hospitality Rx** at **(844) 813-3860** or go to www.hospitalityrx.org to find a network pharmacy.
- Delta Dental provides access to a network of dental care providers. Contact Delta Dental to find a dentist in the **Delta Dental PPO** network at **(800) 323-1743** or go to www.deltadentalil.com.
- Davis Vision provides access to a network of vision care providers. You can stay in the network by using any participating Davis Vision provider. Call **(800) 999-5431** or go to www.davisvision.com to find a **Davis Vision** network provider.

If you have questions about your benefits, or if you need help finding a network provider, you can also call the Fund at **(844) 267-4325**.

Summary of benefits

Please call the Fund with questions about your benefits: **(844) 267-4325**.

Medical Benefits

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

For medical services, your network is the **Tufts EPO Select network***. Non-network benefits aren't available, except for emergency care and certain circumstances (*see page I-3*). **You must have a primary care provider (PCP) in order to have benefits paid on your behalf***. Except in an emergency and for certain care, all your medical care must be provided by or arranged by your PCP.
*See *page D-4* for special rules if you live outside the Tufts network area.

Medical Benefits —*What You Pay*	Network	Non-Network
Calendar Year Deductible	None	
Office Visits		
Preventive Healthcare (*see page I-6*)	$0	Not covered
Primary Care Provider (PCP) Office Visit	$0	
Specialist Office Visit	$0	
Urgent and Emergency Care		
Free-Standing Urgent Care Center or Limited Service Medical Clinic	$0	$0 *Only covered outside Tufts service area*
Emergency Room Services	$100 copay/visit *waived if admitted, in observation (as determined by Tufts), or having day surgery*	
Professional Ambulance Services	$0	
Outpatient Services		
Early Intervention Services — *for children under age 3*	$0	Not covered
Spinal Manipulation — *up to 20 total visits per person each calendar year*	$0	
Day Surgery	$0	
Physical and Occupational Therapy	$0	
Respiratory, Pulmonary, and Cardiac Rehabilitation Therapy	$0	
Chemotherapy and Radiation Therapy	$0	
Hemodialysis	$0	
Laboratory Tests	$0	

Medical Benefits —*What You Pay*	Network	Non-Network
Diagnostic Imaging *(including x-rays, CT/CTA, MRI/MRA, PET, and nuclear cardiology)*	$0	Not covered
Inpatient Treatment		
Inpatient Hospitalization	$0	Not covered
Extended Care Facility *(skilled nursing facility, rehabilitation hospital)*		
Other Services and Supplies		
Diabetes Education	$0	Not covered
Nutrition Counseling — *up to 1 evaluation and 12 total visits per person each calendar year*	$0	
Home Healthcare Services	$0	
Hospice Care	$0	
Durable Medical Equipment and Medical Supplies	$0	
Scalp Hair Prostheses or Wigs for Cancer or Leukemia Patients — *up to $350 per person each calendar year*	$0	
Hearing Aids — *one per ear per prescription change*	$0	
Foot Orthotics	$0	
Special Medical Formulas and Low Protein Foods	$0	

Prescription Drug Benefits—What You Pay			
	Retail Pharmacy *up to a 90–day supply*	**Mail–Order** *up to a 90–day supply*	
Formulary Prescription Drug Benefits	**Per Prescription**		
Preventive Healthcare Services Drugs — *see page I-6*	$0		
Generic Drugs	$1		
Brand Name Drugs	$8		
Select Specialty and Select Biosimilar Drugs*	Not covered	**Generic**	**Brand**
		$1	25%
Non-Formulary Prescription Drugs and Supplies	Not covered, unless an exception is approved		
**Current pharmacy benefit provider will actively manage and determine drugs in tier. Specialty drugs are only available through the specialty mail order pharmacy.*			

Modern Assistance Programs, Inc. (MAP)
For mental health/substance abuse services and alternative care, your network is the **MAP network**. Non-network benefits generally aren't available. Benefits are not payable if MAP does not coordinate and approve your care.

MAP Benefits —*What You Pay*	Network	Non-Network
Mental Health/Substance Abuse Care		
Inpatient Treatment *(including residential treatment)*	$0	Not covered
Outpatient Treatment *(including office visits, partial hospitalization, intensive outpatient, and ambulatory detoxification treatment)*		
Alternative Care		
Acupuncture — *up to 20 visits per person each calendar year*	$0	Not covered
Traditional Chinese Medicine — *up to 12 visits per person each calendar year*		
Naturopathic Medicine — *up to 12 visits per person each calendar year*		
Homeopathic Medicine — *up to 12 visits per person each calendar year*		
Massage Therapy — *up to 12 visits per person each calendar year*		
Nutrition Counseling		
Smoking Cessation Counseling		

Out-of-Pocket Limit *(Network Expenses Only)*	
The most you pay out-of-pocket for copays and coinsurance for certain covered medical and prescription drug expenses in a calendar year	$6,350 per person & $12,700 per family

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

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

Dental PPO Benefits	Delta Dental PPO Providers	Delta Dental Premier Dentists and Non-Network Providers
Calendar Year Maximum Benefit for Dental (non-ortho) Treatment	$2,000 per person	
Lifetime Maximum Benefit for Orthodontia Treatment	$3,000 per person	
Calendar Year Deductible	None	
Description of Services	**What You Pay for Your Covered Dental Care**	
Diagnostic and Preventive Services *(Examples: oral exams, emergency palliative care, x-rays, routine cleaning, fluoride treatment, sealants, space maintainers)*	$0	20%
Minor Restorative Services *(Example: fillings)*	$0	20%
Endodontic Services *(Example: root canals)*		
Periodontic Services *(Examples: scaling and root planing, full-mouth debridement, periodontal (gum) maintenance, certain surgical periodontal services)*		
Oral Surgery *(Examples: Extractions (simple and surgical), certain sedation procedures)*		
Prosthodontic Maintenance *(Example: Repairs to dentures and crowns)*		
Prosthodontic Services *(Examples: complete or partial dentures, bridges, adjustments to dentures)*	40%	60%
Major Restorative Services *(Examples: onlays, crowns)*	40%	60%
Implants	40%	60%
Orthodontic Services	50%	50%

Vision Benefits—*What You Pay*		
Description of Services *Covered once every 24 months*	**Davis Vision Provider**	**Non-Network Provider**
Eye Exam	$0	$0 Plan benefits limited to $16 *Maximum benefit does not apply to exams for children under age 5*
Frames	$0 for Davis Collection Fashion or Designer frames $0 for non-Davis collection frames; Plan benefits are limited to $14	$0 Plan benefits limited to $14
Lenses	$0	$0 Plan benefits limited to: $14 for single vision lenses $23 for bifocal/progressive lenses $29 for trifocal lenses
Elective Contacts *(provided instead of glasses)*	$0 for Davis Collection contacts $0 for non-Davis Vision contacts; Plan benefits are limited to $25	$0 Plan benefits limited to $40
Medically Necessary Contacts	$0	$0

Adoption Assistance Benefit *(Employees Only)—What the Plan Pays*	
Amount of Benefit for Adoption Expenses Incurred for Eligible Adopted Children	$2,000 per child each Plan year

Short-term Disability Benefit *(Employees Only)—What the Plan Pays*	
Amount of Benefit	$500/week for up to 26 weeks
Benefits Start:	
Due to Injury or Having a Baby (Vaginal or Cesarean Delivery)	1st day
Due to Sickness	8th day

Life and Accidental Death & Dismemberment (AD&D) Benefit *(Employees Only)*		
What the Plan Pays if You Have:	**Life Insurance Benefit**	**AD&D Insurance Benefit** (*full amount*)
Less than 4 Years of Service	$5,000	$5,000
4–10 Years of Service	$10,000	$10,000
More than 10 Years of Service	$35,000	$35,000

Prior authorization program

Learn when and why you should call:

- To get prior authorization for your medical care.
- To sign up for the care management program.
- To get prior authorization for mental health/substance abuse care and alternative care.

The prior authorization program is designed to help make sure you and your dependents get the right care in the right setting. It helps make sure you don't get unnecessary medical care and helps you manage complex or long-term medical conditions. The prior authorization program includes mandatory prior authorization of certain types of care to help you make decisions about your healthcare.

Tufts Health Plan (Tufts) provides prior authorization for medical care. Modern Assistance Programs, Inc. (MAP) provides prior authorization for mental health/substance abuse care and alternative care.

Important Phone Numbers for Prior Authorization	
To get prior authorization for	**Call**
Medical care	Tufts **(800) 462-0224**
Mental health/substance abuse care and alternative care	MAP **(617) 774-0331** inside Massachusetts **(800) 878-2004** outside Massachusetts

The prior authorization program is not medical advice. You are still responsible for making any decisions about medical matters. UNITE HERE HEALTH, your health fund ("the Fund"), is not responsible for any consequences resulting from decisions you or your provider make based on the prior authorization program or the Plan's determination of the benefits it will pay.

Get prior authorization for certain medical services and supplies

Prior authorization is required before you get any of the types of care listed below. When you use your Tufts PCP or your PCP refers you to a Tufts specialist, your provider is required to get the prior authorization for you. You will not be penalized if your network provider does not follow the prior authorization program.

- ✓ Prior authorization 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 for prior authorization

- ✓ The prior authorization list may change from time to time. Contact Tufts at **(800) 462-0224** for the most up-to-date information.

You or your healthcare provider should get prior authorization before any of the following:

- Ambulance services (except in emergencies).
- Day surgery and outpatient surgery in a provider's office.
- Diagnostic screening, imaging, and testing (including but not limited to ambulatory EKG testing, human leukocyte antigen (HLA) testing, sleep studies, and diagnostic audiology testing).
- Durable medical equipment, foot orthotics, and prosthetics.
- Extended care.
- Gender reassignment surgical services and certain hormone therapy.
- Home healthcare.
- Hospice care.
- Hospital inpatient care.
- Injectable, infusion, or inhaled medications and oral medications for cancer.
- Laboratory tests.
- Low protein foods, non-prescription enteral formulas, and special medical formulas.
- Medical supplies.
- Non-routine vision care services.
- Oral health services.
- Physical and occupational therapy.
- Prosthetic devices.
- Radiation therapy.
- Reconstructive surgery and procedures.
- Specialty care that is not available from a network provider (this is rare).
- Transplant services.
- Treatment of speech, hearing, and language disorders.

If your PCP recommends any of the above types of services and supplies, he or she will get prior authorization for you. This list changes from time to time. Contact Tufts at **(800) 462-0224** for the most up-to-date information.

If you are admitted as an inpatient after receiving emergency care (an emergency admission), you must call your PCP or Tufts within 48 hours after receiving care. No prior authorization is required for emergency medical treatment.

If you are hospitalized because you are having a baby, you do not need to call Tufts for prior authorization unless your stay will be longer than 48 hours following a vaginal childbirth, or 96 hours following a Cesarean section. This protection under the Newborns' and Mothers' Health Protection Act (NMHPA) also means your benefits are not restricted during the 48-hour period (or 96-hour period, as applicable). However, NMHPA doesn't prohibit your (or your newborn's) attending provider from discharging you or your newborn earlier than 48 hours (or 96 hours as applicable), after consulting with you first.

See *"Rules for prior authorization of benefits" on page H-6* for information about when the applicable entity must respond to your request for prior authorization and information about how to appeal a prior authorization denial.

Care management program

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

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

Mental health/substance abuse care and alternative care benefits

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

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

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

Medical benefits

Learn:

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

UNITE HERE HEALTH has contracted with Tufts so you and your covered dependents can receive medical and surgical services from area hospitals and providers participating in the network. (*See page D-14* for information about your benefits for mental health/substance abuse treatment.)

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

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

Network providers

If you live outside of the Tufts EPO Select network service area, see page D-4 for more information about your network.

Generally, **the Plan only pays benefits for services and supplies when you use Tufts EPO Select network providers *and* the care is provided by or referred by your primary care provider**.

To find network providers for medical care or to get a copy of your medical ID card, contact:

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

(Make sure you look for a provider in the Tufts EPO Select network)

In some special circumstances, the Plan will pay for non-network care. The circumstances are:

- Emergencies, until you can be safely transferred to a network provider.
- Urgent care when you are traveling outside of the Tufts EPO Select service area.
- Certain care you receive from non-network healthcare providers while in a network setting (for example, care from radiologists, pathologists, and anesthesiologists).
- Specialty care that is not available from a network provider (this is rare), as long as you get a referral from your PCP and prior authorization in advance of getting the care.

The Plan will still use the allowable charge based on the network or non-network status to determine the amount paid. Remember, you can be balance-billed for—and you may have to pay—the difference between the Plan payment and the non-network provider's charges.

Tufts EPO Select Service Area

The Tufts service area includes the following Massachusetts counties: Barnstable, Bristol, Essex, Franklin, Hampshire, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, Worcester. The Tufts service area may also include counties in other states and may change from time to time. Contact Tufts with any questions about the Tufts service area. Certain exceptions apply if you live outside the Tufts service area (*see page D-4*).

Your Primary Care Provider (PCP)

- ✓ **You must have a Primary Care Provider (PCP) before non-emergency benefits are payable.** To select a PCP, call Tufts at **(800) 462-0224**.
- ✓ Get referrals from your PCP **before** you get specialty care.

Plan benefits are generally only provided when your PCP coordinates your care or refers you to a specialist. You have the right to choose any primary care provider who participates in the Tufts EPO Select network and who is available to accept you or your family members. You can all have the same PCP, or you can each choose different PCPs. You may choose a pediatrician as your child's PCP.

