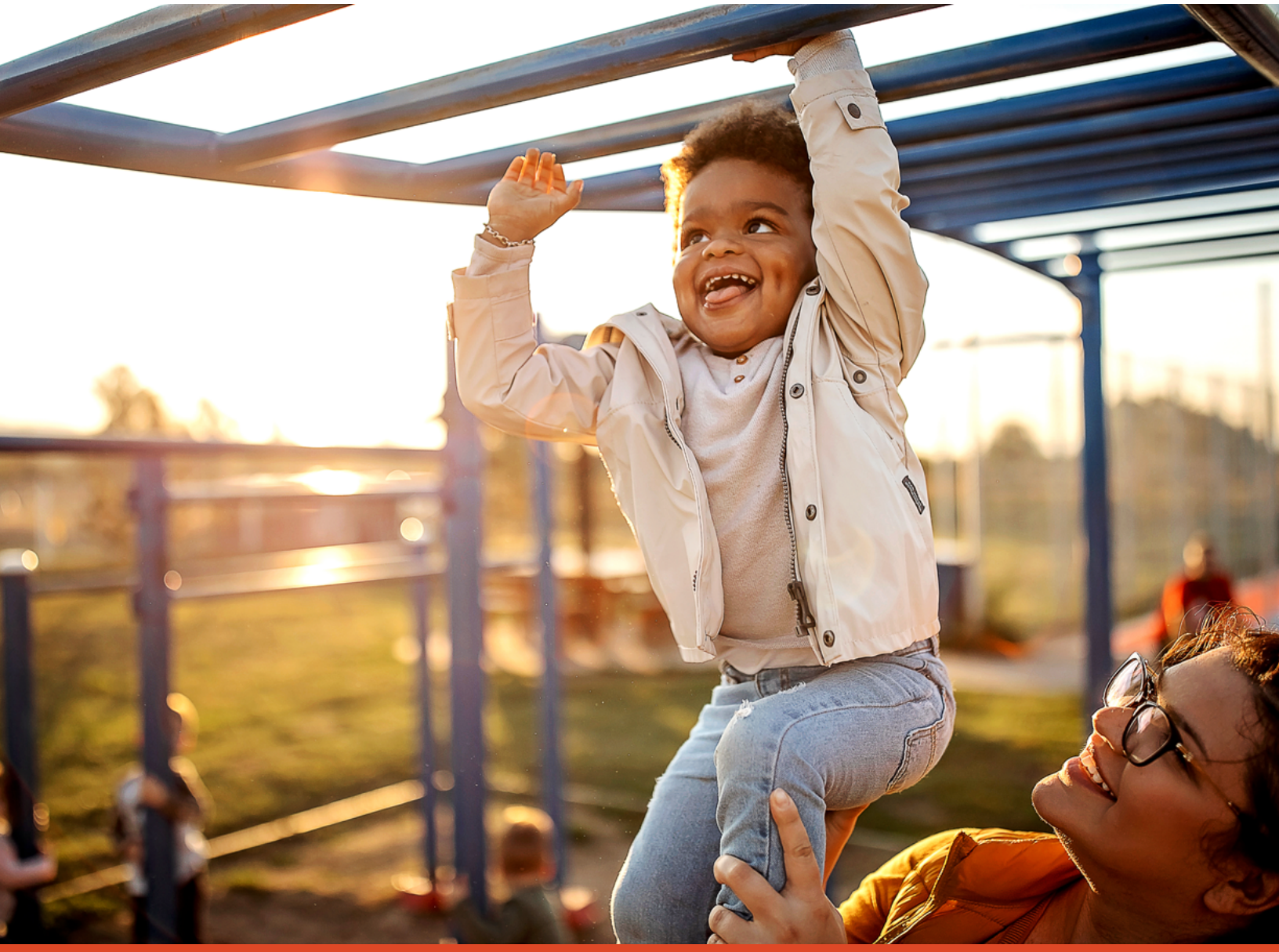
UNITE HERE HEALTH

Long Beach/Orange County

Plan Unit 278



Summary Plan Description

Your Health and Welfare Benefits

UNITE HERE HEALTH

Summary Plan Description
Long Beach/Orange County
Plan Unit 278

Effective October 1, 2023

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

Este folleto contiene un resumen en inglés de sus derechos y beneficios de su plan bajo UNITE HERE HEALTH. Si usted tiene problemas entendiendo cualquier parte de este folleto, usted puede llamar a UNITE HERE HEALTH al (855) 844-5262 (TTY: (855) 386-3889 o (855) FUNDTTY) para asistencia.

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, or a Participation Agreement (PA) between the employer and UNITE HERE HEALTH.

Your coverage is being offered under Plan Unit 278 (Long Beach/Orange County), 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 including Plan Unit 178 (Los Angeles).

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 **(855) 844-5262**. The Fund can help you understand how your benefits work.

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 "Kaiser benefits." If you want to know more about your life or AD&D benefits, read the section titled "Life and AD&D benefits."

How can I get help?

UNITE HERE HEALTH
(855) 844-5262 or **(855) 386-3889 (TTY)**
www.uhh.org

Call the Fund:

- When you have questions about your benefits.
- When you have questions about your eligibility for enrollment or benefits.
- When you have questions about self-payments.
- To update your address.
- To report changes in your family status, such as divorce or a new child.
- To request new ID cards.
- To get forms or a new SPD.

Download the UHH Member Portal mobile app! Get 24/7 access to your benefits and more!

To download the app, scan the QR code or search "UHH Member Portal" in your app store.

iPhone

Android

Este folleto contiene un resumen en inglés de sus derechos y beneficios de su plan bajo UNITE HERE HEALTH. Si usted tiene problemas entendiendo cualquier parte de este folleto, usted puede llamar a UNITE HERE HEALTH al (855) 844-5262 (TTY: (855) 386-3889 o (855) FUNDTTY) para asistencia.

How do I get the most from my benefits?

Learn:

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

Get a primary care provider

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

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

✓ Call Kaiser to get help finding a PCP.

Get preventive healthcare

Certain types of preventive healthcare are covered at 100% when you use network providers. 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 a network provider.*** Benefits won't be paid for preventive healthcare if you use a non-network provider.

Re-think emergency room care

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

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

Get prior authorization for your care

Your provider must get prior authorization before you get certain types of care.

✓ Call Kaiser at **(800) 464-4000**.

Use network providers

Reduce your costs with a network provider

Under the Kaiser HMO and the LIBERTY Dental HMO, benefits will generally only be paid if you use a network provider. If non-network providers are covered, you generally pay less out-of-pocket if you choose a network provider than if you choose non-network care. You only have to pay the difference between the network provider's discounted rate (the allowable charge) and what is paid for your 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 medical network?

If you need help finding a network provider, go to the part of your SPD that explains your specific healthcare benefits. The information in that part of your SPD will tell you how to stay in network. You can also go to www.uhh.org for links to your provider networks.

If you have questions about your benefits or benefit options, call the Fund at **(855) 844-5262**.

Programs to help you

The Fund may, from time to time, offer certain educational or informational programs. These programs will be available at the Fund's sole discretion and may only be offered to certain participants. The Fund will send out information about the programs as available.

