

UNITE **HERE** HEALTH

Plan Unit 278



Summary Plan Description
Your Health and Welfare Benefits

UNITE HERE HEALTH

Summary Plan Description

Long Beach/Orange County Plan Plan Unit 278

Effective April 2017

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

Table of Contents

Using this book.....	A-1
How can I get help?	A-5
How do I get the most from my benefits?	A-9
Summary of benefits	B-1
Medical benefits under the EPO.....	C-1
Prescription drug benefits under the EPO.....	C-13
HMO options.....	C-23
Dental benefits under the LIBERTY DHMO option.....	C-27
Dental benefits under the LIBERTY dental PPO option	C-35
LA Dental Center benefits.....	C-45
Vision benefits.....	C-51
Life and AD&D benefits.....	C-55
General exclusions and limitations	D-1
Coordination of benefits under the EPO medical option.....	E-1
Subrogation	E-5
Eligibility for coverage.....	F-1
Termination of coverage.....	F-13
Reestablishing eligibility	F-17
COBRA continuation coverage	F-21
Claim filing and appeal provisions	G-1
Definitions.....	H-1
Other important information.....	H-9
Your rights under ERISA	H-15
Important phone numbers and addresses.....	H-18
UNITE HERE HEALTH Board of Trustees.....	H-19

Using this book

Learn:

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

Please take some time to review this book.

If you have dependents, share this information with them, 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 hospital-ity industry and is governed by a Board of Trustees made up of an equal number of union and employer trustees. Each employer contributes to UNITE HERE HEALTH according to a specific contract, called a Collective Bargaining Agreement (CBA), between the employer and the union.

Your coverage is being offered under Long Beach/Orange County Plan Unit 278, which has been adopted by the Trustees of UNITE HERE HEALTH to provide medical and other health and welfare benefits through the Fund. Other SPDs explain the benefits for other Plan Units.

What is this book and why is it important?

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

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

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

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

How do I use my SPD?

This SPD is broken into sections. You can get more information about different topics by carefully reading each section. A summary of the topics is shown at the start of each section. When you have questions, you should always 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 (*see page B-2*), how your

benefits are paid, and what rules you may need to follow. You can find more information about a specific benefit in the applicable section. For example, if you want to know more about your life or AD&D benefits, read the section titled “Life and AD&D Benefits.” If you want more information about your medical benefits, read the applicable medical benefits section.

Some terms are defined for you in the section titled “Definitions” starting *on page H-2*. The SPD will also explain what some commonly used terms mean. When you have questions about what certain words or terms mean, contact the Fund at **(855) 844-5262**.

How do my benefit options affect this SPD?

The benefits described in this SPD describe the terms of all of the benefit options available under Plan Unit 278. However, your election choices determine which benefit option you and your family are covered under. For example:

- If you chose the EPO medical benefits, the portion of this SPD describing the EPO medical benefits will apply to you. The portion describing the Kaiser HMO will not apply to you.
- If you chose the HMO medical benefits, the portion of this SPD describing the HMO medical benefits will apply to you. The portion describing the EHS EPO will not apply to you.

The benefits you elect apply to both you and your enrolled dependents. You cannot elect coverage for your dependents only. You must elect coverage for yourself in order to elect coverage for your dependents. When you have questions about your benefit options, contact the Fund at **(855) 844-5262**.

Your benefit options are described more fully on *see page F-4*.

You cannot elect medical, dental, vision, or life/AD&D insurance separately.

How can I get help?

Learn:

- ▶ How to reach UNITE HERE HEALTH.
- ▶ How to reach EHS (for help with the EPO benefit).
- ▶ How to reach Kaiser (for help with the Kaiser HMO benefit).
- ▶ How to reach LIBERTY Dental (for help with the DHMO and the dental PPO benefit).
- ▶ How to reach the LA Dental Center (for help with the LA Dental Center benefit).
- ▶ How to reach UnitedHealthcare (for help with your vision benefits).

How can I get help?