You need a referral from your PCP to see a specialist or get certain healthcare services. Your PCP must also approve any visits to another provider your specialist refers you to. You must get a referral or approval before getting care, otherwise no benefits are payable and you will be responsible for the cost. However, you don't need a referral from your PCP for any of the following:

- Emergency care. If you are admitted as an inpatient, you (or someone acting for you) must call your PCP or Tufts within 48 hours are receiving care.
- Urgent care outside the Tufts service area. However, you must contact your PCP for any follow-up care.
- Urgent care you get inside the Tufts service area when you use a network free-standing urgent care center or network limited services medical clinic. Limited services medical clinics are walk-in clinics, usually based in retail stores, like a CVS Minute Clinic. (Urgent care in a network providers office or hospital-based outpatient walk-in clinic does require a referral from your PCP.)
- The following care provided by a network provider who is an obstetrician, gynecologist, certified nurse midwife, family practitioner, or any other licensed provider offering these services within the scope of their license:
  - Maternity care.

- Medically necessary evaluations and related healthcare services for acute or emergency gynecological conditions.
- Routine annual gynecological exam, including any follow-up obstetric or gynecological care determined to be medically necessary as a result of that exam.

- Mammograms at the following intervals: one baseline at 35-39 years of age; one every year at age 40 and older; or as otherwise medically necessary.
- Spinal manipulations.
- Pregnancy terminations.
- Dental surgery, orthodontic treatment and management, or preventive and restorative dentistry when provided for the treatment of cleft lip or cleft palate for children under age 18.
- Medical treatment from an optometry provider.

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

Unless you are an inpatient or a patient in a partial hospitalization program, you may change your PCP at any time. Make sure you ask the PCP if he or she is taking new patients. Changes won't take effect until you report your choice to a Tufts member specialist, and Tufts approves the change.

If you live outside the Tufts EPO Select service area

If you (the employee) live outside of the Tufts EPO network area (as determined by UNITE HERE HEALTH), certain network and PCP referral rules described in this SPD do not apply to you.

The network you must use depends on where you get care. For care inside Massachusetts, New Hampshire, or Rhode Island, your network is the Tufts PPO network. For care outside Massachusetts, New Hampshire, or Rhode Island, your network is the Cigna PPO network. You can find a network provider by calling the number listed on your Tufts member ID card or by going to mytuftshealthplan.com or mytuftshealthplan.com/CignaPPO.

You should pick a PCP, but you don't need a referral from a PCP in order to see a specialist as described *on page D-3* . However, your PCP can help you find a specialist and make sure you get the right follow up care. We strongly recommend you select a PCP to help coordinate your care.

Your benefits and the types of services and supplies the Plan covers are the same, regardless of where you live. The prior authorization rules (*see page C-1*) still apply. You should make sure you or your provider call Tufts before receiving any of the types of services or supplies listed *on page C-2.* **If you get treatment, services, or supplies that are not approved, not covered, or are not medically necessary, you pay 100% of your care.**

If you have any questions about your network or if your address changes, call the Fund at **(844) 267-4325.**

What you pay

You must pay your cost-share (such as copays) for your share of covered expenses. You must also pay any expenses that are not considered covered expenses (see *"What's not covered" on page D-9* for more information), including any amounts over the allowable charge (*see page I-2* for the definition of an allowable charge) when you use non-network providers, any amounts not paid for failing to get referrals, or charges once a maximum benefit or limitation has been met.

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

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

Copays

The Plan typically pays 100% of covered expenses. However, you pay copays for certain types of care (*see page B-2*). For example, you pay a $100 copay for emergency care in an emergency room. The copay will be waived if you are immediately admitted to the hospital as an inpatient, in observation (as defined by Tufts), or undergo day surgery. You may be responsible for the $100 emergency room copay if you register in an emergency room but leave the facility without receiving care.

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

Out-of-pocket limit for network expenses

Your out-of-pocket cost-sharing for most covered network medical and prescription drug expenses is limited to $6,350 per person ($12,700 per family) each calendar year. Once your out-of-pocket costs for covered expenses meet these limits, the Plan will usually pay 100% for your (or your family's) network medical and prescription drug covered expenses during the rest of that calendar year. Amounts you pay out-of-pocket for prescription drug expenses under the section of this SPD titled *"Prescription drug benefits"* count toward this out-of-pocket limit, too.

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

What's covered

The Plan will only pay benefits for injuries or sicknesses that are not related to your job. Benefits are determined based on allowable charges for covered services resulting from medically necessary care and treatment provided or authorized in advance by your network PCP (except in an emergency).

- **Preventive healthcare services** (*see page I-6*), as required by federal law. Certain limits or rules may apply to when and how you get preventive healthcare based on your gender, age, and health status.
- **Hospital charges** for:
  - Room and board, up to the semi-private room rate unless a private room is medically necessary, and other inpatient services actually administered by the hospital.
  - Outpatient services actually administered by the hospital.
- **Office visits** to diagnose and treat illness or injury, including through telehealth (via phone or video visits), if available.
- **Outpatient surgery** in an office.
- **Spinal manipulation**, up to 20 visits per person each calendar year.
- **Physical and occupational therapy**, provided:
  - Rehabilitative therapy services are needed to restore function lost or impaired as the result of an accidental injury or sickness. Your condition must show significant improvement within 60 days from the start of services.
  - Habilitative services are needed to keep, learn, or improve skills and functioning for daily living that you never learned or had because of a disabling condition.
- Short-term **cognitive rehabilitation and retraining programs** when provided to restore function lost or impaired as the result of an accidental injury or sickness. You must be anticipated to make measurable improvement within a reasonable and predictable period of time.
- **Respiratory therapy and pulmonary rehabilitation** services.
- Diagnosis and treatment of **speech, hearing, and language disorders**.
- Outpatient **cardiac rehabilitation** services for treatment of cardiovascular disease that begins within 26 weeks after you've been diagnosed with cardiovascular disease. The maintenance phase of cardiac rehab is not covered.
- **Early intervention services** provided to a dependent child from birth to the child's third birthday.
- **Allergy testing and treatment**, including antigens and allergy injections.
- **Foot orthotics** or fittings if you have severe diabetic foot disease.
- **Home healthcare** services, if you are homebound as determined by Tufts.
- Outpatient **hemodialysis**, including home hemodialysis and home peritoneal dialysis.

- **Chemotherapy and radiation therapy**.
- **Injectable, infused, or inhaled medications**, including but not limited to total parenteral nutrition therapy, chemotherapy, and antibiotics, that are one of the following:
  - Required for and are an essential part of an office visit to diagnose or treat an illness or injury.
  - Received at home with drug administration services by a home infusion provider.
- **Day surgery** and related charges for anesthesia, provided you are expected to be discharged the same day.
- **Medical supplies**, including ostomy, tracheostomy, and catheter supplies.
- **Scalp hair prostheses** or wigs for hair loss resulting from the treatment of cancer or leukemia, up to $350 each calendar year.
- **Special medical formulas, nonprescription enteral formulas, and low protein foods**, when prescribed by a doctor, but only for the following:
  - Low protein foods when given to treat inherited disease of amino acids and organic acids.
  - Nonprescription enteral formula for home use for treatment of certain medical conditions.
  - Medically necessary infant formula for milk or soy protein intolerance, formula for premature infants, and supplemental formulas for growth failure.
  - Other special medical formulas for the treatment of certain diseases.
- Outpatient **diagnostic imaging, x-rays, and laboratory services**.
- Transportation by a **professional ambulance service**, including ground, sea, or air ambulance transportation for emergency care, and non-emergency ambulance transportation when your medical condition prevents safe transportation by any other means, or for transfer between facilities. If you are treated by EMTs or other ambulance staff, but you refuse to go to the hospital or other medical facility, you will be responsible for the cost of the treatment provided by the EMTs or other ambulance staff.
- **Maternity charges**, including prenatal and postnatal care provided in a healthcare professional's office, and hospital and delivery services.
- **Extended care services** in a facility for skilled nursing, rehabilitation, or chronic disease services.
- Patient care services provided as part of a qualified **clinical trial** for the treatment of cancer or other life-threatening condition, to the same extent that such services would be covered if the care were not received as part of a clinical trial.

- **Bone marrow transplants** for metastatic breast cancer.
- **Hematopoietic stem cell transplants and human solid organ transplants** provided at a Tufts designated transplant facility. Donor expenses and donor search expenses are covered only if they aren't covered by any other plan. No benefits are payable if you are the stem cell or organ donor.
- **Human leukocyte antigen testing** or histocompatibility locus antigen testing for use in bone marrow transplantation.
- **Hospice services** and supplies for a person whose life expectancy is 6 months or less. Bereavement counseling services for family of the terminally ill person will be covered for up to 1 year following such person's death.
- **Mastectomies**, including all stages of surgery to rebuild the removed breast (reconstruction), surgery and reconstruction of the other breast so breasts look even, breast implants and prostheses, and treatment of physical health problems from a mastectomy, including swollen lymph glands (lymphedema).
- **Breast, arm, and leg prosthetic devices**.
- Medically necessary charges for **treatment of cleft lip and cleft palate** for children under age 18, and associated services for management and follow-up care.
- **Non-routine vision services**, including one pair of eyeglass lenses and standard frames following cataract surgery or other surgery to replace the natural lens of the eye.
- **Facility charges for dental procedures** covered under the Plan's dental benefit when an institutional setting is required to safely administer the care, including for treatment if you are suffering from medical or behavioral conditions, such as autism or Alzheimer's, that severely limit your ability to cooperate with the necessary care.
- Outpatient **diabetes self-management training** and educational services, provided by a certified diabetes healthcare professional.
- **Nutrition counseling**, up to 1 evaluation and up to 12 visits per person each calendar year.
- **Durable medical equipment** (DME), for example, power/motorized wheelchairs, breast pumps, cranial helmets, blood glucose monitors, gradient stockings (up to 3 pairs every 365 days), hearing aids (up to one per ear per prescription change), insulin pumps, oral appliances for the treatment of sleep apnea, oxygen concentrators, prosthetic devices other than arms, legs or breast prostheses, scalp hair prostheses specifically made for you or a wig for hair loss due to alopecia areata, alopecia totalis or permanent loss of scalp hair due to injury, and other similar medical equipment or devices. In order to be considered a covered expense, the DME must be purchased from a contracted provider. Tufts must determine that the DME is the most appropriate available amount, supply, or level of service, and whether to rent or purchase DME.

- **Gender reassignment surgery** for individuals with a diagnosis of gender dysphoria and related charges (e.g. laboratory work, x-rays, office visits, etc.). The Plan will cover surgical procedures, including medically necessary corrective surgeries, to change your gender once (for example, if the Plan covers procedures changing your gender from male to female, the Plan will not pay to change your gender back to male). You must be at least 18 years of age and obtain prior authorization for surgical services

What's not covered

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

- Unless specified as covered, non-network care.
- Unless specified as covered, treatment, services, or supplies not approved, referred, or managed by your PCP.
- Treatment, services, or supplies that are not essential to treat an injury, illness, or pregnancy, except for preventive healthcare services.
- A service, supply, or medication if there is a less intensive level of service, supply, or medication, or a more cost-effective alternative which can be safely and effectively provided, or if the service, supply, or medication can be safely and effectively provided in a less intensive setting.
- Services, supplies, or medications primarily for your, or another person's, personal comfort or convenience.
- Custodial care.
- Unless specified as covered, drugs, medicines, materials, or supplies for use outside the hospital or other facility.
- Treatment, services, or supplies required by a third party which are not otherwise medically necessary.
- Facility charges or related services if the procedure performed is not a covered expense, except as specifically stated as covered for dental procedures.
- Cosmetic surgery, procedures, supplies, medications, or appliances, unless that surgery is for one of the following:
  - The relief of pain, or to restore bodily function impaired as a result of a congenital defect, birth abnormality, traumatic injury, or a covered surgical procedure.
  - Services related to mastectomies, as described under *"What's covered"*.

  - Removal of a breast implant, but only if there is evidence of an infection or auto-immune disease, you got the implant after a mastectomy, or your silicone implant has ruptured.

- Costs associated with home births, or cost associated with a doula.
- Infertility services.
- Treatments, medications, procedures, services, or supplies related to the reversal of gender reassignment surgery or reversal of voluntary sterilization.
- All non-conventional medicine services and all related testing, services, supplies, procedures, and supplements associated with this type of medicine, even if these services are provided along with conventional medicine.
- Services (including tuition-based programs) that offer educational, vocational, recreational, or personal development activities, including, but not limited therapeutic schools, camps, wilderness or ranch programs, sports or performance enhancement programs, spas or resorts, leadership or behavioral coaching or Outward Bound.
- Devices and procedures intended to reduce snoring.
- Private duty nursing care.
- Methadone treatment or methadone maintenance.
- Unless you are diagnosed with diabetes, routine foot care, treatment of flat feet or partial dislocation of feet, or orthopedic shoes and related items that are not part of a brace.
- Examinations, evaluations, or services for educational purposes, or developmental purposes, other than as specifically covered as an early intervention service.
- Vocational rehabilitation or retraining services.
- Services to treat learning disabilities, behavioral problems, and developmental delays.
- Equipment that is non-medical in nature or used primarily for non-medical purposes, even if such equipment has limited use as medical equipment.
- Treatment provided by an EMT or other ambulance staff if you refuse to be transported to the hospital or other medical facility.
- Care for conditions that state or local law requires to be treated in a public facility.
- Laboratory tests ordered by you or a dependent, even if provided by a licensed laboratory.
- Fees charged by a healthcare professional as a condition of access, or any amenities that fee is represented to cover.

- Preventive dental care or orthodontia, even when part of other surgical or medical procedures.
- Routine eye exams, eyeglasses, lenses, or frames, except for eyeglass lenses and frames for lenses required following cataract surgery.
- Circumcisions performed in any setting other than a hospital, as day surgery, or in a healthcare professional's office.
- Purchase of an electric hospital-grade breast pump or donor breast milk.
- Acupuncture, hypnotherapy, psychoanalysis, or neuromuscular stimulators.
- Oral contraceptives or over-the-counter contraceptives.
- Weight loss clinics or programs.
- Service or therapy animals and related supplies.
- Services related to excluded treatment, care, or medications.
- Treatment, care, or services related to teeth or dental care, including TMJ and surgical removal of teeth, unless specifically covered under the contract with Tufts.
- Biofeedback training, except for urinary incontinence.
- Unless stated as covered, transportation or lodging.
- Any treatment, services, or supplies that Tufts deems to be excluded from benefits, based on the contract between UNITE HERE HEALTH and Tufts Health Plan.