Summary of benefits

Please call the Fund with questions about your benefits: **(855) 844-5262**

HMO Medical and Prescription Drug Benefits

See page C-2 for more information about your Kaiser HMO medical and prescription drug benefits.

If You Choose the LIBERTY DHMO Option

See your LIBERTY DHMO patient charge sheet and Evidence of Coverage (EOC) for more information about your LIBERTY DHMO benefits, including your cost-sharing (*see page D-1*).

If You Choose the LIBERTY Dental PPO Option — What You Pay

Description of Services	LIBERTY Dental PPO Provider	Non-Network Provider
Dental Services		
Maximum Benefit Payable Each Calendar Year *non-orthodontic treatment*	\$1,500/person *does not apply to exams for persons under age 19*	
Calendar Year Deductible	\$50/person & \$150/family	
	What You Pay for Dental Care	
Diagnostic & Preventive Services	\$0 (no deductible)	30% (no deductible)
Emergency Services *including to treat severe pain*		
Diagnostic X-ray Services		
Minor Restorative Services	20% after deductible	40% after deductible
Periodontic Services		
Endodontic Services		
Oral Surgery		
Major Restorative Services	50% after deductible	60% after deductible
Prosthodontic Services & Repairs		
Orthodontic Services		
Orthodontic Services	50% (no deductible) *Plan benefits limited to a lifetime maximum of \$2,500/person*	

Vision Benefits — What You Pay		
Description of Services *Covered once every 24 months **	**UnitedHealthcare Provider**	**Non-Network Provider**
Eye Exam	$15 copay	$0 copay; $40 maximum
Lenses	$10 copay; $130 maximum for frames *lenses are covered in full*	$0 copay Maximums are: $40 for single vision lenses $60 for bifocal lenses $80 for trifocal lenses $125 for lenticular lenses
Frames		$0 copay; maximum $45
Elective Contact Lenses *instead of glasses*	$10 copay; $105 maximum for non-standard contacts like toric and gas permeable lenses *copay does not apply to non-standard contacts*	$0 copay; $105 maximum
Medically Necessary Contact Lenses	$10 copay	$0 copay; $210 maximum
* *See page D-14 for exceptions to this 24-month limit.*		

Life and AD&D Benefit — What the Plan Pays	
Life Insurance	
Employees	
Employees	$20,000
Dependents	
Spouse	$20,000
Child – live birth up to age 6 months	$3,000
Child – 6 months and older	$20,000
Accidental Death and Dismemberment (AD&D) Insurance	
Employees Only *(full amount)*	$20,000

Kaiser HMO medical and prescription drug benefits

Learn:

- Using your Kaiser HMO benefits.
- Getting more information about your Kaiser HMO.
- Learn how to file grievances, claims, and appeals.

UNITE HERE HEALTH contracts with Kaiser Permanente of Southern California (Kaiser) to provide the HMO medical and prescription drug benefits. If you have questions about your Kaiser HMO benefit, how to pick a primary care provider, or have any questions about how your benefits work, contact Kaiser.

Kaiser Permanente
www.kp.org
(800) 464-4000 (Member services)
(833) 574-2273 (833-KP4CARE) (Advice nurse)

Kaiser administers its benefits in accordance with applicable state and federal law. You'll be given a detailed document that provides information about your cost-sharing and the rules governing your Kaiser benefits. The contract with Kaiser governs how your benefits are paid; however, UNITE HERE HEALTH still determines who is and who is not eligible. You should contact the Fund with any eligibility or enrollment questions. However, if you have any questions about how your Kaiser HMO benefits work, please contact Kaiser.

Using your Kaiser HMO benefits

You must choose a primary care provider (PCP). You may choose any available Kaiser provider. You may also choose a Kaiser pediatrician as the PCP for a child.

Your PCP will help you get care through Kaiser. For example, if you need a referral for certain types of care, your PCP should provide any referrals you need. You do not need a referral or prior authorization to receive obstetrical or gynecological care from a Kaiser healthcare professional who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including getting prior authorization for certain services, following a pre-approved treatment plan, or following procedures to get referrals.

Except in emergencies, you usually have to use a Kaiser provider, hospital, or other facility in order to receive benefits under the Kaiser HMO option. Kaiser will normally not pay any benefits for care you get from a non-network provider—you will have to pay the entire cost yourself.

You can get more information about how your benefits work by reading your benefits description. You can get your benefits description by contacting Kaiser or UNITE HERE HEALTH.

Using this SPD

The contract between UNITE HERE HEALTH and Kaiser Permanente will govern how Kaiser benefits are paid and administered. If there is any discrepancy between any information about the Kaiser benefits provided by UNITE HERE HEALTH and the Kaiser contract, the Kaiser contract will govern. The Kaiser benefits description you get when you enroll in Kaiser will explain the rules that apply to your benefits.

The following sections of this SPD do not apply to benefits Kaiser provides (but may apply to other benefits the Plan provides):

- General exclusions and limitations
- Subrogation
- General claim provisions

Getting more information

You will receive a document containing more detailed information about your Kaiser benefits. This document provides details about your Kaiser HMO benefits, for example, what your cost-sharing is, what is covered, what is excluded, and how to use your benefits. If you need a copy of this document, you can request it by contacting Kaiser or UNITE HERE HEALTH, or by visiting www.uhh.org/library.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or a newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. 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.

Arbitration

Unless there is an exception (see the next paragraph), any dispute between you, your heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings.

Exceptions to Kaiser's binding arbitration rules are: claims subject to the ERISA claims procedure regulations, a Medicare appeals procedure, and any other claim that cannot be subject to binding arbitration under applicable law. More information about binding arbitration and your rights and obligations to use binding arbitration are explained in your evidence of coverage.

Grievance, claims and appeals

✓ *This is a summary of your rights as of the date this SPD was printed.* ***Please note, Kaiser may change its procedures, which supersede this summary.*** *Contact Kaiser or visit any member services office for more information about your rights or for help.*

www.kp.org
(800) 464-4000 (TTY: 711)

Kaiser providers should always file a claim for you. However, you may have to file a claim for non-Kaiser providers. You should include bills, receipts, medical records, or any other related information. Kaiser may ask for additional information; if you do not provide it, Kaiser will make the final decision with the information it has. You may review, without charge, a copy of all relevant information Kaiser has about your grievance, claim, or appeal.

If, after Kaiser pays your claim, you receive a non-Kaiser provider bill for charges other than your cost-sharing, please call Kaiser.

Another person, such as a friend, relative, or attorney, may file your claim, appeal, or grievance for you (you must inform Kaiser in writing who will represent you). You may file grievances, claims, and appeals for your minor children.

Filing Claims and Grievances

Claims are for services you have already received, such as non-plan or out-of-area urgent or emergency services, ambulance services, post-stabilization care, or services that were not authorized by Kaiser. File these with Kaiser as soon as possible.

Grievances are for any expression of dissatisfaction, including prior authorization denials, requests for non-formulary drugs, services your doctor determines are not medically necessary, services that are not covered, services that you have not received, or continued coverage of ongoing courses of treatment. File within 180 days following the incident or action.