Important Phone Numbers		
If you want to:	Contact:	At:
<ul style="list-style-type: none"> Find out about your benefit options Ask questions about your eligibility Update your address 	UNITE HERE HEALTH	(855) 844-5262 www.uhh.org
<i>If you are in the EPO benefit option</i>		
If you need help with your medical/surgical benefits: <ul style="list-style-type: none"> Find a network PCP Get information about your benefits or a claim 	EHS	(844) 480-8444 (866) 293-0134 <i>(nurse advice line)</i> www.ehsm.com/unions
If you need help with your mental health/substance abuse benefits or the EAP: <ul style="list-style-type: none"> Find a network provider or resources Get information about your benefits or a claim 	Beacon Health Options	(844) 376-8085 www.beaconhealthoptions.com
If you need help with your prescription drug benefits: <ul style="list-style-type: none"> Find a network pharmacy Get information about your benefits 	Hospitality Rx	(844) 484-4726 www.hospitalityrx.org
To reach the 24/7 Spanish medical advice line	ConsejoSano	(855) 785-7885 www.consejosano.com
<i>If you are in one of the HMO benefit options</i>		
If you are in either Kaiser medical option: <ul style="list-style-type: none"> Find a network PCP Get information about your benefits 	Kaiser	(800) 464-4000 (888) 576-6225 <i>(nurse advice line)</i> www.kp.org
If you are in the Health Net medical option: <ul style="list-style-type: none"> Find a network PCP Get information about your benefits 	Health Net	(800) 400-8987 (800) 893-5597 <i>(nurse advice line)</i> www.healthnet.com

Dental Benefit Options		
<p>If you are in either the LIBERTY DHMO or dental PPO options:</p> <ul style="list-style-type: none"> • Find a network dentist • Get information about your benefits or a claim 	LIBERTY Dental	<p>(888) 442-4585 www.libertydentalplan.com/uhh</p>
<p>If you are in the LA Dental Center dental option:</p> <ul style="list-style-type: none"> • Make an appointment • Get information about your benefits 	LA Dental Center	<p>(213) 484-9660 (800) 436-3702 <i>(emergency services)</i> www.uhh dental.org</p>
For help with your vision benefits		
<p>If you need help with your vision benefits:</p> <ul style="list-style-type: none"> • Find a network vision care provider • Get information about your benefits or a claim 	UnitedHealthcare	<p>(800) 638-3120 www.myuhcvision.com</p>

This booklet contains a summary in English of your plan rights and benefits under UNITE HERE HEALTH. If you have difficulty understanding any part of this booklet, you can visit or contact UNITE HERE HEALTH at 130 S. Alvarado St, 2nd Floor, Los Angeles, CA 90057. Office hours are from 8:30 a.m. to 4:30 p.m. Monday through Friday. You may also call UNITE HERE HEALTH at (855) 844-5262 (TTY: (855) FUND-TTY or (855) 386-3889) for assistance.

Este folleto contiene un resumen en Español de sus derechos del plan y beneficios bajo UNITE HERE HEALTH. Si tiene alguna dificultad para comprender cualquier parte de este folleto, puede visitar o contactar a UNITE HERE HEALTH en 130 S. Alvarado St, 2do piso, Los Angeles, CA 90057. Las horas de oficina son de 8:30 a.m. a 4:30 p.m. de Lunes a Viernes. También puede llamar a UNITE HERE HEALTH al (855) 844-5262 (TTY: (855) FUND-TTY o (855) 386-3889) 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.
- ▶ How to use network providers to save time and money.
- ▶ How to join the Better Living program to manage your chronic health condition.

How do I get the most from my benefits?

Get a primary care provider

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

If you need specialist care, your PCP has to arrange the care for you. **Your PCP also has to get approval for most types of services or supplies.**

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

- ✓ **If you are in the EHS option:** Call EHS at **(844) 480-8444** or visit www.ehsmid.com/unions to get help finding a PCP.
- ✓ **If you are in the Kaiser option:** Call Kaiser at **(800) 464-4000** or visit www.kp.org/searchdoctors to get help finding a PCP.

Get preventive healthcare

Your Plan pays 100% for most types of preventive healthcare. Getting preventive healthcare helps you stay healthy by looking for signs of serious medical conditions. If preventive healthcare or tests show there is a problem, the sooner you get diagnosed, the sooner you can start treatment.

Re-think emergency room care

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

Regardless of your medical option: If you need emergency care, call 911 or go to the nearest emergency room.