Mental health/substance abuse and alternative care benefits

Learn:

- How to get help.
- What you pay for care.
- What types of care are covered.
- What types of care are not covered.

UNITE HERE HEALTH has contracted with Modern Assistance Programs, Inc. (MAP) to administer your mental health/substance abuse care and alternative care benefits.

MAP Benefits —*What You Pay*	Network	Non-Network
Mental Health/Substance Abuse Care		
Inpatient Treatment *(including residential treatment)*	$0	Not covered
Outpatient Treatment *(including office visits, partial hospitalization, intensive outpatient, and ambulatory detoxification treatment)*		
Alternative Care		
Acupuncture — *up to 20 visits per person each calendar year*	$0	Not covered
Traditional Chinese Medicine — *up to 12 visits per person each calendar year*		
Naturopathic Medicine — *up to 12 visits per person each calendar year*		
Homeopathic Medicine — *up to 12 visits per person each calendar year*		
Massage Therapy — *up to 12 visits per person each calendar year*		
Nutrition Counseling		
Smoking Cessation Counseling		

Network providers

MAP must coordinate and approve care for mental health/substance abuse and alternative care benefits. **The Plan only pays benefits for services when you use a MAP network provider *and* MAP coordinates and approves the care.** Non-network care and care that is not coordinated and approved by MAP is not covered. If you receive emergency care, or urgent care outside the service area, contact MAP to arrange for follow-up care.

MAP is committed to overcoming all physical, language, cultural, or other barriers which may be perceived as an impediment to counseling. If you or a dependent is having a difficult time, please call MAP.

Modern Assistance Programs, Inc. (MAP)
1400 Hancock Street, 2nd Floor
Quincy, MA 02169
located by the MBTA Quincy Center Train Station on the Red Line.

(617) 774-0331 inside Massachusetts
(800) 878-2004 outside Massachusetts
www.modernassistance.com

What the Plan pays

The Plan pays 100% of covered care provided by MAP or managed by a MAP provider.

What you pay

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

What's covered

MAP is here to help you and your dependents in times of need. You can get help for many problems, including stress, marital difficulties, and legal and financial problems. MAP will work with you to assess your situation and develop a treatment plan that best suits your needs. Treatment may include individual or group services, or referral to outside network providers for inpatient or outpatient treatment. You can also get the alternative care services listed below. Services and supplies are only considered covered if they are provided by MAP, offered at MAP, or MAP manages the care through a network provider.

The following services are covered through MAP network providers:

- Inpatient mental health/substance abuse treatment, including residential treatment.
- Outpatient mental health/substance abuse treatment, including counseling sessions by MAP, office visits, partial hospitalization, intensive outpatient, and ambulatory detoxification treatment.
- Acupuncture, up to 20 visits per person each calendar year.
- Traditional Chinese medicine, up to 12 visits per person each calendar year.
- Naturopathic medicine, up to 12 visits per person each calendar year.
- Homeopathic medicine, up to 12 visits per person each calendar year.

- Massage therapy, up to 12 visits per person each calendar year.
- Nutrition counseling.
- Smoking cessation counseling.

What's not covered

See page E-2 for a list of the Plan's general exclusions and limitations. In addition to that list, no benefits will be provided for:

- Services or supplies that are not coordinated or approved by MAP.
- Services or supplies provided by non-network providers.

Prescription drug benefits

Learn:

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

Hospitality Rx (a subsidiary of UNITE HERE HEALTH) provides pharmacy benefit management services. Hospitality Rx contracts with several organizations to provide specialized administrative services. Benefits are only paid if you buy your prescription drugs at a pharmacy that participates in the network, like CVS, Walgreens, and Rite Aid. Not all retail pharmacies are in your pharmacy network. Sam's Club and Wal-Mart are **not** in your network.

Be sure to visit www.hospitalityrx.org to find a network pharmacy.

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

Important Phone Numbers		
If you want to:	**Call:**	**At:**
Find a network pharmacy or ask questions about your benefits	UNITE HERE HEALTH	**(844) 267-4325**
Get prior authorization for prescription drugs or to ask which drugs require prior authorization	Hospitality Rx	**(844) 813-3860**
Get a free glucometer	TrueMetrix *(by Trividia)*	**(866) 788-9618**
	One Touch *(by LifeScan)* *use order code 739WDRX01*	**(888) 883-7091** www.OneTouch.orderpoints.com
Order from the mail-order pharmacy	WellDyneRx Home Delivery (*through Hospitality Rx*)	**(844) 813-3860**
Order from the specialty pharmacy	Diplomat	**(844) 857-5772**

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-24* for information about what's not covered).

Prescription Drug Benefits—What You Pay			
	Retail Pharmacy *up to a 90–day supply*	**Mail–Order** *up to a 90–day supply*	
Formulary Prescription Drug Benefits	**Per Prescription**		
Preventive Healthcare Services Drugs — *see page I-6*	$0		
Generic Drugs	$1		
Brand Name Drugs	$8		
Select Specialty and Select Biosimilar Drugs*	Not covered	**Generic**	**Brand**
		$1	25%
Non-Formulary Prescription Drugs and Supplies	Not covered, unless an exception is approved		
**Current pharmacy benefit provider will actively manage and determine drugs in tier. Specialty drugs are only available through the specialty mail order pharmacy.*			

Drugs and supplies on the formulary are safe, effective, and high-quality. No benefits are paid for drugs not on the formulary unless the Fund approves a drug. Prescription drugs and supplies may be added to or removed from the formulary from time to time. Use the formulary lookup tool at www.hospitalityrx.org or call Hospitality Rx at **(844) 813-3860**, if you or your healthcare provider have questions about which prescription drugs and supplies are on the formulary.

Ask your healthcare provider to prescribe a drug that is on the formulary. If your healthcare provider wants you to take a drug that is not on the formulary, he or she should reach out to Hospitality Rx at **(844) 813-3860** for a formulary exception. The formulary exception process allows your healthcare provider to ask for approval for you to get coverage for a prescription drug not on the formulary. Remember, though, that the Fund will not consider a non-formulary drug for coverage until you have tried all of the formulary prescription drug alternatives that are medically appropriate to your situation.

Prescription drug out-of-pocket limit

Your cost-sharing for most network medical and prescription drug covered expenses is limited to $6,350 per person ($12,700 per family) each calendar year under the out-of-pocket limit. Once your out-of-pocket costs for covered expenses meet these limits, the Plan will usually pay 100% for your (or your family's) network medical and prescription drug covered expenses during the rest of that calendar year. Amounts you pay out-of-pocket for medical covered expenses under the section titled *"Medical benefits"* count toward this out-of-pocket limit, too.

Certain prescription drug expenses don't count toward your out-of-pocket limit. This includes any amounts you must pay in addition to your copay when you or your doctor chooses a brand name drug when a generic equivalent is available (see *"What's not covered"* below). These

expenses do not count toward your out-of-pocket limit and you will continue to be responsible for these expenses even if you have met the out-of-pocket limit for the year.

You can get more information about your out-of-pocket limits on *page D-5* and *I-6*.

What's covered

A medication or supply must be listed on the "smart" formulary in order to be covered (unless you get a formulary exception from the Plan). The Plan pays benefits only for the following formulary expenses:

- FDA-approved medications and supplies which can legally be purchased only with a written prescription from a healthcare provider. This includes oral and injectable contraceptives, and drugs mixed to order by a pharmacist, as long as at least one part of the mixed-to-order drug is an FDA-approved prescription drug.
- The following diabetic supplies: insulin, diabetic test strips, control solution for glucometers, disposable syringes and needles, and lancet devices.
- Prescription and over-the-counter preventive healthcare services and supplies, including immunizations. You must have a prescription for over-the-counter preventive healthcare services and supplies in order for the Fund to pay for these services.
- Vitamins.
- Hormone therapy as long as the hormones are FDA approved and only available by prescription. Prior authorization is required for certain hormone therapy. Hormone therapy for individuals with gender dysphoria is not subject to an age restriction; however, the prior authorization process for individuals under age 18 will include an additional requirement that the treating physician have documentation showing sexual maturity of Tanner stage 2 or more.

Free glucometers

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

(866) 788-9618 for **TrueMetrix (Trividia)** products
no order code is needed

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

If you don't want to use one of the Fund's free glucometers, you may be able to get a glucometer under the medical benefits. Contact your PCP or Tufts for more information.

Safety and cost containment programs for prescription drugs

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

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

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

If a prescription drug is subject to a safety or cost containment program, you must follow the program in order to get benefits for the drug.

See page H-9 for information about appealing a denied request for prior authorization or appealing a denial of prescription drug benefits.

Generic prescription drug policy

Generics have the same active ingredient as the brand name drugs, but you pay less for them. Ask your doctor to help you save money by prescribing generic drugs when possible.

If you or your provider choose a brand name prescription drug when you could get a generic equivalent instead, you pay the difference in cost between the brand name prescription drug and the generic equivalent. For example, if the brand name prescription drug costs $80, and the Fund's cost for the generic equivalent is $30, you must pay the $50 difference. You will also have to pay the 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 Hospitality Rx at **(844) 813-3860**. This rule will also not apply if you get an exception through a safety or cost containment program. Your healthcare provider will need to get prior approval for this exception to apply to your prescription drugs.

If you are approved for an exception to the generic prescription drug policy, you will still have to pay the applicable copay.

Prior authorization

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

Step therapy

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

For example, if you need an ARB (angiotensin receptor blocker) 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 brand name version.

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

Case management

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

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

Quantity limits

The amount of a prescription the Plan will fill at one time is limited to the lesser of:

- The amount prescribed by your healthcare professional.
- If you use a retail pharmacy, up to a 90-day supply.
- If you use the non-specialty mail-order pharmacy, up to a 90-day supply.
- The amount allowed under any safety or cost containment program. For example, most prescriptions filled through the specialty mail-order pharmacy will be limited to less than a 90-day supply.

Exceptions to the standard quantity limits

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

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

Early refills

You generally cannot refill a prescription earlier than allowed under any applicable guidelines, safety or cost containment programs, or other Plan rules. In some cases, you may be able to refill a prescription sooner than is usually allowed. For example, you may get an early refill if:

- You show you will be out of the country when you will run out of a prescription drug.
- Your drug is lost or stolen.
- You run out of a drug too soon because you misunderstood the instructions or accidentally used too much. You will be able to get one such early refill per lifetime for that drug.

You may be required to use the case management program in order to get an early refill.

Call Hospitality Rx at **(844) 813-3860** if you need an early refill for a drug.

Mail-order pharmacy

You can save money by using Hospitality Rx's mail-order pharmacy: WellDyneRx Home Delivery. If you need a prescription drug to treat a chronic, long-term health condition, you can order these prescription drugs through the mail-order pharmacy. You can get up to a 90-day supply of your prescription drug (sometimes called a "maintenance" prescription drug).

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 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 healthcare providers who specialize in helping people with your condition. The specialty pharmacy staff can help make sure your prescription gets refilled on time, and can answer questions about your prescription drugs and your condition.

Diplomat
(844) 857-5772
www.diplomatpharmacy.com

What's not covered

See page E-2 for a list of the Plan's general exclusions and limitations. For example, experimental and investigative treatments, including drugs, are not covered. 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 or its designee 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.
- Drugs or supplies that are not listed on the formulary, unless the Fund or its designee gives prior approval for the drug or supply. You must try all medically appropriate formulary alternatives before you can get a formulary exception.
- Drugs or medications used, consumed or administered at the place where dispensed, other than immunizations. (These drugs may be covered under your medical benefits.)
- Prescriptions or refills in amounts over the quantity limits.
- Vitamins, dietary supplements, or dietary aids, except those specifically included on the formulary.
- Drugs used for cosmetic reasons, including Rogaine and other drugs to prevent hair loss.
- Drugs or other covered supplies not purchased from a network pharmacy.
- Birth control devices and implants other than over-the-counter FDA-approved female contraceptive drugs, devices, or supplies for which you have a prescription.
- Non-sedating antihistamines or histamine receptor blockers.
- Fertility drugs.

- 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.
- Weight control drugs, unless for the treatment of morbid obesity under the direct supervision of a healthcare provider, and authorized in writing by the Fund or its designee.
- Preventive healthcare services and supplies that you must get through the medical benefits.
- Drugs that require review under a safety or cost containment program (such as a drug that requires prior authorization, or a drug subject to the step therapy program) if that safety or cost containment program is not followed, or does not approve the drug.
- New-to-market prescription drugs until the Fund or its designee has reviewed and approved the prescription drug.
- Specialty prescription drugs if you do not use the specialty pharmacy.
- Unless specifically listed on the formulary, over-the-counter drugs.
- 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 Hospitality Rx.
- Diagnostics (drugs used to help in the process of diagnosing certain medical conditions).
- Drugs, medications, or supplies that are not covered under the Fund's or Fund's designee's claims processing guidelines or any other internal rule, including but not limited to any national guidelines used by the medical community.
- Medical foods (medical foods may be covered under the medical benefit (*see page D-7*).

Dental benefits

Learn:

- How to use your dental benefits.
- What you pay for your dental care.
- What types of dental care are covered.
- What types of dental care are not covered.