Initial Filing		
Grievances	**Claims for non-Kaiser provider emergency services, post-stabilization care, out-of-area urgent care, or emergency ambulance services**	**All other services**
• Call member services: **(800) 464-4000 (TTY: 711)** • Visit www.kp.org **OR** • ***Non urgent grievances:*** Mail or take your grievance to any member services office* • ***Urgent grievances:*** Mail to: Kaiser Foundation Health Plan Inc. Expedited Review Unit P.O. Box 23170 Oakland, CA 94623-0170	• Mail your claim to: Kaiser Foundation Health Plan Claims Administration–SCAL P.O. Box 7004 Downey, CA 90242-7004	• Mail or take your claim to any member services office* • Call member services: **(800) 464-4000 (TTY: 711)** • Visit www.kp.org

** See your enrollment booklet or visit www.kp.org for a directory*

- For grievances for nonformulary prescription drugs, Kaiser will notify you of the decision within 72 hours (24 hours for an urgent request).
- For urgent grievances, you will receive oral notice as soon as your clinical condition requires, but within 72 hours. Contact Kaiser for information about when a grievance is urgent.

Unless you filed an urgent grievance or a grievance for nonformulary prescription drugs, Kaiser will give you its written decision within 30 days after receipt of your initial filing, but may request 15 more days for circumstances beyond its control. Kaiser will make a decision within these extra 15 days.

Filing Appeals

You may appeal a grievance or a claim denied in full or in part within 180 days of receiving Kaiser's denial. Kaiser will send the final decision within 30 days after receiving your appeal.

Filing an Appeal		
Appealing grievances	**Appealing non-Kaiser provider emergency services, post-stabilization care, out-of-area urgent care, or emergency ambulance services**	**Appealing all other services**
• Mail or take your appeal to any member services office* • Call member services: **(800) 464-4000 (TTY: 711)** • Visit www.kp.org	• Mail your appeal to: Kaiser Foundation Health Plan Special Services Unit P.O. Box 23280 Oakland, CA 94623 • Call member services: **(800) 464-4000 (TTY: 711)** • Visit www.kp.org	• Mail or take your appeal to any member services office* • Call member services: **(800) 464-4000 (TTY: 711)** • Visit www.kp.org

** See your enrollment booklet or visit www.kp.org for a directory.*

Independent review organization (IRO) reviews for nonformulary prescription drugs

You may request an IRO review of a denied nonformulary drug within 180 days of receiving the denial.

- Call **(888) 987-7247 (TTY: 711)** or fax: **(888) 987-2252**
- Visit any member services office (see your enrollment booklet or visit www.kp.org for a directory)
- Complete a grievance form at www.kp.org
- Mail a written request to:

  Kaiser Foundation Health Plan Inc.
  Expedited Review Unit
  P. O. Box 23170
  Oakland, CA 94623-0170

You will receive a decision within 72 hours for non-urgent reviews (24 hours for urgent reviews). If the IRO does not decide in your favor, you may request independent medical review or submit a complaint to the California Department of Managed Healthcare.

Independent medical review

Independent medical review is available if you believe that Kaiser improperly denied, modified, or delayed services or payment of services, and that either (1) the denial was based on a finding that the services are not medically necessary, or (2) for life-threatening or seriously debilitating conditions, the requested treatment was denied as experimental or investigational. Also, if you file a grievance and you later need help with it because your grievance is an emergency, it hasn't been resolved to your satisfaction, or it's unresolved after 30 days, you may call the California Department of Managed Health Care toll free at **(888) HMO-2219** and a TDD line **(877) 688-9891** for the hearing and speech impaired for assistance.

Additional appeal rights

You may have additional rights beyond your Kaiser internal and external appeals. Contact Kaiser for more information.

Kaiser
(800) 464-4000 (TTY: 711)
www.kp.org

If you need help with a grievance involving an emergency or a grievance unresolved after 30 days, contact the California Department of Managed Health Care:

California Department of Managed Health Care
(888) HMO-2219 TDD: **(877) 688-9891**
www.dmhc.ca.gov

Dental benefits under the LIBERTY DHMO option

Learn:

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

This section only applies if you choose the LIBERTY DHMO option.
If you choose the LIBERTY dental PPO, please see the section starting on page D-3 for information about your dental benefits.

Dental benefits under the LIBERTY DHMO option

Retirees and their dependents are not eligible for dental benefits.

UNITE HERE HEALTH (the Fund) has contracted with LIBERTY Dental Plan (LIBERTY) to provide DHMO dental benefits to you and your dependents if you choose this benefit option. This part of the SPD summarizes your dental benefits. You'll be given a detailed document that also lists any other type of dependents you can enroll in dental coverage, in addition to the dependents listed in this SPD. The rules about who your dependent is under the LIBERTY DHMO only apply to dental benefits, and do not apply to any other benefits offered under the Plan. Call the Fund at **(855) 844-5262** if you need help understanding what dependents are eligible for LIBERTY DHMO coverage, since the Fund makes all eligibility decisions.

If there is any conflict between this SPD and LIBERTY documents, which contain certain state-specific rules about benefits and cost-sharing, the terms of the LIBERTY documents govern. If you have any questions about dental benefits, please contact LIBERTY. You will also get a copy of the evidence of coverage (EOC) that describes how your DHMO works, your cost-sharing for your dental care, and other important information. This EOC generally supersedes the DHMO information in this SPD. However, your SPD explains your correct eligibility rules.

LIBERTY Dental Plan
(888) 442-4585
8 a.m. – 5 p.m. (Pacific time) Monday – Friday;
24/7 emergency services available
libertydentalplan.com/uhh

Dental benefits under the LIBERTY dental PPO option

Learn:

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

This section only applies if you choose the LIBERTY dental PPO option.
If you choose the LIBERTY DHMO, please see the section starting on page D-1 for information about your dental benefits.

Retirees and their dependents are <u>not</u> eligible for dental benefits.

UNITE HERE HEALTH (the Fund) has contracted with LIBERTY Dental Plan (LIBERTY) to administer dental benefits for you and your dependents.

If You Choose the LIBERTY Dental PPO Option — What You Pay		
Description of Services	**LIBERTY Dental PPO Provider**	**Non-Network Provider**
Dental Services		
Maximum Benefit Payable Each Calendar Year *non-orthodontic treatment*	\$1,500/person *does not apply to exams for persons under age 19*	
Calendar Year Deductible	\$50/person & \$150/family	
	What You Pay for Dental Care	
Diagnostic & Preventive Services	\$0 (no deductible)	30% (no deductible)
Emergency Services *including to treat severe pain*		
Diagnostic X-ray Services		
Minor Restorative Services	20% after deductible	40% after deductible
Periodontic Services		
Endodontic Services		
Oral Surgery		
Major Restorative Services	50% after deductible	60% after deductible
Prosthodontic Services & Repairs		
Orthodontic Services		
Orthodontic Services	50% (no deductible) *Plan benefits limited to a lifetime maximum of \$2,500/person*	

Network providers

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

LIBERTY Dental Plan
(888) 442-4585
8 a.m. – 5 p.m. (Pacific time) Monday – Friday;
24/7 emergency services available

libertydentalplan.com/uhh

What you pay

You must pay your deductible and coinsurance amounts for your share of covered expenses. You must also pay any expenses that are not considered covered expenses, including any amounts over the allowable charge when you use non-network providers.