Get extra help if you are in the EHS EPO benefit option

Call the EHS Nurse Line 24/7

(866) 293-0134

<http://www.ehsmid.com/24hr/>

For English and Spanish speakers. Get in touch with an EHS nurse 24/7.

Call for medical advice (Spanish speakers only) / Llame para consulta médica

(855) 785-7885

www.consejosano.com

¡Llama GRATIS hoy mismo!

- Asesoría Médica General
- Dieta, Obesidad & Nutrición
- Apoyo Emocional & Psicológico
- Asesoría Para Padres de Familia
- ConsejoSano: Consulta médica que no es de emergencia en español

ConsejoSano es un servicio de consejería médica en Español por teléfono diseñado. Puedes llamar a cualquier hora y hablar de inmediato con un asesor médico en Español acerca de cualquier pregunta de salud. ¡Toma el control de tu salud y la de tu familia y mantén un estilo de vida saludable!

¡Ahora es más fácil cuidar de tu salud!

- Todos nuestros asesores médicos son Hispanos y hablan Español.
- Nos tomamos el tiempo para escucharte, entenderte y brindarte la mejor asesoría médica posible.
- Nuestros asesores médicos se adaptan a tu horario y están disponibles las 24 horas, 7 días de la semana, todo el año.
- Llama todas las veces que necesites pro el tiempo que tu desees, ¡no hay limite de llamadas!

Habla hoy con un asesor médico en Español

- **PASO 1:** Baja nuestra aplicación móvil ConsejoSano llama y habla con un asesor médico en segundos.
- **PASO 2:** No tienes un smarthphone? Sólo llámanos desde cualquier teléfono al (855) 785-7885.
- **PASO 3:** Brinda tu nombre y número de cliente al asesor médico con el que hables. ¡Así de fácil!

How do I get the most from my benefits?

Use the EAP

You can get help for a wide variety of issues, including dependent care, alcohol/substance abuse, work-life balance, and financial issues, through the EAP. If you need help dealing with stress, call Beacon's EAP for help! You get three free visits with the EAP each year.

Beacon Health Options

(844) 376-8085

www.beaconhealthoptions.com

Use network providers

For most of your benefits, you must use a network provider to get your network benefits.

For those benefits, like your vision benefits, that covers your care if you go out of network, it still pays to stay in network. If you go out of network, you will usually pay more of the cost (or all of the cost) yourself.

How do I stay in the network?

- **If you are in the EPO option you must use a network provider for your healthcare:**
 - **Employee Health Solutions (EHS)** provides access to a network of doctors, hospitals, and other healthcare providers for your medical/surgical care. To find a provider in the EPO network, call **(844) 480-8444** or visit www.ehsmd.com/unions.
 - **Beacon Health Options (Beacon)** provides access to a network of doctors, hospitals, and other healthcare providers for your mental health and substance abuse care. To find a provider in the Beacon network, call **(844) 376-8085** or visit www.beaconhealthoptions.com.
 - **Hospitality Rx** provides access to a network of retail pharmacies. To find a network pharmacy, call **(844) 484-4726** or visit www.hospitalityrx.org.
- **If you are in the Kaiser HMO option**, your network for your healthcare (medical, behavioral health, prescription drugs) is the Kaiser Permanente network. To find a network provider, call **(800) 464-4000** or visit www.kp.org.
- **UnitedHealthcare (UHC)** provides access to a national network of vision care providers. You can stay in the network by using any participating UHC vision provider. To find a network provider, call **(800) 839-3242** or visit www.myuhcvision.com.
- For dental benefits, if you are in:
 - The **LIBERTY DHMO**, you have access to a network of California dentists through the DHMO network. You can find a dentist participating in the LIBERTY DHMO by calling **(888) 442-4585**, or visiting www.libertydentalplan.com/uhh.

How do I get the most from my benefits?

- ▶ The **LIBERTY dental PPO**, you have access to a national network of dentists. You can find a dentist participating in the LIBERTY dental PPO by calling **(888) 442-4585**, or visiting www.libertydentalplan.com/uhh.
- ▶ The **LA Dental Center**, you must use the LA Dental Center to stay in network. The LA Dental Center is located at 130 S. Alvarado Street, Los Angeles, CA 90057. Call **(213) 484-9660** to make an appointment, or visit www.uhhdental.org for more information.

Join Better Living!