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

Dental PPO Benefits	Delta Dental PPO Providers	Delta Dental Premier Dentists and Non-Network Providers
Calendar Year Maximum Benefit for Dental (non-ortho) Treatment	$2,000 per person	
Lifetime Maximum Benefit for Orthodontia Treatment	$3,000 per person	
Calendar Year Deductible	None	
Description of Services	**What You Pay for Your Covered Dental Care**	
Diagnostic and Preventive Services *(Examples: oral exams, emergency palliative care, x-rays, routine cleaning, fluoride treatment, sealants, space maintainers)*	$0	20%
Minor Restorative Services *(Example: fillings)*	$0	20%
Endodontic Services *(Example: root canals)*		
Periodontic Services *(Examples: scaling and root planing, full-mouth debridement, periodontal (gum) maintenance, certain surgical periodontal services)*		
Oral Surgery *(Examples: Extractions (simple and surgical), certain sedation procedures)*		
Prosthodontic Maintenance *(Example: Repairs to dentures and crowns)*		
Prosthodontic Services *(Examples: complete or partial dentures, bridges, adjustments to dentures)*	40%	60%
Major Restorative Services *(Examples: onlays, crowns)*	40%	60%
Implants	40%	60%
Orthodontic Services	50%	50%

Network vs. non-network providers

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

- ✓ Your network is the Delta Dental PPO network.
- ✓ If you choose a Delta Dental Premier dentist, your cost-sharing is the non-network benefit percentages. You may still save money using Premier dentists, because they will not balance bill you. (This means they won't bill you for the difference between Delta Dental's allowable charge and the dentist's actual charge.)

To find a network provider near you, contact:

Delta Dental of Illinois
(800) 323-1743
www.deltadentalil.com

What you pay

You must pay your cost-share (coinsurance) for covered expenses. You must also pay any expenses that aren't covered, including any amounts over the allowable charge that non-network dentists are allowed to bill you.

Maximum benefits

Dental care maximum benefit for non-orthodontic care

The Plan pays up to $2,000 per person each year for dental care (network and non-network combined). Once the Plan pays this maximum benefit, it won't pay for any more dental care for the rest of that year.

Delta Dental may allow you to carry over all or part of the unused portion of your annual maximum for non-orthodontic treatment, up to $2,000. You must have been eligible for dental benefits for the entire calendar year, and have submitted at least one claim during the year that applied to your annual maximum benefit. Contact Delta Dental for more information about carrying over all or part of your maximum benefit.

Orthodontic care maximum benefit

The Plan pays up to a lifetime maximum of $3,000 per person for orthodontic treatment (network and non-network combined). Once the Plan pays this maximum benefit, it won't pay for any more orthodontic treatment.

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 will be based on the less expensive alternate type of treatment. This rule applies if the alternate type of dental treatment is both:

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

What's covered

"Covered expenses" means all allowable charges made by a dentist for the types of services and supplies listed below. 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 hasn't passed since the service or supply was last provided, you may have to pay 100% of the cost. You can always contact Delta Dental at **(800) 323-1743** to find out the last time you got benefits for a certain service or supply. A time limit starts on the date you last got the service or supply. Time limits are measured in consecutive months or years.

Diagnostic and preventive services

- Oral exams, including periodontal evaluations and problem-focused exams.
- Comprehensive dental examinations—1 every 60 months.
- Periodic oral exams—1 every 6 months.
- X-rays:
  - Intra-oral periapical radiographs.
  - Bitewing x-rays—1 series every 6 months.
  - Full mouth x-rays (which include panoramic and vertical bitewing x-rays)—1 every 60 months.
- Diagnostic casts.
- Pulp vitality tests—1 per visit.
- Prophylaxes (cleaning)—1 every 6 months.

✓ If you have certain conditions, you may be eligible for additional cleanings each year. See the *"Enhanced benefits program"* below.

- Topical application of fluoride for children under age 19—1 every 6 months.

  ✓ If you have certain conditions, you may also be eligible for topical application of fluoride. See the *"Enhanced benefits program"* below.

- Space maintainers for children under age 14—1 per tooth per lifetime.
- Recementation of space maintainers—1 per calendar year.
- Sealants to the unrestored permanent molars of dependent children under age 16 and for children from age 16 up to age 19 who have had a recent cavity and are at risk for decay—1 per tooth every 4 years.
- Emergency palliative care (to temporarily relieve pain and discomfort)—3 every 12 months.
- Chlorhexidine mouth rinse when administered and dispensed in the dentist's office following scaling and root planing.
- Fluoride toothpaste when administered and dispensed in the dentist's office following periodontal surgery.

Minor restorative services

- Amalgam and resin-based composite fillings—1 per surface every 24 months.
- Sedative fillings—1 per tooth per lifetime.
- Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores, and crowns—1 per tooth every 12 months.
- Prefabricated stainless steel crowns on deciduous (primary) teeth only.

Endodontic services

- Pulpal and root canal therapy.
- Pulpal therapy (resorbable filling)—1 per tooth per lifetime.
- Apicoectomy—1 per tooth every 24 months.
- Retrograde filling—1 per filling per root.

Periodontic services

- Periodontal therapy, including treatment for diseases of the gums and bones supporting the teeth—1 per quadrant every 24 months.

- Gingivectomy or gingivoplasty; gingival flap procedures.
- Clinical crown lengthening (hard tissue).
- Osseous surgery (including flap entry and closure)—1 per quadrant every 36 months.
- Guided tissue regeneration.
- Bone replacement and soft tissue grafts.
- Periodontal scaling and root planing.
- Full mouth debridement—1 per lifetime.
- Periodontal maintenance—1 every 3 months.
  - ✓ If you have certain conditions, you may be eligible for additional periodontal maintenance each year. See the *"Enhanced benefits program"* below.

Oral surgery

- Simple extractions.
- Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
- Removal of impacted tooth (soft tissue, partially bony, completely bony).
- Tooth reimplantation of an accidentally evulsed or displaced tooth and/or alveolus.
- Surgical access of an unerupted tooth.
- Biopsy of oral tissue; brush biopsy.
- Alveoloplasty.
- Surgical excision of soft tissue or intra-osseous lesions.
- Other covered surgical/repair procedures.
- Deep sedation/general anesthesia when provided in conjunction with oral surgery (other than simple extractions).
- Intravenous conscious sedation/analgesia when provided in conjunction with oral surgery (other than simple extractions).

Prosthodontic maintenance

- Repairs to complete and partial dentures—1 every 12 months
- Crown repair.

- Replacement of missing or broken teeth.
- Addition of tooth or clasp to existing partial dentures.
- Replacement of all teeth and acrylic on cast-metal framework.
- Denture rebase—1 every 36 months.
- Denture relines—1 every 36 months.
- Temporary partial dentures to replace any of the 6 upper or lower front teeth only.

Prosthodontic services

- Complete and partial dentures.
- Adjustments to complete and partial dentures—2 every 12 months.
- Pontics.
- Fixed partial denture retainers (inlays, onlays, crowns).
- Recement fixed partial denture—1 per lifetime.
- Cast or prefabricated post and core; core build-up.

Major restorative services

- Onlays (permanent teeth only).
- Crowns and ceramic restorations (permanent teeth only).
- Pin retention.
- Cast or prefabricated posts and cores; core buildup.

Implants—once every 60 months for patients age 16 and older.

Orthodontic treatment

Enhanced benefits program

If you have certain health conditions, you may be able to get additional cleanings or fluoride treatments. Cost-sharing and maximum benefits still apply. Contact Delta Dental at **(800) 323-1743** to sign up if you have any of these conditions or are getting any of these treatments:

- Periodontal (gum) disease
- Diabetes

- Pregnancy
- High-risk cardiac conditions
- Kidney failure, or dialysis
- Cancer-related chemotherapy and/or radiation
- Suppressed immune system due to: HIV, organ transplants, and/or stem cell (bone marrow) transplants

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 treatments, services, and supplies aren't covered under the dental PPO benefits:

- Pulp vitality tests billed in conjunction with any service except for an emergency exam or palliative treatment.
- Periodontal cleanings provided in combination with preventative cleanings.
- Recementation of space maintainers within 6 months of initial placement.
- Fillings, when crowns are allowed for the same teeth.
- Replacement of any existing cast restoration (crowns, onlays, ceramic restorations) with any type of cast restoration within 60 months following initial placement of existing restoration.
- Replacement of a stainless steel crown with any type of cast restoration by the same office within 24 months following initial placement.
- Cast restorations if radiographic evidence doesn't show decay or missing tooth structure, or restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures.
- A crown build-up if there isn't radiographic evidence of sufficient vertical height (more than 3 millimeters above the crestal bone) on a tooth to support a cast restoration.
- Recementing of inlays, onlays, partial coverage restorations, cast and prefabricated posts and cores and crowns by the same office within 6 months of the initial placement.
- Additional procedures to construct a new crown under the existing partial denture framework within 6 months following initial placement.
- Sedative fillings requested or placed on the same date as a permanent filling.

- Retreatment of the same tooth within 2 years when a benefit has been issued for endodontic services.
- Endodontic procedures performed in conjunction with complete removable prosthodontic appliances.
- Surgical periodontic services not performed in association with natural teeth.
- Surgical periodontic services rendered in a surgical day care or hospital setting.
- Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/ sinus lift, extractions or periradicular surgery/apicoectomy.
- Crown lengthening or gingivoplasty, if not performed at least 4 weeks prior to crown preparation.
- Bone replacement grafts performed in conjunction with extractions or implants.
- Periodontal splinting to restore occlusion.
- Replacement of any existing prosthodontic appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontic appliance within 60 months following initial placement of the existing appliance.
- A fixed partial denture, when requested or placed in the same arch as a removable partial denture.
- Reline or rebase of an existing appliance within 6 months following initial placement.
- Fixed or removable prosthodontics for a patient under age 16.
- Temporary partial dentures, unless installed during the period of healing immediately following the loss of any of the 6 upper or lower front teeth for a patient age 16 or older.
- A pontic when the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth.
- When performed in conjunction with other oral surgery, mobilization of an erupted or malpositioned tooth to aid eruption or placement of a device to facilitate eruption of an impacted tooth.
- Services, supplies, or treatment provided more frequently than stated as covered, or more frequently than commonly accepted according to the dental standards determined by Delta Dental, or more frequently than specified in the contract with Delta Dental.
- Any treatment, services, or supplies as set forth in the Section of your SPD titled “General exclusions and limitations.”

- Services compensable under Workers' Compensation or Employer's Liability laws.
- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.
- Services performed to correct developmental malformation, including but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and congenitally missing teeth. This exclusion doesn't apply to newborn infants.
- Services performed for purely cosmetic purposes, including but not limited to, tooth-colored veneers, bonding, porcelain restorations, and microabrasion.
- Charges for services completed prior to the date the patient became covered under this program.
- Services for anesthetists or anesthesiologists.
- Temporary procedures, other than certain temporary partial dentures.
- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.
- Services performed on non-functional teeth (second or third molar without an opposing tooth).
- Services performed on deciduous (primary) teeth near exfoliation.
- Drugs or the administration of drugs, except for general anesthesia and intravenous conscious sedation.
- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.
- Services with respect to any disturbance of the temporomandibular joint (jaw joint).
- Procedures that Delta Dental considers to be included in the fees for other procedures.
- The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.
- Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.
- Broken appointments.
- Services and supplies for any illness or injury occurring on or after you become covered under the Plan as a result of war or an act of war.

- Services and supplies received from either your or your spouse's relative, any individual who ordinarily resides in your home, or any such similar individual.
- Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance, or the commission of a felony.
- Charges for services for inpatient/outpatient hospitalization.
- Services or supplies for oral hygiene or plaque control programs.
- Services and supplies to correct harmful habits.

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, but contacting Delta Dental before you have complex or expensive dental work will help you and your dentist understand what the Plan will pay for your proposed care. By contacting 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 doesn't 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.

Vision benefits

Learn:

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

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

Vision Benefits—*What You Pay*		
Description of Services *Covered once every 24 months*	**Davis Vision Provider**	**Non-Network Provider**
Eye Exam	$0	$0 Plan benefits limited to $16 *Maximum benefit does not apply to exams for children under age 5*
Frames	$0 for Davis Collection Fashion or Designer frames $0 for non-Davis collection frames; Plan benefits are limited to $14	$0 Plan benefits limited to $14
Lenses	$0	$0 Plan benefits limited to: $14 for single vision lenses $23 for bifocal/progressive lenses $29 for trifocal lenses
Elective Contacts *(provided instead of glasses)*	$0 for Davis Collection contacts $0 for non-Davis Vision contacts; Plan benefits are limited to $25	$0 Plan benefits limited to $40
Medically Necessary Contacts	$0	$0

Network and non-network vision providers

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

To find a network provider near you, contact:

Davis Vision
toll free: **(800) 999-5431**
www.davisvision.com
(Register for detailed information)

At your appointment, tell them you have Davis Vision. You don't need an ID card. If you'd like a card, you can request one at www.davisvision.com. (You must register for an account.)

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

What you pay

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

Upgrade options through network providers

Although the Plan will not pay for any upgrades or options, if you use a network provider, you can get certain upgrades or options for a set fee. Common lens options include but are not limited to anti-reflective coatings, progressive lenses, polycarbonate lenses for adults, and photochromic lenses. Standard scratch resistant coatings and, for children under age 19, polycarbonate lenses, are available with no copay to you.

You can also get discounts on laser eye surgery. (Benefits are not payable for laser eye surgery.)

Get your questions about upgrades and options answered by contacting Davis Vision, or by asking your network provider. Your cost for an upgrade depends on which upgrade(s) you pick.

What the Plan pays

The Plan pays 100% of covered expenses after you make any applicable copay. If you use a non-network provider, the Plan only pays up to the maximum shown in the table for your vision care.

What's covered

Benefits are available every 24 months, measured from the first day of the month during which the covered expense was last incurred (the last date of service). For example, if you have an exam and get glasses on January 15, 2021, the next time the Plan would cover your exam and lenses would be January 1, 2023.

- Exams (including dilation when professionally indicated).
- Lenses, including single vision, bifocal lenses, trifocal lenses, or lenticular lenses.
- Frames.
- Standard contact lenses (soft, daily-wear, disposable, or planned replacement) in lieu of glasses.

  - Disposable and planned replacement contacts will be supplied in quantities determined by Davis Vision.
- Medically necessary contacts, with prior authorization from Davis Vision.