Deductibles

Your deductible applies to both network and non-network dental care. The deductible does not apply to diagnostic or preventive care, emergency palliative treatment, diagnostic x-ray services, or to orthodontia.

You only have to pay the deductible once each year. Once you have paid your deductible (sometimes called "satisfying your deductible"), you do not have to make any more payments toward your deductible for the rest of that year. The same rule applies if two or more members of your family satisfy the $150 deductible. Once your family deductible has been satisfied, no one else in your family has to pay deductibles for the rest of that year.

Your $50 individual and $150 family deductibles only apply to the LIBERTY dental PPO benefits.

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

Maximum benefits

Non-Orthodontic dental care

The Plan pays up to $1,500 per person each year for network and non-network dental care combined. Once the Plan pays $1,500 for your dental care during a year, no more benefits will be paid for your dental care for the rest of that year.

The calendar year maximum benefit for non-orthodontic dental care does not apply to dental exams for persons under age 19.

Orthodontic care

The Plan pays up to a lifetime maximum of $2,500 per person for network and non-network orthodontic care combined. Once the $2,500 lifetime maximum is reached, no more benefits will be paid for your orthodontic care.

Alternate course of treatment

If there is a different type of treatment that would be at least as effective as your dental treatment, but costs less, the allowable charge 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 LIBERTY.
- Recognized by most dentists to be appropriate based on current national dental practices.

What's covered

There may be limits on how often certain services and supplies are covered. If the amount of time in any limitation shown below has not passed since the service or supply was last provided, you may have to pay the entire cost. You can always contact LIBERTY to find out the last time you got benefits for a certain service or supply. If you need a service or supply that isn't listed below, contact LIBERTY to find out if there any applicable limits.

- **Diagnostic and preventive services** and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease, including but not limited to exams, cleanings, and consultations with a non-treating dentist.
  - Routine cleaning (prophylaxis) and periodontal cleaning—two every 12 months.
  - Oral exams—two every 12 months.
  - Bitewing x-rays—two series every 12 months.
  - Full mouth x-rays (which include bitewing x-rays)—one every 36 months. Panographic x-rays (including bitewings) are considered a full mouth x-ray.
  - Topical application of fluoride if you are under age 19—one every 6 months.
  - Sealants to the first and second permanent molars if you are under age 16—one application during your lifetime. Sealants are covered only on the first or second molar, and only if the tooth is free of decay and has not had a restoration.
- **Emergency palliative care**, including treatment to temporarily relieve pain and discomfort.
- **Diagnostic x-rays** to diagnose a specific condition.
- **Oral surgery**, extractions and other surgical procedures, including pre-operative and post-operative care, and general anesthesia.
- **Endodontic services** and procedures to treat teeth with diseased or damaged nerves (for example, root canals).

- Benefits for root canal treatment on primary teeth will be limited to the benefits provided for a pulpotomy.

- **Periodontic services** to treat diseases of the gums and teeth.
  - Periodontal surgery, including sub-gingival curettage—once per quadrant every 24 months.
  - If you have gingival inflammation, periodontal scaling (deep cleaning) will be paid the same as a regular cleaning (prophylaxis).
  - Deep cleaning (periodontal scaling and root planing)—one full mouth deep cleaning every 24 months; no more than two quadrants performed in same visit or on the same day.
  - Periodontal maintenance — two every 12 months.
  - Full mouth debridement — one every 24 months.
- **Restorative services** to rebuild, repair, or reform the tissues of the teeth, including but not limited to:
  - Minor restorative services such as amalgam, synthetic porcelain, or resin restorations.
    - Amalgam or resin restoration — one per tooth per surface every 12 months.
    - Benefits for resin restorations are limited to those for amalgam restorations if x-rays show decay in the molar or pre-molar on which the resin restoration is placed.
    - Benefits for multiple restorations on the same tooth will be limited to the benefits provided for one multi-surface restoration.
  - Major restorative services such as crowns, jackets, and gold restorations if the tooth cannot be restored with another filling.
    - Crowns, inlays, onlays, and bridges — one per tooth every 60 months.
    - Benefits for inlays will be limited to the benefits provided for comparable amalgam restorations.
    - Benefits for 4-surface onlays will be limited to the benefits provided for 3-surface onlays.
  - Benefits for cast restorations with cosmetic (elective) components will be limited to the benefits provided for cast metal restorations.
  - Benefits for teeth which cannot have cast restorations because of decay or missing tooth structure on less than 4 surfaces are limited to the benefits provided for amalgam or resin restorations.

- **Prosthodontic services** and appliances that replace missing natural teeth, including bridges, partial dentures, and complete dentures.
  - Denture rebase or reline—once per arch in a period of 24 consecutive months.
  - Denture adjustments—once per arch in a period of 6 consecutive months.
  - Complete denture or partial denture — once per arch every 60 months, unless the existing partial denture cannot be made to work because of natural tooth loss.
  - Benefits for a fixed partial denture placed in a dental arch with three or more missing teeth are limited to the benefits provided for removable dentures. However, this limit does not apply to a pre-existing fixed partial denture that is considered covered.
  - Benefits for pontics are limited to the benefit for one pontic if the space between teeth created by a missing tooth is greater than the size of the original tooth.
  - Benefits for personalization of dentures, precision attachments, stress breakers, or specialized techniques are limited to the benefits provided for conventional dentures.
- **Prosthodontic repairs** and relines to prosthetic appliances.
- **Orthodontic services** including x-rays, diagnostic tests, casts and treatment, and fixed or removable appliances, including retention appliances. Only one appliance per person for tooth guidance or to control harmful habits will be covered. Each month of active treatment is a separate service.

What's not covered

In addition to expenses related to any general Plan exclusion or limitation, the following types of treatments, services, and supplies are not covered:

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

- Alveolectomy/alveoloplasty performed in conjunction with extractions.
- Replacement of a cast restoration within 60 months after initial placement of an existing restoration.
- Crown buildup when x-rays show evidence of sufficient vertical height to support a cast restoration.
- Recementing of inlays, onlays, or crowns by the same office within 6 months of the initial placement.
- Periodontal surgery or therapy in the absence of x-ray evidence of bone loss.
- Grafts or gingivectomies performed in conjunction with osseous surgery.
- Guided tissue regeneration.
- Crown lengthening or gingivoplasty if not performed at least 4 weeks prior to crown preparation.
- Periodontal maintenance procedures performed within 3 months after active periodontal therapy.
- Replacement of an existing prosthodontic appliance within 60 months after initial placement.
- Prosthodontic appliances related to implants.
- Reline or rebase of an existing appliance within 6 months after initial placement.
- Fixed prosthodontics for anyone under age 16.
- Tissue conditioning.
- A pontic when the space between teeth created by a missing tooth is less than 50% of the size of the original tooth.
- Recementing of fixed partial dentures by the same office within 6 months after initial placement.
- Services for injuries or conditions for which you may be able to receive benefits under Workers' Compensation or Employer's Liability laws.
- Services that are available from:
  - Any federal or state government agency, other than programs provided under Medicaid.
  - Any municipality, county, or other political subdivision.
  - Any community agency, foundation, or similar entity.