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

Join the program, and you will learn how to:

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

Workshop leaders

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

Support along the way

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

Contact the Fund Office at **(855) 844-5262** for more information about the Better Living Program!

Copay Reimbursement

Join Better Living to get help paying for your prescription drugs!

Once you complete the Better Living class, you can attend monthly graduate meetings to get a refresher, get more help, or just stay in touch with program leaders and participants. Once you have

How do I get the most from my benefits?

attended graduate classes for at least a 3-month period, the Fund will reimburse you up to \$100 each month for your out-of-pocket prescription drug copays for chronic prescription drugs.

Once you qualify, you can get your drugs copays reimbursed for any month during which you attend a graduate Better Living class.

Contact the Fund Office at **(855) 844-5262** for more information about the copay reimbursement program or for help getting reimbursed for your prescription drug copays.

Summary of benefits



Summary of benefits

B

EPO BENEFIT OPTION

Your PCP must refer you to specialists, and get any required prior authorization for your medical care.

An “EPO” is an “exclusive provider option”. This means that **you must use a network provider for your medical care**. Except for urgent care, ambulance transportation, or emergencies, **benefits are paid only if you use a network provider**.

This section shows what you pay for your care (called your “cost-sharing”) if you choose the EPO benefit option (*see page F-4* for information about your benefit options). You pay any copays, deductibles, your coinsurance share, any amounts over a maximum benefit, and any expenses that are not covered, including any charges that are more than the allowable charge when you use non-network providers (*see page H-2*).

What You Pay if You Choose the EPO Benefit Option

	EHS Network Provider	Non-Network Provider
Calendar Year Deductibles		
Calendar Year Deductibles	None	Not covered
Annual Out-of-Pocket Limits		
For Network Medical Care	\$1,500/person & \$3,000/family	Not covered
For Network Prescription Drugs	\$1,200/person & \$2,400/family	Not covered
Office Visits		
Preventive Healthcare (<i>See page H-6</i>)	\$0	Not covered
Primary Care Provider (PCP) Office Visit	\$0	Not covered
Specialist Visit	\$0	Not covered
Mental Health/Substance Abuse Office Visit	\$0	Not covered
ConsejoSano Advice Line	\$0	Not covered
Acupuncture Treatment	\$0	Not covered
EAP Office Visit — <i>up to three visits per person each year</i>	\$0	Not covered

Commencement of Legal Action

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

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

B-2

Summary of benefits

B

What You Pay if You Choose the EPO Benefit Option		
	EHS Network Provider	Non-Network Provider
Urgent and Emergency Care		
Urgent Care Center	\$0	\$0
Hospital Emergency Room — <i>copay waived if admitted</i>	\$50/visit	\$50/visit
Professional Ambulance Services	\$0	\$0
Outpatient Services		
Laboratory Services	\$0	Not covered
Radiology	\$0	Not covered
Diagnostic Imaging	\$0	Not covered
Outpatient Surgery	\$0	Not covered
Physical, Speech, or Occupational Therapy	\$0	Not covered
Habilitative Therapy for Children with Autism Spectrum Disorder — <i>for treatment starting before June 1, 2018; certain other limits apply (see page C-8)</i>	\$10/day of treatment	Not covered
Diabetes Education or Nutritional Counseling	\$0	Not covered
Inpatient Treatment		
Inpatient Hospitalization	\$0	Not covered
Inpatient Hospitalization for Mental Health/Substance Abuse Treatment (including residential treatment)	\$0	Not covered
Skilled Nursing Facility — <i>up to 100 total days per person each year</i>	\$0	Not covered
Other Services and Supplies		
Kidney Dialysis	\$0	Not covered
Chemotherapy, Radiation Therapy, or Infusion Medication	\$0	Not covered
Home Healthcare Services — <i>up to 100 total visits per person each year</i>	\$0	Not covered
Hospice Care	\$0	Not covered
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment	\$0	Not covered
Durable Medical Equipment	\$0	Not covered