What's not covered

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

- Non-prescription lenses.
- Any type of lenses, frames, services, supplies, or options that are not covered under the Davis Vision contract.
- Two pairs of glasses instead of bifocals.
- Contacts and eyeglasses during the same 24-month period.
- Low vision services or supplies that are not pre-approved, or that are more than the maximum benefits or frequency limits specified in the contract with Davis Vision.
- Medical treatment of eye disease or injury (may be covered under "Medical benefits").
- Replacement of lost, stolen, or broken contacts, lenses, or frames before the beginning of a 24-month benefit period.

Adoption assistance benefit

Learn:

- What the adoption assistance benefit is.
- What's covered.
- What's not covered.

Adoption assistance benefits are for employees only. Dependents are not eligible for adoption assistance benefits.

UNITE HERE HEALTH has contracted with Modern Assistance Programs, Inc. (MAP) to administer the adoption assistance benefit.

Modern Assistance Programs, Inc. (MAP)
1400 Hancock Street, 2nd Floor
Quincy, MA 02169
(617) 774-0331 inside Massachusetts
(800) 878-2004 outside Massachusetts

The adoption assistance benefit is designed to reimburse you for adoption expenses you incur for adopting a child. MAP will determine whether the expenses you incur are eligible for reimbursement. Contact MAP for questions about the adoption assistance benefit.

Who's an eligible adopted child

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

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

Adoptions from another state or country

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

What the Plan pays

The Plan will reimburse you for eligible expenses you incur up to $2,000 per eligible adopted child each Plan year. The Plan year runs from each April 1 through the following March 31.

What's covered

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

What's not covered

The following expenses are not covered under the adoption assistance benefit:

- Expenses you incur while you are not covered under this Plan or while you continue your coverage under this Plan through COBRA as described *on page G-22*.
- Expenses incurred in violation of state or federal law, or for adoptions not legal in the state or country from which the child is adopted.
- Expenses incurred in carrying out any surrogate parenting program.
- Expenses in connection with the adoption of a child who is a child of your spouse.
- Expenses that you take a federal income tax credit for under Section 23 of the IRS Code.
- Expenses that are covered by any other means, including expenses for legal services provided under the Greater Boston Hotel Employees Local 26 Group Legal Services Plan and for legal work performed by another attorney when the work could have been performed by the Greater Boston Hotel Employees Local 26 Group Legal Services Plan.
- Expenses incurred for an adoption of a child that doesn't meet the definition of an eligible adopted child described *on page D-44*.

Short-term disability benefit

Learn:

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

This benefit is available for employees only. No short-term disability benefits are payable for dependents, except for a dependent spouse who is paying for two-way coverage (*see page G-9*)**.**

Short-term Disability Benefit *(Employees Only)—What the Plan Pays*	
Amount of Benefit	$500/week for up to 26 weeks
Benefits Start:	
Due to Injury or Having a Baby (Vaginal or Cesarean Delivery)	1st day
Due to Sickness	8th day

Short-term disability (STD) provides money when you cannot work due to non-work-related illness or injury. (For work-related illness or injury, you may be able to file for Workers' Compensation through your employer.) You must submit a completed short-term disability claim form, and your doctor must certify your disability BEFORE benefits will be paid. The maximum benefit period for a disability is 26 weeks. The actual number of weeks you can get disability benefits depends on your specific illness/injury. If you are disabled because you are having a baby (vaginal or cesarean delivery), you will get at least 13 weeks of STD benefit payments, unless you return to work sooner.

No benefits are available for any period of continuous disability beginning:

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

You are considered disabled if you are prevented by injury or sickness from engaging in the normal activities of your job and you are receiving regular and appropriate care from a doctor. You must submit a completed application for benefits and a doctor's statement establishing total disability before benefits can begin. Contact the Fund for the required forms, or visit www.uhh.org.

What the Plan pays

The Plan pays the applicable weekly benefit for as long as you are disabled—up to 26 weeks during any 1 period of disability. If disability benefits are paid for less than a full week, a daily rate equal to 1/7th of the weekly benefit will be paid for the partial week.

Benefits begin on:

- The 1st day of disability caused by injury or having a baby (vaginal or cesarean delivery).
- The 8th day of disability caused by sickness.

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

The Plan may reimburse your employer up to $2,500 for the cost of a workplace modification done to help you return to or stay at work.

Multiple periods of disability

Except as described below, periods of disability will be treated as 1 period of disability (a recurring disability) if all of the following are true:

- You return to active work right after your STD benefits ended.
- Your disability starts again (recurs) less than two weeks after the end of your previous disability.
- Your disability is due to the same or related cause as the earlier disability.
- You do not become covered under any other similar group income replacement plan during the time you return to active work.
- You continue to meet the Plan's eligibility rules, including the requirement that employer contributions be made on your behalf, following your return to active work.

Otherwise, your disability will be treated as a new period of disability.

Total disability after delivering a baby

If you are eligible under the Plan on the day you deliver a baby, your total disability after your delivery will be considered a new period of disability, with a new maximum number of weeks of payments. This applies even if you received STD benefit payments while you were pregnant, for example because your doctor requires you to be on bed rest.

What's not covered

No STD benefits will be paid for any disability caused by or related to any of the following:

- War or act of war.
- Service in the military.
- Your participation in a riot or in civil disorder.
- Your commission of, or attempted commission of, a felony for which you have been convicted.
- Your involvement of an incident, including but not limited to, a motor vehicle accident, in which you are intoxicated at the time of the incident. "Intoxication" means blood alcohol

concentration that meets or exceeds the level that would be required in order to charge the person with driving while intoxicated under the laws of the jurisdiction in which the incident occurred, regardless of whether or not you are ever charged.

- Intentional self-inflicted injuries.
- Job-related or on-the-job injuries.

In addition, no STD benefits will be paid for any period of disability:

- During which you are confined to a facility due to the conviction of a crime.
- During which you are receiving medical treatment or care outside the United States or Canada, unless expressly authorized by the Fund.
- Which begins before you are covered under the Plan or after your employment terminates.
- During which your loss of earnings is not solely due to your disability.

When coverage ends

Benefits end on the earliest of the following:

- The end of the maximum number of weeks benefits are payable.
- The date you are no longer considered totally disabled.
- The date you perform any work for wage or profit.
- The date you fail to provide proof of loss as required by this plan.
- The date you have been outside the United States for more than 2 months in a 12-month period.
- The date you die.
- The date you are no longer receiving regular and appropriate care from a doctor.
- The date you are able to perform the major duties of your own job on a full-time basis with reasonable accommodation.

Life and AD&D benefits

Learn:

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

Life and AD&D benefits are for employees only. Dependents are not eligible for life and AD&D benefits, except for a dependent spouse who is paying for two-way coverage.

Life and Accidental Death & Dismemberment (AD&D) Benefit *(Employees Only)*		
What the Plan Pays if You Have:	**Life Insurance Benefit**	**AD&D Insurance Benefit** (*full amount*)
Less than 4 Years of Service	$5,000	$5,000
4–10 Years of Service	$10,000	$10,000
More than 10 Years of Service	$35,000	$35,000

Life insurance and AD&D insurance benefits are provided under an insured group insurance policy issued to UNITE HERE HEALTH by Dearborn Life Insurance Company, branded as Blue Cross and Blue Shield of Illinois (BCBSIL). The terms and conditions of your (the employee's) life and AD&D insurance coverage are contained in a certificate of insurance. The certificate describes, among other things:

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

The terms of the certificate are summarized below. If there is a conflict between this summary and the certificate of insurance, the certificate governs. You may request a copy of the certificate of insurance, free of charge, by contacting UNITE HERE HEALTH at **(844) 267-4325**.

Life insurance benefit

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

Continuation if you become totally disabled

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

- Your total disability ends.
- You fail to provide satisfactory proof of continued disability.

- You refuse to be examined by the doctor chosen by UNITE HERE HEALTH.
- Your 70th birthday.

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

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

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

Converting to individual life insurance coverage

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

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

BCBSIL
701 E. 22nd St., Suite 300
Lombard, IL 60148
(800) 348-4512

Terminal illness benefit

If you have a terminal illness (an illness so severe that you have a life expectancy of 24 months or less or if you are continuously confined in an eligible institution, as defined by BCBSIL, because of a medical condition and you are expected to remain there until your death), your life insurance pays a cash lump sum up to 75% of the death benefit in force on the day you were diagnosed with a terminal illness. The remaining portion of your death benefit will be paid to your named beneficiaries after your death. Certain exceptions may apply. See your certificate or call BCBSIL for more details.

Accidental death & dismemberment insurance benefit

If you die or suffer a covered loss within 365 days of an accident that happens while you are eligible for coverage, AD&D benefits will be paid as shown below. However, the total amount payable for all losses resulting from one accident is your full amount (the amount your beneficiary would receive if you died).

Your AD&D Benefit for a loss (death or dismemberment) within 365 days of an accident				
Event	**Benefit if you have less than 4 years of service**	**Benefit if you have 4-10 years of service**	**Benefit if you have more than 10 years of service**	**Who Receives**
Death	$5,000	$10,000	$35,000	Your beneficiary
Loss of both hands or feet				You
Loss of sight in both eyes				
Loss of one hand and one foot				
Loss of one hand and sight in one eye				
Loss of one hand or one foot	$2,500	$5,000	$17,500	
Loss of the sight in one eye				
Loss of index finger and thumb on same hand	$1,250	$2,500	$8,750	

AD&D exclusions

AD&D benefits do not cover losses resulting from or caused by:

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

See your certificate for complete details.

Additional accidental death & dismemberment insurance benefits

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

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

Naming a beneficiary

Your beneficiary is the person or persons you want BCBSIL to pay if you die. Beneficiary designation forms are available on www.uhh.org or by calling the Fund. 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 first surviving relative 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, BCBSIL may pay benefits up to an applicable limit, 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, BCBSIL may make payments to that person's legal guardian.

Additional services

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

- **Travel Resources Services** help you and your dependents if you travel 100 miles or more from your home. For example, you can access translation and travel information services, get help finding medical services, replace eyeglasses or medications, or get help finding legal assistance, among other services. Travel resources are provided by Generali Global Assistance, Inc. (GGA).

  Generali Global Assistance, Inc.
  (877) 715-2593 *(U.S. and Canada)*
  (202) 659-7807 *(call collect outside of the U.S. and Canada)*
  ops@us.generaliglobalassistance.com

- **Beneficiary Resource Services** provides grief counseling, online will preparation, help planning a funeral, and other services to your beneficiaries (and to you if you are eligible for the terminal illness benefit). Services are provided by telephone, face-to-face contact, online, or through referrals to local resources. Limits may apply to certain services. Beneficiary resources are provided by Morneau Shepell.

  Morneau Shepell
  (800) 769-9187
  www.beneficiaryresource.com
  (username: beneficiary)

John Wilhelm Scholarship

Learn:

- What the John Wilhelm Scholarship is.
- Who can apply.
- How to apply.

John Wilhelm Scholarship

The John Wilhelm Endowed Scholarship Benefit (John Wilhelm Scholarship) helps you or your dependents get an undergraduate degree (bachelor's degree) in the health sciences field at the University of Nevada, Las Vegas (UNLV).

Who is eligible

You or your dependents must meet the following rules in order to be eligible to apply for the scholarship.

You must meet the following requirements:

- Fund eligibility. You must either be:
  - A current employee, both currently eligible under the Fund and have been eligible for at least 36 continuous months. (You may meet this rule based on months you were eligible under any plan or fund that merges into UNITE HERE HEALTH.)
  - An eligible dependent of a current employee who meets the above rule.
- Be admitted to UNLV, and pursuing an undergraduate degree in Public Health, Nursing, or other major within the School of Allied Health Sciences.
- Have a 3.0 or higher cumulative grade point average (GPA).
- Be enrolled as a part-time or full-time student, and have a class standing of a junior or higher.

How to apply

You may apply for the scholarship through the UNLV financial aid and scholarship office by completing the Free Application for Federal Student Aid (FAFSA) and any other required materials. Contact UNLV for help getting or completing the required application materials, or for information on application deadlines.

You must apply for the scholarship each year, even if you have received it in the past. You may re-apply each year, even if you did not receive it in prior years.

Scholarship decisions

Based on numerous factors, the Fund will determine the amount and number of scholarships, if any, awarded for each academic year. The Fund will also determine if you meet the Fund eligibility requirement described above. Determinations regarding the eligibility requirement will be made in the sole and independent discretion of the Fund and shall be final and binding for all persons who apply for the scholarship.

UNLV will select the final scholarship recipients and will give preference based on financial need and past receipt of the scholarship. All decisions regarding the recipients will be made in the sole and independent discretion of UNLV and shall be final and binding for all persons who apply.

Other important information

- The scholarship may only be used for tuition at UNLV. You cannot use the scholarship for registration fees, student body fees, activity fees, books, supplies, equipment, tools, meals, lodging, parking, or transportation.
- The scholarship cannot be applied towards post-graduate degrees.
- Scholarships are not guaranteed each year and may not be awarded in any particular year.
- Scholarship amounts will be applied to tuition only after all other financial aid, such as public or private financial assistance, fellowships, scholarships, or grants, is applied.

Appeal rights

If you or your dependent(s) do not get the scholarship benefit because you do not meet the Fund eligibility requirement described in "Who is eligible," you may appeal the denial within 60 days of receiving the denial notice. Submit your appeal to:

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

See page H-11 for more information about the subcommittee's review of your appeal, and when you will be notified of the Appeal Subcommittee's decision.

General exclusions and limitations

Learn:

- The types of care not covered by the Plan.