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

- Services performed as a component of another procedure.
- Temporary services or procedures.
- Infection control procedures and fees associated with the rules of the Occupational Safety and Health Administration (OSHA).
- Placement of an additional appliance in the same dental arch less than 60 months following placement of the initial appliance.
- Services covered under the medical benefits.
- Services or supplies provided more frequently than allowed under the contract with LIBERTY.

Predetermination of dental benefits

If your dentist recommends dental care that is estimated to cost $300 or more, you can ask LIBERTY to help you determine how much the Plan will pay. This is a voluntary program, but contacting LIBERTY 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 LIBERTY 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, LIBERTY will review your dentist's records and provide you and your dentist with an estimate of what you must pay, and what the Plan will pay. Predetermination of benefits does not guarantee what benefits the Plan will pay or that any benefits will be paid for dental treatment or services provided. As always, any treatment decisions are between you and your dentist. All Plan rules will apply to any dental claims you file.

Dental benefits after eligibility ends

If your coverage ends, Plan benefits will only be paid for allowable charges incurred for covered expenses before your coverage ends. Contact LIBERTY with questions about dental treatment in progress if you lose eligibility before treatment is finished.

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

Vision benefits

Learn:

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

Retirees and their dependents are <u>not</u> eligible for vision benefits.

UNITE HERE HEALTH (the Fund) has contracted with UnitedHealthcare to provide vision benefits to you and your dependents. This part of the SPD summarizes your vision benefits.

If there is any conflict between this SPD and the UnitedHealthcare contract, the terms of the UnitedHealthcare contract govern. If you have any questions about vision benefits, please contact UnitedHealthcare.

Vision Benefits — What you pay		
Description of Services *Covered once every 24 months **	**UnitedHealthcare Provider**	**Non-Network Provider**
Eye Exam	$15 copay	$0 copay; $40 maximum
Lenses	$10 copay; $130 maximum for frames *lenses are covered in full*	$0 copay Maximums are: $40 for single vision lenses $60 for bifocal lenses $80 for trifocal lenses $125 for lenticular lenses
Frames		$0 copay; maximum $45
Elective Contact Lenses *instead of glasses*	$10 copay; $105 maximum for non-standard contacts like toric and gas permeable lenses *copay does not apply to non-standard contacts*	$0 copay; $105 maximum
Medically Necessary Contact Lenses	$10 copay	$0 copay; $210 maximum

Services are covered once every 24 months, regardless of whether you use a network or a non-network provider. However, you can get the following extra benefits if you are (1) pregnant, or (2) a child under age 13:

- A second eye exam during the 24-month benefit period. (The eye exam copay shown in the table above will apply.)
- A new pair of glasses (frames and lenses) if your prescription changes by 0.5 diopters or more during the 24-month benefit period. (The frame/lenses copay shown in the table above will apply.)

Network and non-network vision providers

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

UnitedHealthcare Vision
toll free: **(800) 638-3120**
www.myuhcvision.com

If you use a network provider, you may also be able to get discounts on lens upgrades and other services that the Plan doesn't cover.

What you pay

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

Maximum benefit

This Plan only pays up to the maximum benefit or allowance shown in the table *on page D-14* for your particular type of vision care (you pay any charges over the maximums).

What's covered

Benefits are available once every 24 months.

- Exams, consultations, or treatment by a licensed vision care professional (including dilation when professionally indicated).
- Standard lenses, including single vision, bifocal lenses, trifocal lenses, or lenticular lenses.
  - If you use a network provider, standard scratch resistant coatings, ultraviolet coating, fashion, sun, or gradient tinted lenses, and polycarbonate lenses are covered for children under age 19 at no additional cost.
- Frames.
- Elective contact lenses (soft, daily-wear, disposable, or planned replacement) instead of glasses.
  - Four boxes of disposable multi-packs of contact lenses will be covered if you use a network provider.
  - If you use a network provider, the filling/evaluation, and up to two follow-up visits are covered only for formulary contacts. If you choose non-formulary contacts, the network allowance does not include charges for fitting and evaluation.
- Medically necessary contacts, with prior authorization from UnitedHealthcare.

What's not covered

The contract with UnitedHealthcare determines what is covered and what is not covered. The following types of treatments, services, and supplies are examples of what is not covered:

- The fitting or evaluation of contact lenses if you use a non-network provider.
- Non-prescription items (except if specifically covered under the contact with UnitedHealthcare).
- Any type of lenses, frames, services, supplies, or options that are not specifically listed as covered under the contract with UnitedHealthcare.
- Services not actually performed.
- Two or more pairs of glasses during the same 24-month benefit period instead of bifocals or trifocals.
- Contacts and eyeglasses during the same 24-month benefit period.
- Replacement or repair of lost or broken lenses or frames before the beginning of a 24-month benefit period.
- Low vision services.
- Technological devices such as smart phones or tablets used as optical low vision aids.
- Medical/surgical treatment for eye disease which requires the services of a physician.
- Missed appointment charges.
- Applicable sales tax charged on services.
- Any eye examination required by an employer as a condition of employment, by virtue of a labor agreement, a government body, or agency.
- Services or supplies that are cosmetic, other than elective contact lenses.
- Orthoptics or vision training.
- Malign or congenital malformations of the eye.
- Services which may be covered under Worker's Compensation or similar employer liability law.
- Services obtained without cost through any government organization or program.
- Services that are experimental or investigative.
- Intraocular lenses.

Life and AD&D benefits

Learn:

- What your and your dependents' 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.

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

Life and AD&D Benefit — What the Plan Pays	
Life Insurance	
Employees	
Employees	$20,000
Dependents	
Spouse	$20,000
Child – live birth up to age 6 months	$3,000
Child – 6 months and older	$20,000
Life Accidental Death and Dismemberment (AD&D) Insurance	
Employees Only *(full amount)*	$20,000

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 and your dependents' 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.

Life insurance benefit

Your life insurance benefit is $20,000 and will be paid to your beneficiary(ies) if you die while you are eligible for coverage or within the 31-day period immediately following the date coverage ends.

In addition, a life insurance benefit is available for your enrolled dependents. The amount of the benefit is shown in the table above. If your dependent dies while he or she is eligible for coverage (or within the 31-day period immediately following the date coverage ends), the amount of the life insurance will be paid to you. Dependents do not get AD&D benefits or the terminal illness benefit.

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 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 (or your dependent's) 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. Even if you decide to elect COBRA for your health benefits, the 31-day deadline for life insurance applies to you.

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. If you think you might want to convert your group life insurance to an individual policy you pay for yourself, go to www.uhh.org/conversion to get the "Application to Convert Group Life Insurance" form. You can also get the form by calling Member Services. 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**	**Who Receives**
Death	$20,000	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	$10,000	
Loss of the sight in one eye		
Loss of index finger and thumb on same hand	$5,000	

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 Dearborn National. If there is a conflict between these highlights and the certificate, the certificate governs.