B-3

Summary of benefits

B

<i>What You Pay if You Choose the EPO Benefit Option</i>		
	EHS Network Provider	Non-Network Provider
Podiatric Orthotics— <i>covered only to treat diabetes-related complications</i>	\$0	Not covered
Travel and Lodging— <i>see page C-10 for information</i>	Reimburse 100% up to \$250/day and \$10,000/episode	
Medical Foods— <i>see page C-8 for information</i>	Reimburse 100%	
Other Covered Expenses	\$0	Not covered
Prescription Drug Benefits		
Preventive Prescription Drugs or Supplies on the Formulary	\$0	Not covered
Generic Drugs on the Formulary	\$5	Not covered
Brand Name Drugs on the Formulary	\$15	Not covered
Specialty and Biosimilar Drugs on the Formulary	25%, up to \$15/prescription	Not covered

KAISER BENEFIT OPTIONS

You must pick a primary care provider (PCP). Your PCP must refer you to specialists, and get any required prior authorization for your medical care.

You must use a network provider for your medical care. Except for urgent care, ambulance transportation, or emergencies, benefits are paid only if you use a network provider.

Your benefits under the Kaiser HMO options are shown in your Kaiser enrollment booklet. With respect to any benefits provided by Kaiser, if there is a conflict between this SPD booklet and any information provided by Kaiser, the information provided by Kaiser governs.

HEALTH NET BENEFIT OPTIONS

(for certain grandfathered employees only)

You must pick a primary care provider (PCP). Your PCP must refer you to specialists, and get any required prior authorization for your medical care.

You must use a network provider for your medical care. Except for urgent care, ambulance transportation, or emergencies, benefits are paid only if you use a network provider.

Your benefits under the Health Net HMO benefit option are listed in your Health Net summary of benefits and disclosure booklet. With respect to any benefits provided by Kaiser, if there is a conflict between this SPD booklet and any information provided by Health Net, the information provided by Health Net governs.

Remember, if you decide to leave the Health Net HMO and enroll in the EHS option or either of the Kaiser HMO benefit options, you will not be allowed to re-enroll in Health Net.

B-4

DENTAL BENEFIT OPTIONS

This section shows what you pay for your dental care (called your “cost-sharing”) under each dental benefit option. You pay any copays, deductibles, your coinsurance share, any amounts over a maximum benefit, and any expenses that are not covered, including any charges that are more than the allowable charge when you use non-network providers (*see page H-2*).

If You Choose the LIBERTY DHMO Option—see page C-27 for more information about the LIBERTY DHMO Dental benefit.

Description of Services	LIBERTY HMO Network Dentist	Non-Network Provider
Dental Services		
Maximum Benefit Payable Each Calendar Year	n/a	Not covered*
Calendar Year Deductible	n/a	Not covered
What You Usually Pay for Selected Dental Care <i>copays apply to certain services—see your LIBERTY DHMO charge sheet for more information</i>		
Routine Exams	\$0	Not covered
Routine X-Rays	\$0	Not covered
Routine Cleanings	\$0	Not covered
Fluoride Treatment for a Child	\$0	Not covered
Space Maintainers	\$0	Not covered
Amalgam Fillings	\$0	Not covered
Crowns	\$0	Not covered
Deep Cleaning (periodontal scaling & root planing)	\$0	Not covered
Complete Upper Denture (maxillary denture)	\$0	Not covered
Orthodontic Services		
Comprehensive Orthodontic Services	\$1,550 <i>Plan benefits limited to 24 months of treatment</i> <i>Additional copays may apply for x-rays and casts</i>	Not covered

* LIBERTY Dental will reimburse you up to \$75 per person each year for emergency dental treatment provided by a non-network provider.

Summary of benefits

B

If You Choose the LIBERTY Dental PPO Option—see page C-35 for more information about the dental PPO option.

Description of Services	LIBERTY Dental PPO Provider	Non-Network Provider
Dental Services		
Maximum Benefit Payable Each Calendar Year	\$1,500/person	
Calendar Year Deductible	\$50/person & \$150/family	
What You Pay for Dental Care		
Diagnostic & Preventive Services	\$0 (no deductible)	30% (no deductible)
Emergency Services— <i>including to treat severe pain</i>	\$0 (no deductible)	30% (no deductible)
Diagnostic X-ray Services	\$0 (no deductible)	30% (no deductible)
Minor Restorative Services	20%, after deductible	40%, after deductible
Periodontic Services	20%, after deductible	40%, after deductible
Endodontic Services	20%, after deductible	40%, after deductible
Oral Surgery	20%, after deductible	40%, after deductible
Major Restorative Services	50%, after deductible	60%, after deductible
Prosthodontic Services & Repairs	50%, after deductible	60%, after deductible
Orthodontic Services		
Orthodontic Services	50% (no deductible) <i>Plan benefits limited to a lifetime maximum of \$2,500/person</i>	

If You Choose the LA Dental Center Option—see page C-45 for more information about the LA Dental Center benefit.