General exclusions and limitations

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

- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a healthcare provider.
- Any injury, sickness, or dental or vision treatment which arises out of or in the course of any occupation or employment, or for which you have gotten or are entitled to get benefits under a workers' compensation or occupational disease law, whether or not you have applied or been approved for such benefits.
- Any treatment, services, or supplies:
  - For which no charge is made.
  - For which you, your spouse or 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 healthcare provider or not medically necessary in treating the injury or sickness as defined by UNITE HERE HEALTH (*see page I-5*).
- Experimental treatment (*see page I-4*), or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH.
- Any 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 medical emergency treatment. The decision of the Trustees in determining whether an emergency existed will be final.
- Any charges incurred for treatment, services, or supplies as a result of a declared or undeclared war or any act thereof; or any loss, expense or charge incurred while a person is on active duty or in training in the Armed Forces, National Guard, or Reserves of any state or any country.

- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault.
- Any expense greater than the Plan's maximum benefits, or any expense incurred before eligibility for coverage begins or after eligibility terminates, unless specifically provided for under the Plan.
- Preventive care, services, or supplies, unless specifically included as covered services.
- Any charges incurred for education or training, unless specifically included as covered services.
- Cosmetic services.
- To the extent of any charges denied or penalty assessed for any treatment or services requiring prior authorization, when this mandatory program is not used as required.
- 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.
- Procedures to reverse a voluntary sterilization.
- Treatment for or in connection with infertility, other than for diagnostic services.
- Hospital charges for personal comfort items, including but not limited to telephones, televisions, cosmetics, guest trays, magazines, and beds or cots for family members or other guests.
- Supplies or equipment for personal hygiene, comfort or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, tanning bed, or water bed.
- Home construction for any reason.
- Any expense or charge by a rest home, old age home, or a nursing home.
- Any charges incurred while you are confined in a hospital, nursing home, or other facility or institution (or a part of such facility) which are primarily for education, training, or custodial care.
- Eye exams or hearing exams, except as specifically stated as covered.
- Any dental treatment of teeth or their supporting structures, or services or supplies associated with such treatment, except as specifically stated as covered.
- Charges or claims incurred as a result, in whole or in part, of fraud, false information, or misrepresentation.
- With respect to the benefits administered by each contracted provider, any service or supply not covered under the terms of the contract.

Coordination of benefits

Learn:

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

These coordination of benefits provisions only apply to medical benefits, mental health/substance abuse benefits, alternate medical benefits, and dental benefits. Tufts and Delta Dental may follow their own rules to coordinate medical and dental benefits. Their rules may be slightly different than the rules shown below. Contact Tufts with questions about coordination of your medical benefits and Delta Dental for coordination of your dental benefits.

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

This Plan coordinates benefits with the following types of plans:

- Group, blanket, or franchise insurance coverage.
- Group Blue Cross or Blue Shield coverage.
- Any other group coverage, including labor-management trusteed plans, employee organization benefit plans, or employer organization benefit plans.
- Any coverage under governmental programs or provided by any statute, except Medicaid.
- Any automobile insurance policies (including but not limited to "no fault" coverage containing personal injury protection (PIP)).

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

Which plan pays first

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

Order of payment

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

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

- Plans that have COB and cover a person (or dependent of such person) who is laid off, retired, or enrolled in continuation coverage in accordance with federal or state law will be secondary to active coverage, including self-paid coverage.
- Continuation of coverage offered in accordance with federal or state law, such as COBRA, will be secondary to any non-continuation coverage, subject to the rule for military or government plans, below.
- Generally, military or government coverage will be secondary to all other coverage.
- With respect to plans that have COB and cover dependent children under age 18 whose parents are not separated, plans that cover the parent whose birthday falls earlier in a year pay before plans covering the parent whose birthday falls later in that year.
- With respect to plans that have COB and cover dependent children under age 18 whose parents are separated or divorced:
  - Plans covering the parent whose financial responsibility for the child's healthcare expenses is established by court order pay first.
  - If there is no court order establishing financial responsibility, the plan covering the parent with custody pays first.
  - If the parent with custody has remarried and the child is covered as a dependent under the plan of the stepparent, the order of payment is as follows:
    - The plan of the parent with custody.
    - The plan of the stepparent with custody.
    - The plan of the parent without custody.
- With respect to plans that have COB and cover adult dependent children age 18 and older under both parents' plans, regardless of whether these parents are separated or divorced, or not separated or divorced, the plan that covers the parent whose birthday falls earlier in a year pays before the plan covering the parent whose birthday falls later in the year, unless a court order requires a different order.
- With respect to plans that have COB and cover adult dependent children age 18 and older under one or more parents' plan and also under the dependent child's spouse's plan, the plan that has covered the dependent child the longest will pay first.

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

COB, prior authorization, and referrals

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

Special rules for Medicare

I am an active employee

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

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

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

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

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

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

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

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

I have COBRA coverage or retiree coverage

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

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

How to get help with Medicare

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

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

If you and your spouse are both employees under this Plan

If both you and your spouse are covered as employees under this Plan and you or your spouse cover the other person as your dependent, the Plan will coordinate benefits with itself (internal coordination of benefits). Any benefit maximums and copay requirements will be administered as if only one employee had coverage under the Plan.

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

Subrogation

Learn:

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

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

The Plan's right to recover payments

When injury is caused by someone else

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

Typical examples include injuries sustained:

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

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

Statement of facts and repayment agreement

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

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

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

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

Settling your claim

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

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

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

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

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

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

Eligibility for coverage

Learn:

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

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

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

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

Who is eligible for coverage

Employees

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

- You work for an employer who is required by a CBA to contribute to UNITE HERE HEALTH on your behalf.
- The contributions required by that CBA are received by UNITE HERE HEALTH. Contributions include any amounts you must pay for your share of coverage.
- You make any employee contribution (EC) payment required by UNITE HERE HEALTH.
- You meet the Plan's eligibility rules.

You are required to make payments toward the cost of providing coverage for you and your family. You must arrange with your employer to make those payments by payroll deduction.

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 can't start before your coverage starts. You cannot decline coverage for yourself and sign up your dependents.

Coverage for your dependents is not free. You must sign up all dependents you want covered by the Plan and make any required payments (employee contributions) for your share of the cost of coverage. You can add dependents after your coverage starts, but only at certain times. *See page G-10* for more information about enrollment events.

If you don't sign up your dependent, or you don't make any required payments for your share of dependent, the Plan will not pay benefits for that person.

Who your dependents are

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

- Your legal **spouse.**
- Your **children** who are under age 26, including any of the following:
  - Biological children.
  - Step-children.
  - Adopted children or children placed with you for adoption, if you are legally responsible for supporting the children until the adoption is finalized.
  - Children for whom you are the legal guardian or for whom you have sole custody under a state domestic relations law.
  - Children entitled to coverage under a Qualified Medical Child Support Order.
  - Your foster children, but only if the child was covered under the Greater Boston Hotel Employees Local 26 Health and Welfare Fund as of April 30, 2014.

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

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

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

You must provide proof of the mental or physical handicap within 30 days after the date coverage would end because the child becomes age 26. The Fund may also require you to provide proof

of the handicap periodically. (Special rules apply to children with a mental or physical handicap when a new employer begins participation in this Plan. Contact the Fund with questions.)

Enrollment requirements

Employees

You and your employer must provide the Fund with any required information before benefits will be paid on your behalf. You must provide the required information by the end of your initial enrollment period. UNITE HERE HEALTH will tell you when this information is due. By electing the Plan, you also agree to have the required payments toward the cost of providing coverage made by payroll deduction. You can choose the level of coverage right for you. At the time this SPD was published, the general monthly employee contribution amounts were:

- $8 two-way coverage.
- $16 single coverage.
- $32 single plus one coverage.
- $48 family coverage.

The Trustees have the right to change these employee contribution amounts at any time. (*See page G-9* for more information about two-way coverage.)

If you choose to waive coverage, or if you do not enroll yourself by the deadline, you will have the opportunity to elect coverage during open enrollment periods designated by the Plan or during special enrollment periods required by federal law. For more information about special enrollment periods, *see page G-10.*

Dependents

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

In order to enroll your dependents, you must provide any requested information during your initial enrollment period. UNITE HERE HEALTH will tell you when this information is due. If you choose to just cover yourself (no dependent coverage), or if you do not provide the required enrollment materials by the due date, you will have to wait to enroll your dependents until the next open enrollment or special enrollment period. (*See page G-10* for more information.)

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

Your or your spouse's name must be listed on the proof document as the dependent child's parent or legal guardian. No benefits of any kind will be paid for your dependents until they are properly enrolled.

The following rules are applicable to employees of most employers. For the rules applicable to employees of John B. Hynes Veterans Memorial Convention Center and Boston Convention and Exhibition Center (Hynes/BCEC), *see page G-8.*

When your coverage begins (initial eligibility)

Applicable to most employers

Your coverage begins at 12:01 a.m. on the first day of the coverage period corresponding to the first work period for which you meet all of the below requirements.

For purposes of establishing initial eligibility:

- **Work Period** means a calendar month for which your employer must make contributions to UNITE HERE HEALTH on your behalf (including any payroll deductions) and for which you are credited with at least 80 hours.
- **Lag Period** means the 2 calendar months (in a row) between the end of a work period and the beginning of the corresponding coverage period. This is the time when your employer reports and pays contributions.
- **Coverage Period** means the calendar month you get coverage for benefits (based on the related work period).

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

Suppose you start working in July, employer contributions (including payroll deductions) are required on your behalf, and you are credited with 80 hours during your first work period. Your coverage for benefits begins on October 1 and continues through the rest of the month.

Continuing eligibility

Applicable to most employers

Once you establish eligibility, you continue to be eligible as long as you are credited with the required number of hours during the corresponding work periods, contributions continue to be required on your behalf, and the appropriate payroll deductions are made.

For purposes of continuing eligibility:

- **Work Period** means a calendar month for which your employer must make contributions to UNITE HERE HEALTH on your behalf (including any payroll deductions) and for which you are credited with at least 80 hours.
- **Lag Period** means the 2 calendar months (in a row) between the end of a work period and the beginning of the corresponding coverage period.
- **Coverage Period** means the calendar month you get coverage for benefits (based on the related work period).

Example: Continuing Eligibility		
Work Period	**Lag Period**	**Coverage Period**
August	September and October	November
September	October and November	December
October	November and December	January

Suppose you became covered October 1 because you met all of the requirements for the July work period. If a contribution is required on your behalf (including payroll deductions) and you are credited with at least 80 hours for August, your benefits continue during November. Contributions and credit for 80 hours for September continues your benefits for December, October will continue your benefits for January, and so on.

General hours bank

✓ Your hours bank can help you keep coverage, up to 3 times per calendar year.

You have an hours bank to help you keep eligibility. If you are credited with more than 100 hours in a work period, the Fund will put the extra hours (over 100) in your hours bank. The Fund moves hours in and out of your bank for you. You don't have to do anything. If you are credited with fewer than 80 hours in a work period and you have enough hours in your bank, the Fund will automatically apply them to that work period so you don't lose eligibility - up to 3 times per calendar year. If you don't have enough hours in your bank to meet the 80-hour requirement, your banked hours won't be applied and will stay in your hours bank.

Examples: Adding hours to your hours bank:

- If you are credited with 90 hours for the February work period: 0 hours will be put in your hours bank.
- If you are credited with 120 hours for the March work period: 20 hours will be put in your hours bank.

Examples: Using your hours bank:

- If you are credited with 70 hours for the April work period and you have 20 hours in your hours bank: The Fund takes 10 hours out of your bank so you have the 80 hours you need for April, providing coverage for July.
- If you are credited with 70 hours for the April work period and you have 5 hours in your hours bank: The 5 hours in your bank aren't enough to meet the 80-hour requirement. That means the 5 hours stay in your bank.

Hours bank rules

If you use your hours bank to keep your eligibility 3 times in the same calendar year, the next time you can use your hours bank will be January (the first work period of the next calendar year). Extra hours over 100 will still be added to your hours bank.

Your banked hours are available for up to 12 months from the work period you earned them. After 12 months, the hours expire if they're not used.

Your banked hours can't be used to keep eligibility past the date:

- Coverage would have otherwise ended because your employment terminates.
- Your employer terminates participation in the Plan.
- The Plan terminates.
- The special termination rules shown *on page G-15* apply.

However, if you're reestablishing eligibility after your employment terminates or you're laid off, and your hours bank still has usable (unexpired) hours, you can use those hours to get coverage under the reestablishing eligibility rules shown *on page G-19* .

Eligibility rules applicable to employees of the John B. Hynes Veterans Memorial Convention Center and Boston Convention and Exhibition Center (Hynes/BCEC)

The CBA governs certain eligibility rules for Hynes/BCEC employees. Coverage will only be provided to a set number of eligible employees who meet the seniority and hours requirement in the CBA, and to grandfathered long-end employees. Coverage will be provided 12-month periods of time (May through April), except as set forth below, provided the required contributions are made.

A review will be completed each year before April. If you meet both the seniority and hours requirements during the prior April through January period, you will be offered coverage for the period of May through April.

If you are a grandfathered long-end employee, you are not required to meet the hours requirement, but will be counted toward the set number of eligible employees.

If you choose not to enroll in the plan, you will not be able to elect coverage until the next time an offer of coverage is made.

If the coverage of an eligible Hynes/BCEC employee ends, an offer of coverage will be made to the next most senior employee who also met the hours requirement. If you're offered coverage and enroll in the Plan, your coverage will become effective on the first day of the month immediately following the month in which the terminated employee's coverage ends, provided contributions are made.

Self-payments during remodeling or restoration

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

However, if the facility is not reopened, if you are not recalled, or if you decline recall, no further self-payments will be accepted to continue your coverage. Your coverage will terminate on the last day of the month for which a payment was last accepted. However, you may be eligible for COBRA coverage (*see page G-21*).

Self-payments during a strike

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

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

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

Two-way coverage

Coverage option if your spouse is also an employee

If you and your spouse both work for contributing employers, your spouse can waive coverage as an employee and be covered as your dependent for purposes of the medical benefits, prescription drug benefits, mental health/substance abuse benefits, alternative care benefits, dental benefits, and vision benefits. You must satisfactorily enroll your spouse as a dependent and make the appropriate payroll deduction.