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

Naming a beneficiary

Your beneficiary is the person or persons you want 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 any 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

Your life insurance benefits include medical emergency and travel emergency assistance programs when you're traveling 100 or more miles from home.

- **Medical Emergency Assistance** helps you and your dependents get care and support during a medical emergency. Examples of services currently offered include:
  - Medical referrals.
  - Medical monitoring.
  - Medical evacuation.
  - Foreign hospital admission assistance.
  - Prescription assistance.
- **Travel Emergency Assistance** helps you and your dependents get assistance if you have an emergency while traveling. Examples of services currently offered include:
  - Travel for a companion to join you if you're hospitalized alone.
  - Emergency minor childcare if you are injured.
  - Transportation for a companion if you need to be transported for medical care.
  - Transportation for your body if you die.
  - Other services, including return of your vehicle, legal and interpreter referrals, emergency cash and bail coordination, and pre-trip planning information.

Assist America
(800) 872-1414 (toll free in the U.S.)
(609) 986-1234 (outside the U.S.)
medservices@assistamerica.com
Reference number: 01-AA-TRS-12201
You can also get the mobile app.

All services must be arranged by Assist America and limits may apply.

Beneficiary Resource Services

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 referral 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, IL 60504-4197

See page H-6 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

This section only applies to benefits provided under the LIBERTY dental PPO.

In addition to the list of the types of treatment, services, and supplies that are not covered in the LIBERTY dental PPO section (*see page D-3*), 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.
- 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.
- Experimental treatment, or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH.
- Preventive care, unless specifically considered preventive healthcare, or as otherwise stated as covered. If you don't meet the criteria for preventive healthcare the Plan otherwise covers, it might not be covered under the Plan.
- Any expense or charge for failure to appear for an appointment as scheduled, or charge for completion of claim forms, or finance charges.
- Any treatment, services, or supplies provided by an individual who is related by blood or marriage to you, your spouse, or your child, or who normally lives in your home.
- Any treatment, services, or supplies purchased or provided outside of the United States (or its Territories), unless for a medical emergency. The decision of the Trustees in determining whether an emergency existed will be final.
- Any expense or charge by a rest home, old age home, or a nursing home.
- Any charges incurred while you are confined in a hospital, nursing home, or other facility

or institution (or a part of such facility) which are primarily for education, training, or custodial care.

- Any treatment, services or supplies for or in connection with the pregnancy of a dependent child except for preventive healthcare services. For example, ultrasounds, treatment associated with a high-risk pregnancy, non-preventive care, and delivery charges are not covered with respect to the pregnancy of a dependent child.
- Hospital charges for personal comfort items, including but not limited to telephones, televisions, cosmetics, guest trays, magazines, and bed or cots for family members or other guests.
- 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.
- Treatment for or in connection with infertility, other than for diagnostic services.
- Weight loss programs or treatment, except to treat morbid obesity if the program is under the direct supervision of a healthcare provider, or as specifically stated as covered (for example, diabetes education, or nutrition counseling).
- Any smoking cessation treatment, drug, or device to help you stop smoking or using tobacco, other than preventive healthcare services or as otherwise stated as covered.
- Any charges incurred for treatment, services, or supplies as a result of a declared or undeclared war or any act thereof; or any loss, expense or charge incurred while a person is on active duty or in training in the Armed Forces, National Guard, or Reserves of any state or any country.
- Any elective procedure (other than sterilization or abortion, or as otherwise specifically stated as covered) that is not for the correction or cure of a bodily injury or sickness.
- Procedures to reverse a voluntary sterilization.
- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault.
- Any dental treatment of teeth or their supporting structures, or services or supplies associated with such treatment, unless specifically listed as covered.
- Eye examinations or hearing examinations, unless specifically listed as covered, or for the diagnosis or treatment of bodily injury.
- Eyeglasses, contact lenses or hearing aids, unless specifically listed as covered.
- Massage therapy, rolfing, acupressure, or biofeedback training.

- Naturopathy or naprapathy.
- Athletic training.
- Education or training, unless specifically stated as covered.
- Services provided by or through a school, school district, or community or state-based educational or intervention program, including but not limited to any part of an Individual Education Plan (IEP).
- Court-ordered or court-provided treatment of any kind, including any treatment otherwise covered by this Plan when such treatment is ordered as a part of any litigation, court ordered judgment or penalty.
- Treatment, therapy, or drugs designed to correct a harmful or potentially harmful habit rather than to treat a specific disease, other than services or supplies specifically stated as covered.
- Megavitamin therapy, primal therapy, psychodrama, or carbon dioxide therapy.
- Christian Science.
- Cosmetic services.
- Services, treatment, or supplies provided by a non-network provider when Plan benefits are only payable if the service, treatment, or supply is provided by a network provider.
- A service or item that is not covered under the Plan's claims processing guidelines or any other internal rule, guideline, protocol or similar criterion that the Plan relies upon.
- Any expense greater than 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.
- Charges of claims incurred as a result, in whole or in part, of fraud, false information, or misrepresentation.

Subrogation

Learn:

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

This section does not apply to claims for benefits provided through the HMOs or through the vision benefits.

The Plan's right to recover payments

When injury is caused by someone else

Sometimes, you or your dependent suffer injuries and incur 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 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 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 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.

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 any 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 the coverage.
- You meet the Plan's eligibility rules.

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

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

Dependents

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

If you don't sign up your dependent, or don't make any required payments for your share of dependent coverage, 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**.
- As long as you are enrolled in the Kaiser HMO, your domestic partner may be considered your spouse if you provide a copy of the Declaration of Domestic Partnership from the state of California. Any child of your domestic partner may also be considered a dependent if he or she meets the definition of "child" below.
- Your **children** who are under age 26, including any of the following:
  - Biological children.
  - Step-children.
  - Adopted children or children placed with you for adoption, if you are legally responsible for supporting the children until the adoption is finalized.
  - Children for whom you are the legal guardian or for whom you have sole custody under a state domestic relations law.
  - Children entitled to coverage under a Qualified Medical Child Support Order.

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

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

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

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

Enrollment requirements

Employees

You or your employer must provide the Fund with any required information before benefits will be paid on your behalf. 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.

Dependents

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

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

See page G-7 for information about when coverage for your dependents starts.

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.
- If you are enrolling in an HMO and have a domestic partner, you must provide the Fund with a copy of your Declaration of Domestic Partnership from California in order to enroll your domestic partner.

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 number of dependents you enroll, if any, does not affect the amount of any payment you must make for your share of the cost of coverage.

Eligibility

When your coverage begins (initial eligibility)

Your coverage begins at 12:01 a.m. on the first day of the coverage period corresponding to the first work period for which contributions are required on your behalf. You must also make any required payment for your share of your coverage. You must also meet the eligibility requirements each month of the work period.