Description of Services	LA Dental Center	Care Not Provided at the LA Dental Center
Dental Services Only		
Maximum Benefit Payable Each Calendar Year	n/a	Not covered
Calendar Year Deductible	n/a	Not covered
What You Pay for Dental Care		
Diagnostic & Preventive Services	\$0	Not covered
Emergency Services— <i>including to treat severe pain</i>	\$0	Not covered
Diagnostic X-ray Services	\$0	Not covered
Minor Restorative Services	10%	Not covered
Periodontic Services	10%	Not covered
Endodontic Services	10%	Not covered

B-6

Summary of benefits

B

If You Choose the LA Dental Center Option—see page C-45 for more information about the LA Dental Center benefit.

Major Restorative Services	15%	Not covered
Oral Surgery	15%	Not covered
Prosthodontic Services & Repairs	15%	Not covered

VISION CARE BENEFIT

The table below shows what you pay for your covered vision care. You can get the most from your vision care benefits by using a provider that participates in the UnitedHealthcare network. Services are covered once every 24 months, regardless of whether you use a network or a non-network provider.

What You Pay for Your Vision Care Benefits—see page C-51 for more information about your vision care benefits.

Description of Services <i>Covered once every 24 months</i>	UnitedHealthcare Provider	Non-Network Provider
Exam	\$15 copay	\$0 copay Plan benefits limited to \$40
Lenses	\$10 copay Plan benefits limited to \$130 for frames (lenses are covered in full)	\$0 copay Plan benefits limited to: \$40 for single vision lenses \$60 for bifocal lenses \$80 for trifocal lenses \$125 for lenticular lenses
Frames		\$0 copay Plan benefits limited to \$45
Elective Contact Lenses (instead of glasses)	\$10 copay Plan benefits limited to \$105 for non-standard contacts like toric and gas permeable lenses (copay does not apply to non- standard contacts)	\$0 copay Plan benefits limited to \$105
Medically Necessary Contact Lenses	\$10 copay	\$0 copay Plan benefits limited to \$210

Life and Accidental Death & Dismemberment (AD&D) Benefit (*Employees Only*) - What the Plan Pays

Life Insurance	\$1,000
AD&D Insurance (<i>full amount</i>)	\$1,000

B-7

Medical benefits under the EPO

Learn about your medical benefits if you chose the EPO option:

- How to use your EPO benefits.
- What you pay for healthcare.
- How the out-of-pocket limits protect you from large out-of-pocket expenses.
- How to get medical advice in Spanish any time.
- What types of medical healthcare are covered.
- What types of medical healthcare are not covered.

This section only applies to you if you choose the EPO option through EHS. If you choose one of the HMO benefit options, please see the section starting on [page C-23](#) for information about your medical and prescription drug benefits.

Medical benefits under the EPO

The Plan uses two different organizations to provide you and your family with healthcare coverage:

- **Medical/surgical treatment**—EHS Medical Group (EHS) provides access to a network of providers. EHS also processes and pays your claims.
- **Mental health/substance abuse treatment**—Beacon Health Options (Beacon) provides access to a network of providers. Beacon also processes and pays your claims.

Make sure you contact the right organization for the type of care you get. You should also make sure you follow the right set of rules for the type of care you are getting.

Be sure to follow EHS's rules for medical/surgical care

- **Make sure you use a network provider. If you don't use a network provider, you will have to pay 100% of the cost of your care yourself.**

An "EPO" is an "exclusive provider option". This means that **benefits are only paid if you use a network provider**. *Only non-network emergency room care, ambulance transportation, and urgent care centers will be paid if you use a non-network provider.* You may be balance billed for any of this non-network care if the allowable amount (*see page H-2*) is less than the non-network provider's billed charges.