Your spouse may continue his or her benefits as an employee under the short-term disability benefits and life and AD&D benefits by applying for two-way coverage, as long as your spouse meets the eligibility rules and makes the appropriate payroll deduction.

Contact the Fund at **(844) 267-4325** for more information about two-way coverage.

When dependent coverage starts

Dependent coverage cannot start before your coverage starts. Dependent coverage cannot continue after your coverage ends (except in certain limited circumstances, *see page G-11* and *G-22)*. Remember, you must enroll each of your dependents and provide any required documentation before the Plan will pay benefits (*see page G-4*).

If you satisfactorily enroll your dependents within your initial enrollment period and make the required payroll deductions, coverage for those dependents begins on the same date your coverage begins.

If you chose coverage for just yourself when you became initially eligible or want to add a new dependent, you have to wait until the next open enrollment or special enrollment period to enroll dependents (*see page G-10*).

Continued coverage for dependents

Your dependents will remain covered as long as you remain eligible, you continue to make the required payroll deductions, *and* they continue to meet the definition of a dependent.

Enrollment periods

Open enrollment periods

Open enrollment periods give you the chance to elect coverage for yourself and your dependents if you declined coverage. It also gives you a chance to change your coverage tier (for example, you decide to change your election from coverage for just yourself and your children to family coverage so your spouse is also covered), or if you only enrolled some of your dependents. If you want to enroll yourself or more dependents, you must provide the required enrollment material and arrange to make any required payments. Your open enrollment materials will describe the deadlines for enrollment and when coverage will start.

Special enrollment periods

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

- Termination of other health coverage you (or your dependent) had when you first became eligible for coverage (or your dependent first became eligible for coverage). If your (or your dependent's) other coverage was COBRA, you have a special enrollment right only if you (or your dependent) have exhausted the COBRA maximum continuation period.
- Your marriage.
- The birth of your child.
- The adoption or placement for adoption of a child under age 26.
- A dependent previously residing in a foreign country comes to the United States and takes up residence with you.
- The loss of your or a dependent's eligibility for Medicaid or Child Health Insurance Program (CHIP) benefits.
- When you or a dependent becomes eligible for financial assistance under Medicaid or CHIP to help pay for the cost of UNITE HERE HEALTH's dependent coverage.

As long as you enroll within 60 days and start making any required payments toward the cost of coverage, your and/or your dependents' coverage will start:

- the 1st of the month following your marriage or the loss of other coverage, or
- the date of the event, for all other special enrollment events.

If you do not take advantage of a special enrollment period, or if you do not make the required payments toward the cost of coverage, you will have to wait until the next open enrollment or special enrollment period to enroll yourself or your dependents.

Survivor eligibility

If you die while eligible for benefits, your dependents will continue to be eligible for the same benefits as other dependents, including medical benefits, mental health/substance abuse benefits, alternative care benefits, prescription drug benefits, dental benefits, and vision benefits for three full months following your death. Your surviving dependents' coverage will terminate:

- The last day of the third full month following the date of your death.
- The date the dependent child no longer meets the definition of a dependent.
- The date the Plan terminates.

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

Your surviving dependents may then be eligible for COBRA coverage.

Termination of coverage

Learn:

- When your coverage and your dependents' coverage ends.

Your and your dependents' coverage continues as long as you maintain your eligibility as described in the previous section of this SPD and you make any required payments for your share of coverage. However, your coverage ends if one of the events described below happens. If your coverage terminates, you may be eligible to make payments to continue your coverage (called COBRA continuation coverage). *See page G-22*.

If you (the employee) are absent from covered employment because of uniformed service, you may elect to continue healthcare coverage under the Plan for yourself and your dependents for up to 24 months from the date on which your absence due to uniformed service begins. For more information, including the effect of this election on your COBRA rights, contact UNITE HERE HEALTH at **(844) 267-4325**.

When employee coverage ends

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

- The date the Plan is terminated.
- *For all employees of employers other than Hynes/BCEC:* If you are terminated, the last day of the month following the month in which you are terminated.
- *For all employees of employers other than Hynes/BCEC:* The last day of the coverage period corresponding to the last work period for which your employer was required to make a contribution on your behalf, and you were credited with the minimum number of hours required to maintain eligibility.
- If you are laid off, the last day of the coverage period for which you have satisfied the continuing eligibility rules.
- The last day of the coverage period during which you waive coverage.
- The last day of the coverage period for which you last made a timely self-payment, if allowed to do so.
- The last day of the last month for which you pay your share of the cost of coverage.
- If you have two-way spouse coverage, the last day of the coverage period for which you make the appropriate payment for two-way coverage.
- *For employees of Hynes/BCEC:* If you are terminated or if you lose long-end status, coverage will end the later of:
  - The last day of the month following the month in which you were terminated or lost long-end status.
  - The last day of the month following the month in which the Fund is notified of your termination or loss of long-end status.

- *For employees of Hynes/BCEC:* April 30, unless you are offered coverage beginning May 1, are enrolled in such coverage, and meet both the seniority and hours requirements during the prior April through January period.

See page G-15 for special rules that apply if your employer's CBA expires.

When dependent coverage ends

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

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

See page G-11 for more information about when a surviving dependent's coverage terminates.

You may also ask the Fund to stop covering your dependent (or dependents). Contact the Fund at **(844) 267-4325** for more information about how to stop covering a dependent, or how to re-enroll a dependent if you change your mind.

The effect of severely delinquent employer contributions

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

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

Special termination rules

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

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

Then: Your coverage ends on the last day of the month during which the decertification, disclaimer of interest, or change in your collective bargaining representative is determined to have occurred.

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

Then: Your coverage ends on the last day of the coverage period corresponding to the last work period for which contributions were received.

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

Then: Your coverage ends on the last day of the 12th month after the Collective Bargaining Agreement expires, unless the Trustees approve an extension.

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

Then: Your coverage ends on the last day of the month for which your employer has an obligation to make contributions to UNITE HERE HEALTH.

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

Certificate of creditable coverage

You or your dependent 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. The Fund will only send a certificate of creditable coverage if you or your dependent request it.

Contact the Fund when you have questions about certificates of creditable coverage.

Reestablishing eligibility

Learn:

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

Portability

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

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

Family and Medical Leave Act (FMLA)

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

Your coverage will be continued while you are on FMLA leave. Contact the Fund or your employer if you have questions about making payments for your share of coverage for the time you are on leave.

The effect of uniformed service

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

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

- For service of less than 31 days or for an absence of any length to determine your fitness for uniformed service, you must report by the first regularly scheduled work period after the completion of service PLUS a reasonable allowance for time and travel (8 hours).
- For service of more than 30 days but less than 181 days, you must submit an application no later than 14 days following the completion of service.
- For service of more than 180 days, you must return to work or submit an application to return to work no later than 90 days following the completion of service.

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

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

✓ Your rights to reinstate coverage are governed by The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you have any questions, or if you need more information, contact the Fund at **(844) 267-4325**.

Reestablishing eligibility lost for other reasons

The following rules are applicable to employees of most employers. For rules applicable to employees of John B. Hynes Veterans Memorial Convention Center and Boston Convention and Exhibition Center (Hynes/BCEC), *see page G-8.*

If you are terminated or laid off

✓ If you have unexpired hours in your hours bank, those hours can be used to help you meet the hours requirements when you are reestablishing eligibility.

If you (and your dependents) lose eligibility because you are terminated or laid off, you will reestablish your (and your dependents') eligibility as of the first day of the month following the month in which you are rehired or reinstated if:

- You are rehired or reinstated within 12 months of the month you were terminated or laid off.
- You are credited with 1 or more hours during the month in which you were rehired or reinstated.

- You were eligible during the months you were terminated or laid off.
- If rehired, you elect to continue your coverage within 30 days of rehire.
- You make any required payments for your share of the cost of coverage.

Under this rule, your hours requirement will be deemed to have been met during the first two calendar months following the month in which you are rehired or reinstated.

In order to continue your coverage during the third month, you must be credited with at least 80 hours during the first calendar month following the month in which you are rehired or reinstated.

In order to continue your coverage during the fourth month, you must be credited with at least 80 hours during both the first and second calendar months following the month in which you are rehired or reinstated

Thereafter, the continuing eligibility rules will apply.

If you don't have enough hours

If you lose eligibility because you do not have enough hours to continue your eligibility, you must again satisfy the Plan's continuing eligibility rules in order to reestablish your eligibility. If you lose eligibility because of a leave of absence under the Uniformed Services Employment and Reemployment Rights Act, other rules apply (*see "The effect of uniformed service"*).

If you stop making required payments

If you or your dependents lose eligibility because you stop making the required payments, you will not be able to re-enroll yourself or your dependents until the next special enrollment period or the next open enrollment period (*see page G-10*), whichever happens first.

COBRA continuation coverage

Learn:

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

The right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. **This part of your SPD explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** For more information about your rights and obligations under the Plan and under federal law, you should read this SPD or contact the Fund.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage, including the following benefits, as applicable: medical, prescription drug, dental, and vision. However, you cannot continue life and accidental death and dismemberment insurance (if applicable), short-term disability benefits (if applicable), or adoption assistance benefits. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct; or
- Your employer withdraws from UNITE HERE HEALTH.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse's employer withdraws from UNITE HERE HEALTH;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee's employer withdraws from UNITE HERE HEALTH;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

UNITE HERE HEALTH uses its own records to determine when participants' coverage under the Plan ends.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

UNITE HERE HEALTH
Attn: COBRA Department
P. O. Box 6557
Aurora, IL 60589-0557

You should use the Fund's forms to provide notice of any qualifying event, if you or a dependent are determined by the Social Security Administration to be disabled, or if you are no longer disabled. You can get a form by calling the Fund at **(866) 711-4373**.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

You must complete a COBRA continuation coverage election form and submit it within 60 days from the later 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.

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 (or other method acceptable to UNITE HERE HEALTH), payable to UNITE HERE HEALTH, and mailed to:

UNITE HERE HEALTH
Attn: COBRA Department
P. O. Box 809328
Chicago, IL 60680-9328

Generally, COBRA continuation coverage is a temporary continuation of coverage that generally lasts for up to 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To qualify for this special extended COBRA Coverage, the individual must send (or bring) to the Fund Office the Social Security disability determination before the initial 18 months of continuation coverage expires. After the Plan receives a copy of the disability determination, you will be notified of any increase in cost required to continue the COBRA Coverage for the extended period (the period between 18 and 29 months). Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

When will COBRA continuation coverage end?

COBRA continuation coverage will end no later than the maximum period of time for which coverage can be continued is reached. However, continuation coverage will end on the first to occur of any of the following:

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

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

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through self-pay (if you have that option), or the Health Insurance Marketplace, in Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out-of-pocket than you would under COBRA because the new coverage may impose a new deductible.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.). For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

UNITE HERE HEALTH
Attn: COBRA Department
P. O. Box 6557
Aurora, IL 60589-0557
(866) 711-4373

Claim filing and appeal provisions

Learn:

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

Filing a benefit claim

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

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

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

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

Claims for life or AD&D benefit claims may require 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 the Fund at **(844) 267-4325**.

Medical claims, other than mental health or substance abuse claims
Network providers will generally file the claim for you. However, if you need to file a claim, for example because you used a non-network provider in cases which services and supplies are covered, you must mail the completed claim form, including all required information, to Tufts Health Plan.

Tufts Health Plan
Member Reimbursement Claims
P.O. Box 9191
Watertown, MA 02471-9191

Mental health/substance abuse, alternative care, and adoption assistance claims
Network providers will generally file the claim for you. However, if you need to file a claim, you should mail the claim to MAP.

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

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 network pharmacy, you should send it to:

WellDyneRx Claim Reimbursement
P.O. Box 90369
Lakeland, FL 33804

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

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

Vision claims
Davis Vision network providers will generally file vision 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:

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

All other claims
All life, AD&D, or short-term disability claims, or any claims denied because you are not eligible, should be mailed to:

UNITE HERE HEALTH
P.O. Box 6020
Aurora, IL 60598-0020
(844) 267-4325

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

Deadlines for filing a benefit claim

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

Deadline for filing a claim	
Type of claim	**Deadline to file**
Medical	1 year following the date the claim was incurred
Short-term disability	• *Notice* must be filed within 20 days of the date of the disability (or as soon as reasonably possible). • *Proof* of loss must be received within 90 days of the date of the loss (or as soon as reasonably possible).
Life insurance	Within a reasonable amount of time
AD&D insurance	• Written *notice* must be received within 31 days of loss (or as soon as possible). • Written *proof* of loss must be received within 90 days of loss (or as soon as possible). Other deadlines may apply to your additional AD&D insurance benefits—your insurance certificate provides more information.
All other claims—Including adoption assistance, and healthcare claims including, mental health/substance abuse, alternative care, prescription drug, dental and vision	18 months following the date the claim was incurred

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

Individuals who may file a benefit claim

You, a healthcare provider (under certain circumstances), or an authorized representative acting on your behalf 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. Call UNITE HERE HEALTH to obtain a form and submit it to:

UNITE HERE HEALTH
Attention: Claims Manager
P.O. Box 6020
Aurora, IL 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 your claim is received. In general, benefits for medical/surgical services will be paid to the provider of those services.

This 30-day period may be extended one time for up to an additional 15 days if necessary 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 did not submit the information needed, you have 60 days from the date you are told more information is needed. You will be told what additional information you must provide. If you do not provide the required information within 60 days, your claim will be denied, and any benefits otherwise payable will not be paid.

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

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

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

Short-term disability claims
In general, you will be notified of the decision on your claim for short-term disability benefits no later than 45 days after receiving your claim. This 45-day period may be extended for up to an additional 30 days periods if special circumstances require additional time. The Fund will notify you in writing if it requires more processing time before the end of the first 45-day period.

The Fund may extend this additional 30-day period of time for up to an additional 30 days if it notifies you prior to the expiration of the initial 30-day extension period, of the circumstances requiring the extension of time and date by which the Fund expects to render a decision.