For purposes of establishing initial eligibility:

- **Work period** means the 3-calendar-month period for which your employer must make contributions to UNITE HERE HEALTH on your behalf, including any amount you are required to contribute under the terms of your Collective Bargaining Agreement, and for which you are credited with the minimum number of required hours shown *on page G-6*. You must meet the eligibility requirements each month of the work period.
- **Lag period** means the calendar month period between the end of a work period and the beginning of the corresponding coverage period.
- **Coverage period** means the 2-calendar-month period you get coverage for benefits (based on the related work period).

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

Suppose employer contributions are required for each of the months of July, August, and September. Your coverage begins on November 1 and continues through the entire month of November and December.

Continuing eligibility

Once you establish eligibility, you continue to be eligible as long as your employer is required to make contributions on your behalf as explained in your CBA.

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 amount you are required to contribute under the terms of your Collective Bargaining Agreement, and for which you are credited with the minimum number of required hours shown *on page G-6*.
- **Lag period** means the 2-calendar-month period between the end of a work period and the beginning of the corresponding coverage period.
- **Coverage period** means the calendar month you get coverage for benefits (based on the related work period).

Example—Continuing Eligibility		
Work Period	Lag Period	Coverage Period
October	November and December	January
November	December and January	February
December	January and February	March

Suppose you became covered November 1 through December 31 because your employer was required to make contributions on your behalf for the July, August, and September work period (and you made any required payment for your share of coverage). If a contribution is required on your behalf for October, your coverage continues during January. A contribution for November continues your coverage for February, December will continue your coverage for March, and so on.

Hours requirement for initial and continuing eligibility

The number of hours you must be credited with each month to earn initial or continuing eligibility depends on whether your employer is a hotel or not.

- If your employer is in the hotel industry, you must be credited with at least 90 hours each month during the work period.
  - However, if you are a hotel banquet server or a hotel banquet bartender (banquet employee), you must be credited with at least 70 hours each month. If you aren't credited with at least 70 hours per month as a banquet employee, your banquet hours count towards the 90 hours needed to earn eligibility as a hotel industry employee.

  - If you earn hours in both the hotel and the non-hotel industries, the rules for employees working in more than one industry apply.

- If your employer is not in the hotel industry, you must be credited with at least 80 hours each month during the work period.

If you work in more than one industry

These rules apply if:

- You work for both an employer in the hotel industry and an employer which is not in the hotel industry.
- You work in the hotel industry, but you work some hours as a hotel banquet server or banquet bartender, and some hours not as a hotel banquet server or banquet bartender.

Your eligibility requirements will be based on the employer for which you worked the most hours. For example, if you are credited with 60 hours each month for an employer in the hotel industry during July, August, and September, and 30 hours each month for an employer which is not in the hotel industry, you will be considered to work for the employer in the hotel industry during all three months. You will become eligible during the November—December coverage period because you are credited with at least 90 hours each month, meeting the 90-hour rule that applies to employers in the hotel industry.

If you work the exact same number of hours during a work period for both a hotel employer and a non-hotel employer, you must be credited with at least 80 hours to continue your coverage.

See page G-8 for information about using vacation hours to continue your eligibility if you don't work any hours during a work period.

See page G-8 for information about how vacation hours apply when you regularly work for both a hotel employer and a non-hotel employer.

Dependent coverage

Your dependents' coverage cannot start before your coverage starts. Your dependents will remain covered as long as you remain eligible and they continue to meet the definition of a dependent. Dependent coverage cannot continue after your coverage ends (except in certain limited circumstances, *see page G-21*). There is no cost to you to cover your dependents, but you must enroll your dependents before the Plan will pay benefits (*see page G-4*).

Your dependents will have the same coverage as you have. For example, if you choose the LIBERTY DHMO option, your dependents will also have the LIBERTY DHMO option. If you choose the LIBERTY PPO dental option, your dependents will also be covered under the LIBERTY PPO dental option.

Once you are enrolled, you can enroll an existing dependent any time. The dependent's coverage

will start the first day of the month during which you provide all information UNITE HERE HEALTH needs to enroll the dependent. For example, if UNITE HERE HEALTH gets all required information about your child's enrollment on October 10, your child will become eligible on October 1. (*See page G-9* for the special enrollment rules for exceptions.)

Self-payments

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 work place 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-22*).

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.

Vacation hours

Whether or not you earn vacation hours depends on your CBA. Vacation hours will be automatically applied to help you maintain your eligibility during coverage periods for which you are short hours.

- Vacation hours can not be used to continue eligibility during coverage periods before the hours were earned.
- You will lose any vacation hours that are not used within 12 months.

If you regularly work for both a hotel employer and a non-hotel employer, but you are not credited

with any hours during a work period, you will need 80 vacation hours in order to continue your coverage during the related coverage period.

Contact UNITE HERE HEALTH with questions about vacation hours.

Enrollment periods

Open enrollment periods

Open enrollment periods give you the chance to enroll, add dependents (other than as shown *on page G-7*), or change your dental benefit options. You must arrange to make any required payments for your share of the cost of coverage If you want to enroll dependents, you must provide any required enrollment information. 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, add dependents (other than as shown *on page G-7*), or change your dental benefit options. You can make these changes within 60 days after any of the following events:

- Termination of other health coverage you (or your dependent) had when you previously 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 a child.
- The adoption or placement for adoption of a child under age 26.
- A dependent previously living 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 begin making any required payments for your share of the cost of coverage, your coverage, your new dependent's coverage, or your new dental benefit option will take effect:

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

If you have questions about special enrollment periods or when your change takes effect, contact UNITE HERE HEALTH.

If you don't take advantage of a special enrollment period, you must wait until the next open enrollment period or special enrollment period to change your dental benefit option. (*See page G-7* for information about adding a dependent outside of the open or special enrollment periods.)

Retiree Eligibility

Retiree benefits are provided only for retired employees who filed for and qualified under the retiree benefits offered through the UNITE HERE Long Beach and Orange County Health Benefit Fund rules on or before July 31, 2012. Retired employees may also cover their spouses.

The medical benefits offered to retired employees are the same medical benefits as offered to active employees (the Kaiser HMO medical and prescription drug benefits). Retired employees are not entitled to dental benefits, vision benefits, or life and accidental death and dismemberment insurance benefits.

If you made monthly payments to the UNITE HERE Long Beach and Orange County Health Benefit Fund for your retiree eligibility, you must continue to make payments for your retiree eligibility under UNITE HERE HEALTH. Monthly payments are due the 15th day of the month prior to the coverage period. At the time this book was printed, the monthly payment amount was $250. Contact UNITE HERE HEALTH for information about the amount of the monthly payment or with questions about your benefits.

Send your monthly payment to:

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

If you were not required to make monthly payments to UNITE HERE Long Beach and Orange County Health Benefit Fund for your retiree eligibility, you do not need to make payments for your retiree eligibility under UNITE HERE HEALTH.

If you do not make any required monthly payment by the 15th day of the month prior to the coverage period, your eligibility will terminate. You will not be able to make self-payments for retiree coverage in the future.

If you are a retired employee (and you meet the rules to get retiree coverage), you may continue your benefits until your death. If you die, your dependent spouse's eligibility will terminate on the last day of the month in which you die. He or she will not be able to continue coverage.