To find a network provider for medical/surgical treatment, contact:

EHS Medical Group—EPO Network

toll free: **(844) 480-8444**

www.ehsmd.com/unions

- **Make sure your primary care provider (PCP) gets prior authorization for your medical care, including if you need specialist care.**

EHS requires your PCP to get prior approval for most types of medical care, or to refer you to a specialist. In some rare cases, a specialist may need to refer you to a sub-specialist. Your EHS PCP should handle prior approvals for medical care and specialist referral. If you need help, or want to make sure your EHS provider has gotten approval for your proposed treatment, call EHS.

You do not need a referral or prior authorization to receive obstetrical or gynecological care from an EHS 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.

If you need a particular type of specialist or provider that isn't available through the EHS network, your PCP should contact with EHS, which will help you find the specialist or provider that you need and approve the care outside of the network.

Medical benefits under the EPO

- ▶ Once the non-network provider contracts with EHS for your medical care, the provider will be considered a network provider while you get the contracted medical care. The Plan will pay benefits under the network provider schedule of benefits, and the provider should not balance bill you for the contracted medical care.

Remember, the provider will only be a network provider for the contracted services. If you get other types of care, the provider will not be considered a network provider, and you will have to pay 100% of the cost of your care.

- ▶ If the non-network provider does not agree to a contract with EHS, the Plan may give you prior authorization for the medical care anyway. This medical care will be paid under the network provider schedule of benefits. However, the provider may balance bill you for the difference between the provider's charges and the allowable amount (*see page H-2*) determined by the Plan. You will have to pay 100% of the cost of any of the care the Plan does not prior authorize.

If you use a non-network provider (except for non-urgent or non-emergency care), or if you don't get prior authorization for your medical care, the Plan will not pay benefits. You will have to pay 100% of the cost of your care.

Be sure to follow Beacon's rules for mental health/substance abuse care

- **Make sure you use a network provider. If you don't use a network provider, you will have to pay 100% of the cost of your care yourself.**

Benefits are only paid if you use a network provider. *Only non-network emergency room care, ambulance transportation, and urgent care centers will be paid if you use a non-network provider.* You may be balance billed for any of this non-network care if the allowable amount (*see page H-2*) is less than the non-network provider's billed charges.

To find a network provider for mental health/substance abuse treatment, contact:

Beacon Health Options
toll free: **(844) 376-8085**
www.beaconhealthoptions.com

- **You or your provider should always contact Beacon before you get care.** If you get treatment before you contact Beacon, you should still reach out to Beacon as soon as you can.

Why is this so important? Beacon can tell you if your proposed care is medically necessary before you start getting bills for your care. If your healthcare isn't medically necessary, the Plan won't cover the healthcare, and you will have to pay the entire cost yourself.

Medical benefits under the EPO

Contacting Beacon before you get care is especially important for:

- Inpatient treatment
- Electroconvulsive therapy (ECT)
- Psychiatric testing
- Methadone treatment
- Transcranial magnetic stimulation (TMS)
- Extended outpatient visits (visits of 53 minutes or more)

If you don't contact Beacon before you get mental health/substance abuse treatment, the Plan will still pay benefits for any medically necessary covered expenses.

Choosing a PCP

You should choose a PCP (primary care provider) for yourself and for each of your dependents. You can all have the same PCP, or you can each choose different PCPs. For children, you may choose a pediatrician as your child's PCP. You have the right to choose any PCP who is available to accept you or your family.

Contact EHS at **(844) 480-8444** if you need help choosing a PCP. You can change your PCP at any time. You don't have to tell EHS who your PCP is, or if you decide to change your PCP.

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

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

What you pay

You must pay any cost share (such as copays) for your share of covered expenses. You must also pay any expenses that are not covered expenses (*see page C-11* for information about excluded expenses), including any amounts over the allowable charge when you use non-network providers, or charges once a maximum benefit or limitation has been met.

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

Copays

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

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

Out-of-Pocket limit

Your out-of-pocket cost sharing for most covered expenses for your medical care is limited to \$1,500 per person (\$3,000 per family) each calendar year. Once your out-of-pocket costs for covered expenses meet these limits, the Plan will usually pay 100% for your (or your family's) covered expenses for medical care during the rest of that calendar year. Amounts you pay out of pocket for prescription drug expenses under the section titled "Prescription drug benefits under the EPO option" do not count toward this out-of-pocket limit.