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

This 90-day period may be extended for up to an additional 90 days if special circumstances require additional time. BCBSIL 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, this 15-day period may be extended by 15 days for circumstances beyond the control of the prior authorization company, including if you or your healthcare provider did not submit all of the information needed to make a decision. If extra time is needed, you will be informed, before the end of the original 15-day period, why more time is needed and when a decision will be made.

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

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

If you don't follow the rules for requesting prior authorization, you will be given notice how to

file such a request. This notice will be provided within 5 days (24 hours in case of an urgent care claim) of the failure.

Special rules for decisions involving concurrent care

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

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

If a request for prior authorization is denied

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

Appealing a benefit prior authorization denial

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

If a benefit claim is denied

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

Life and AD&D claims

You can file an appeal within 60 days of BCBSIL's decision. BCBSIL will generally respond to your appeal within 60 days (but may request a 60-day extension). If you need help filing an appeal, or have questions about how BCBSIL's claim and appeal process works, contact BCBSIL.

BCBSIL
Attn: Claim Department Appeals Specialist
P.O. Box 7070
Downers Grove, IL 60515-5591

Appealing the denial of a claim (other than life and AD&D claims)

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

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

Two levels of appeal for medical, mental health/substance abuse, alternative care benefit, and adoption assistance benefit denials

First level of appeal

All appeals for medical claims denied (including prior authorization denials, extensions of treatment beyond limits previously approved, and post-service claims) must be sent within 180 days of your receipt of the denial. All appeals for mental health/substance abuse benefit claims, alternative care benefit claims, and adoption assistance benefit claims denied (including prior authorization denials, extensions of treatment beyond limits previously approved, and post-service claims) must be sent within 12 months of your receipt of the denial.

For medical treatment:

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

For alternative care, adoption assistance, and mental health/substance abuse treatment:

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

Second level of appeal

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

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

Two levels of appeals for prescription drug claim denials

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

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

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

One level of appeal for most other claims

John Wilhelm Scholarship benefits
If you or your dependent(s) do not get the scholarship benefit because you do not meet the Fund eligibility requirement as described *on page D-58*, you may appeal the denial within 60 days of receiving the denial notice to:

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

The Fund will generally respond to your appeal within 60 days (but may request a 60-day extension).

Short-term disability claim denials

If you disagree with all or any part of a short-term disability denial and you wish to appeal the decision, you or your authorized representative must submit an appeal within 180 days of your receipt of the claim denial to:

The Appeals Subcommittee
UNITE HERE HEALTH
711 N. Commons Dr.
Aurora, IL 60504-4197

All other claims
If you disagree with all or any part of a vision claim denial, dental claim denial, or short-term disability denial and you wish to appeal the decision, you must follow the steps in this section. You must submit an appeal within 12 months of the date you received notice of the claim denial to:

The Appeals Subcommittee
UNITE HERE HEALTH
711 N. Commons Dr.
Aurora, IL 60504-4197

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

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

Appeals involving urgent care claims

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

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

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

Appeals under the sole authority of the plan administrator

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

- UNITE HERE HEALTH's refusal to accept self-payments, including payments for dependent coverage, 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 payment or late application was refused to:

The Plan Administrator
UNITE HERE HEALTH
711 N. Commons Dr.
Aurora, IL 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-4* for details).

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

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

Notice of the decision on your appeal

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

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

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

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

Independent external review procedures

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

The Plan will conduct a preliminary review of your eligibility for external review within five business days after receiving your request. To be eligible for external review, you must meet all of the following requirements:

- You must have been eligible for benefits at the time you incurred the medical expense.
- Your claim denial must involve a medical judgment or rescission of coverage.
- The denial must not relate to your failure to meet the Plan's eligibility requirements (eligibility claims are not subject to external review).
- You must have exhausted your internal appeal rights.
- You must submit all the necessary information and forms.

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

If you are eligible for external review, the Plan will send your information to the review organization. The external review will be independent and the review organization will afford no deference to the Plan's prior decisions. You may submit additional information to the review organization within ten business days after the review organization receives the request for review. This information may include any of the following:

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

Within 45 days of receiving the request for review, you will be given notice of the external review decision. The notice from the review organization will explain the decision and include other important information. The external review organization's decision is binding on the Plan. If it approves your request, the Plan will provide immediate coverage.

Internal appeal exception

In certain situations, if the Plan fails to follow its claims procedures, you are deemed to have exhausted the Plan's internal appeals process and may immediately seek an independent external review or pursue legal action under Section 502(a) of ERISA. Please note this exception does not apply if the Plan's failure is de minimis; non-prejudicial; based on good cause or matters beyond the Plan's control; part of a good faith exchange of information between you and the Plan; and not reflective of a pattern or practice of plan non-compliance. If you believe the Plan violated its own internal procedures, you may ask the Plan for a written explanation of the violation. The Plan will provide you with an answer within ten (10) days. To use this exception, you must request external review or commence a legal action no later than 180 days after receipt of the initial adverse determination. If the court or external reviewer rejects your request for immediate review, the Plan will notify you (within 10 days) of your right to pursue internal appeal. The applicable time limit for you to now file your internal appeal will begin to run when you receive that notice from the Plan.

Non-assignment of claims

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

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

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

Commencement of legal action

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

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

Definitions

Learn:

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

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

Allowable charges

An **allowable charge** is the amount of charges for covered treatments, services, or supplies that the Plan uses to calculate the benefits it pays for a claim. 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. The Plan will not pay benefits for charges that are more than the **allowable charge.**

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

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

Copay or copayment

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

You can get more information about your medical, prescription drug, and 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. For example, if the allowable charge for a covered dental service with a network provider is $1,000, your 20% **coinsurance** equals $200. The Fund pays the rest of the allowable charge.

Cosmetic services

Cosmetic services are intended to better your appearance. "**Cosmetic services**" do not include reconstructive services, which are mainly to restore bodily function or to significant deformity caused by accidental injury, trauma, congenital condition, or previous therapeutic process.

Mastectomies, and reconstruction following a mastectomy, will not be considered a **cosmetic service.**

Medically necessary gender reassignment services are not **cosmetic services**.

Covered expense

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

Deductible

The amount you owe for covered expenses before benefits are payable on your claims.

At the time this SPD was published, no deductibles apply to your benefits.

Durable medical equipment (DME)

Durable medical equipment (DME) is a device or instrument of a durable nature that:

- Is reasonable and necessary to sustain a minimum threshold of independent daily living.
- Is made primarily to serve a medical purpose.
- Is not useful in the absence of illness or injury.
- Can withstand repeated use.
- Can be used in the home.

Some examples of **DME** are: blood glucose monitors, breast pumps, cranial helmets, therapeutic/molded shoes and shoe inserts for a member with severe diabetic foot disease, gradient stockings, oxygen concentrators (stationary and portable), insulin pumps, oral appliances for the treatment of sleep apnea, and other similar medical equipment or devices.

Emergency medical treatment

Emergency medical treatment means covered medical services used to treat a medical condition displaying acute symptoms of sufficient severity (including severe pain) that an individual with

average knowledge of health and medicine could expect that not receiving immediate medical attention could place the health of a patient, including an unborn child, in serious jeopardy or result in serious impairment of bodily functions or bodily organs or body parts.

Experimental, investigational, or unproven (experimental or investigational)

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

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

A different definition may apply to benefits administered by Tufts or MAP.

Healthcare provider

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

A **primary care provider** (PCP) is defined as the physician, physician assistant, or nurse practitioner you have chosen who has an agreement with Tufts to provide primary care and to coordinate, arrange, and authorize care.

A **specialist** is a healthcare provider who specializes in a field other than those designated as primary care above.

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

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

A relative related by blood or marriage, or a person who normally lives in your home, with you will not be considered a **healthcare provider**.

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 includes certain treatments and conditions, including: mental health conditions and substance abuse; pregnancy and pregnancy-related conditions, including abortion; and voluntary sterilization.

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 is considered **medically necessary** for covered expenses incurred based on the treatment recommended by the patient's healthcare provider, as required under federal law.

However, 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. Determinations of **medical necessity** and whether or not a procedure is experimental or investigative are solely for the purpose of establishing what services or courses of treatment are covered by the Plan. All decisions regarding medical treatment are between you and your healthcare provider and should be based on all appropriate factors, only one of which is what benefits the Plan will pay.

A different definition may apply to benefits administered by Tufts or MAP.

Out-of-pocket limit for network care and treatment

In order to protect you and your family, the Plan limits your cost-sharing for covered network services during a calendar year. Your **out-of-pocket limit** limits the amount of coinsurance and copays you pay during one calendar year for network medical and prescription drug covered expenses.

Amounts you pay out-of-pocket for services and supplies that are not covered, amounts over the allowable charges, or care or treatment you receive after the Plan's maximum benefit, do not count toward your **out-of-pocket limit**. In addition, amounts you pay in addition to your prescription drug copay when you choose a brand name drug when a generic equivalent is available or for early refill surcharges, do not count toward your **out-of-pocket limit**.

Out-of-pocket costs for non-network care or treatment do not count toward your **out-of-pocket limit**, except for emergency medical treatment. The Plan will not pay 100% for services or supplies that are not covered, or that are provided by a non-network provider, even if you have met your **out-of-pocket limit(s)** for the year.

You can get more information about your **out-of-pocket limits** in the medical and prescription drug benefit sections of this SPD. (*See page D-5* and *D-19*.)

Plan document

The rules and regulations governing the Plan of benefits provided to eligible employees and dependents participating in Plan Unit 108 (Greater Boston Local 26 Health Plan).

Preventive healthcare

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

- Services rated "A" or "B" by the United States Preventive Services Task Force (USPSTF).
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention.
- Preventive care and screenings for women as recommended by the Health Resources and Services Administration.
- Preventive care and screenings for infants, children, and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Certain **preventive healthcare** may be covered more liberally (for example, more frequently or at earlier/later ages) than required. The Plan also considers preventive vitamin D (with a prescription) to be preventive healthcare.

Contact Tufts with questions about what types of **preventive healthcare** is covered, and to find out if any age, risk, or frequency limitations apply. You can also go to: www.healthcare.gov/preventive-care-benefits for a summary. This website may not show all applicable limitations and may included certain services that aren't yet required to be included under your Plan. If you don't meet the criteria for preventive healthcare, it might not be covered under the Plan at all.

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

Other important information

Who pays for your benefits?

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

What benefits are provided through insurance companies?

This Plan provides the following benefits on a self-funded basis; however the Plan may contract with other organizations to help administer certain benefits. 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.

- Medical benefits. These benefits are administered by Tufts Health Plan (Tufts).
- Mental health/substance abuse benefits, alternative care benefits, and the adoption assistance benefit. These benefits are administered by Modern Assistance Programs, Inc. (MAP).
- Prescription drug benefits. These benefits are administered by Hospitality Rx, LLC, a wholly owned subsidiary of UNITE HERE HEALTH.
- Dental benefits. These benefits are administered by Delta Dental of Illinois (Delta Dental).
- Vision benefits. These benefits are administered by Davis Vision.
- Short-term disability benefits.

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

Interpretation of Plan provisions

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

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

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

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

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

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

Restriction of Venue

Any action, claim, controversy, or dispute relating to or arising under the Fund, Plan, Summary Plan Description, and/or Trust Agreement shall be brought and resolved only in the United States District Court for the Northern District of Illinois and in any courts in which appeals from such court are heard.

Amendment or termination of the Plan

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

In accordance with the Trust Agreement, the Trustees also reserve the right to amend or terminate your Plan or any other Plan Unit, or to amend, terminate or suspend any benefit schedule under any Plan Unit at any time. Such termination or suspension, as well as, the termination,

expiration, or discontinuance of any insurance policy under UNITE HERE HEALTH shall not necessarily constitute a termination of UNITE HERE HEALTH.

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

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

Free choice of provider

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

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

Workers' compensation

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

Type of Plan

UNITE HERE HEALTH is a welfare plan providing healthcare and other benefits, including life insurance and accidental death and dismemberment insurance, adoption assistance benefits, and short-term disability benefits 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, and

within 10 days of a request to review, at the following locations: regional offices, the main offices of employers at which at least 50 participants are working, or the main offices or meeting halls of local unions.

Employer and employee organizations

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

Plan administrator and agent for service of legal process

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

UNITE HERE HEALTH
Chief Executive Officer
711 North Commons Drive
Aurora, IL 60504-4197
(630) 236-5100

Employer identification number

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

Plan number

The Plan Number is 501.

Plan year

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

Remedies for fraud

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

Limited retroactive terminations of coverage allowed

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

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

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

Creditable coverage under Massachusetts law

UNITE HERE HEALTH believes the medical and pharmacy benefits under Plan Unit 108 meets Massachusetts's definition of minimum creditable coverage. Because Plan Unit 108 is minimum creditable coverage, you should not owe an individual mandate tax penalty to Massachusetts for months you are covered under Plan Unit 108. (UNITE HERE HEALTH is not offering tax advice or any guarantee under any tax law.)

If you live in Massachusetts and need help understanding how the Plan meets Massachusetts's rules for minimum creditable coverage, please call the Fund at **(844) 267-4325.** To to get a copy of your MA Form HC-1099 call Tufts at **(800) 462-0224.**

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

Blue Cross and Blue Shield of Illinois (Dearborn)
701 E. 22nd St.
Suite 300
Lombard, IL 60148
(800) 367-6401
www.bcbsil.com/ancillary

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

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

Hospitality Rx
P.O. Box 6020
Aurora, IL 60598-0020
(844) 813-3860
www.hospitalityrx.org

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

UNITE HERE HEALTH
711 North Commons Drive
Aurora, IL 60504-4197
(630) 236-5100
www.uhh.org

Tufts Health Plan
705 Mount Auburn Street
Watertown, MA 02472-1508
(800) 462-0224
www.tuftshealthplan.com/local26

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