Retiree benefits are not vested

Retiree benefits provided through the Fund are not vested or accrued benefits. This means the retiree benefits are not guaranteed to continue indefinitely. The Trustees have full and exclusive authority to change or terminate the benefits and the eligibility requirements at any time.

Termination of coverage

Learn:

- When your coverage and your dependents' coverage ends.

Your and your dependents' coverage continues as long as you maintain your eligibility as described *on page G-5* and you make any required payments for your share of your dependents' 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 **(855) 844-5262**.

When employee coverage ends

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

- The date the Plan is terminated.
- The last day of the coverage period corresponding to the 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 during the corresponding work period, as long as you made any required payment for your share of the cost of your coverage.
- The last day of the coverage period for which you last made a timely self-payment, if allowed to do so.

If you waive coverage under this Plan in order to enroll in your employer's plan, your coverage will terminate as of the date you become covered under your employer's plan.

See page G-15 for special rules that apply if your employer's CBA expires. *See page G-10* for special rules that apply to retired employees.

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.

You may also ask the Fund to stop covering your dependent (or dependents). Contact the Fund

at **(855) 844-5262** 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 UNITE HERE HEALTH 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

The Fund complies with federal law governing leaves of absence under the Family and Medical Leave Act (FMLA), including continuing your and your dependents' coverage during your leave and reinstating your coverage following your leave. Your employer may still be required to make contributions on your behalf, and you may still be required to make any applicable payments for your or your dependents' coverage. Contact your employer with questions about FMLA leaves of absence.

The effect of uniformed service

The Fund complies with federal law governing military leaves of absence under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Provided your return to work is in accordance with federal law and you make any applicable payments for your or your dependents' coverage, your and your dependents' coverage will be reinstated immediately upon your return to covered employment (no waiting period will apply).

Reestablishing eligibility lost for other reasons

Reestablishing eligibility for employees

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

Reestablishing eligibility for dependents

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

If dependent coverage terminates because you lose eligibility for reasons other than termination of employment, dependent coverage will be reestablished when your (the employee's) coverage is reestablished.

COBRA continuation coverage

Learn:

- How you can make 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, except that you cannot continue life and accidental death and dismemberment insurance. 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 **(855) 844-5262**.

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 can 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 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 when you have reached the maximum period of time for which coverage can be continued. However, continuation coverage will end sooner if any of the following occur:

- 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
(855) 844-5262

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.

This section does not apply to claims for benefits provided through the HMOs.

See page C-4 **for more information about Kaiser claim filing, appeals, and grievances (including your right to external appeals in some cases).**

See your LIBERTY DHMO EOC for more information about LIBERTY DHMO claim filing and appeals.

Filing a benefit claim

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

- Your name.
- Your Social Security number 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.

Claims for life or AD&D benefits 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 **(855) 844-5262**.

LIBERTY PPO dental claims

LIBERTY dentists will generally file dental claims for you. However, you may need to file a claim if you choose a non-network dentist. Send your claim, with all information LIBERTY needs, to:

LIBERTY Dental Plan
Claims Department
P.O. Box 26110
Santa Ana, CA 92799-6110

Vision claims
Generally, if you use a UnitedHealthcare vision provider, you do not need to file a claim for vision care because UnitedHealthcare vision providers will file the claim on your behalf. However, if you need to file a claim because you used a provider who is not in the UnitedHealthcare vision network, submit it to UnitedHealthcare. You will need to include your unique member service number, plus the patient's name and date of birth on all claims. If you have claims for services or materials purchased on different dates, you must file the claim at the same time.

UnitedHealthcare
ATTN: Claims Department
P.O. Box 30978
Salt Lake City, UT 84130
Fax: **(248) 733-6060**

All other claims
All life or AD&D 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
(855) 844-5262

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**
LIBERTY dental PPO claims	365 days following the date the claim was incurred
Vision claims	12 months following the date the claim was incurred
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 claims denied because you are not eligible	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 power of attorney, or who is executor of your estate.

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

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

Determination of claims

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

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

Life and AD&D 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.

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

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

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

John Wilhelm Scholarship benefits: one level of appeal

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-26*, you may appeal the denial within 60 days of receiving the denial notice to:

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

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

Vision care claims: one level of appeal

You can file an appeal within 180 days of UnitedHealthcare's decision. UnitedHealthcare will generally respond to your appeal within 60 days (but may request a 60-day extension). If you need help filing a claim or appeal, or have questions about how UnitedHealthcare's claim and appeal process works, contact UnitedHealthcare:

UnitedHealthcare
ATTN: Claims Department
P.O. Box 30978
Salt Lake City, UT 84130
Fax: **(248) 733-6060**
(800) 638-3120

LIBERTY dental PPO claims: two levels of appeals

First level of appeal
All appeals for denied LIBERTY dental PPO claims must be sent within 12 months of the date the claim was denied to:

LIBERTY Dental Plan
Grievance Analyst
P.O. Box 26110
Santa Ana, CA 92799-6110

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

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

All other claims: one level of appeal

If you disagree with all or any part of any other claim, including a claim denied because you are not eligible, and you wish to appeal the decision, you must follow the steps in this section. You must submit an appeal within 12 months of your receipt 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 contacting the applicable vendor.

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:

Type of Claim	Time Limit
Subject to one level of appeal	Within a reasonable time period, but not later than 60 days
Subject to two levels 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.

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 any external review available through the Kaiser HMO (*see page C-6* and *page C-7*).

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.

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.

- LIBERTY Dental Plans of California, Inc. administers the LIBERTY dental PPO dental benefit option.
- John Wilhelm Scholarship benefit.

The following benefits are provided on a fully insured basis. This means that the benefits are funded and guaranteed under group policies underwritten by an entity other than UNITE HERE HEALTH:

- HMO medical and prescription drug benefits through Kaiser Foundation Health Plan, Inc. Southern California Region.
- Dental HMO benefits through LIBERTY Dental Plans of California, Inc.
- Vision benefits through UnitedHealthcare.
- Life and accidental death & dismemberment (AD&D) benefits through a group policy underwritten by Dearborn National (branded as BCBSIL).

Interpretation of Plan provisions

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 governing the Plan, the Plan Document will govern.

The Plan Document is the rules and regulations governing the Plan of benefits provided to eligible employees and dependents participating in Plan Unit 278 (Long Beach/Orange County).

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

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

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

Benefits not vested

Retiree benefits provided through the Fund are not vested or accrued benefits. This means the retiree benefits are not guaranteed to continue indefinitely. The Trustees have full and exclusive authority to change or terminate the benefits and the eligibility requirements at any time.

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

Kaiser Permanente
(800) 464-4000
www.kp.org

Kaiser Foundation Health Plan
Member Case Resolution Center
P.O. Box 9390011
San Diego, CA 92193-90011

LIBERTY Dental Plan
1730 Flight Way, Suite 125
Tustin, CA 92782
(888) 442-4585
www.libertydentalplan.com

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

UnitedHealthcare Vision
Liberty 6, Suite 200
6220 Old Dobbin Lane
Columbia, Maryland, 21045
(800) 638-3120
www.myuhcvision.com

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Board of Trustees

Union Trustees

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