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

ConsejoSano (for non-emergency medical advice in Spanish)

(855) 785-7885

www.consejosano.com

ConsejoSano provides access to non-emergency medical advice in Spanish 24/7. You can call or chat with a health advisor any time. This is a free service for you!

See page A-11 for more information.

Call for:

- Medical advice on common ailments: colds, allergies, pain, and more.
- Support for first time mothers: from nursing to answers about your baby's health.
- Emotional and mental support: stress, relationships, self-image and more.
- Diabetes and obesity: help you understand lab results and provide advice.
- Nutrition and weight loss: personalized diets and meal plans.

What's covered

The Plan will only pay benefits for injuries or sicknesses that are not related to your job. Benefits are determined based on allowable charges for covered services resulting from medically necessary care and treatment prescribed or furnished by a healthcare provider. **Unless otherwise stated, medical care is only covered if you use a network provider.**

Medical benefits under the EPO

- **Preventive healthcare services** (*see page H-6*). Certain limits or rules may apply to when and how you get preventive healthcare based on your gender, age, and health status. However, breast pumps purchased through a non-network provider will be considered a covered expense.
 - PSA tests are covered annually for men ages 40 through 69.
 - Cervical cancer screening (pap smear) is covered once every 36 months for just the pap smear, or once every 60 months if both a pap smear and human papillomavirus screening are done together. Cervical cancer screenings are only covered for women from age 21 to age 65.
 - Screening mammography is covered for women every two years for women ages 40 through 74. Your PCP will help you determine how often you should get a mammogram.
- **Professional services of a healthcare provider.** Non-network urgent care will also be covered.
- **Injectable medications**, including immunizations provided by a healthcare provider.
- Treatment of **mental health conditions and substance abuse**, including inpatient and residential treatment, outpatient care, partial hospitalization, intensive outpatient care, and ambulatory detoxification.
- **Acupuncture services.**
- Non-routine **podiatric care**, including podiatric orthotics.
- **Outpatient services** in a clinic or urgent care center. Non-network urgent care centers will also be covered.
- Hospital **emergency room** services. Non-network emergency room services will also be covered.
- Transportation by a **professional ambulance service** to an area medical facility that is able to provide the required treatment. Non-network ambulance services will also be covered.

If you have no control over whether the ambulance was called, for example when the ambulance is called by a healthcare professional, employer, law enforcement, school, etc., the ambulance will be considered medically necessary. Contact EHS if you had no control over an ambulance being called.
- **Ambulatory surgical facility services**, including general supplies, anesthesia, drugs, and operating and recovery rooms. If you have multiple surgeries, covered expenses are limited to charges for the primary surgery.
- **Radiology**, including but not limited to x-rays, ultrasounds, and fetal monitoring.

Medical benefits under the EPO

- **Laboratory services.**
- **Diagnostic imaging**, including but not limited to MRIs, MRAs, CT scans, PET scans, and cardiac testing.
- **Hospital charges** for room and board, and other inpatient or outpatient services. The Plan's benefits for a private room will be limited to the semi-private room rate.
- **Pregnancy** and pregnancy-related conditions for employees and spouses, including childbirth, miscarriage, abortion, and preventive healthcare (*see page H-6*). No benefits are payable for pregnancy or pregnancy-related conditions for a dependent child, unless the care is considered preventive healthcare (*see page H-6*).

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

- **Mastectomies**, including reconstruction of the breast upon which the mastectomy is performed, surgery and reconstruction on the other breast to produce a symmetrical appearance, breast implants, and treatment of physical complications resulting from a mastectomy, including swollen lymph glands.
- **Medical services for organ transplants** if the following rules are all met:
 - The transplant must be covered by Medicare, including meeting Medicare's clinical, facility, and provider requirements.
 - You must use any case management program recommended by the Fund or its representative.
 - You must get prior authorization for the transplant.
 - Donor expenses for your transplant are only covered if the donor has no other coverage.
 - Transplant coverage does not include your expenses if you are giving an organ instead of getting an organ.
- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- **Skilled nursing facility care**, limited to a total of 100 days per person each year.
- Professional services for **diabetes education** and training for the care, monitoring, or treatment of diabetes.

Medical benefits under the EPO

- Professional services for **nutrition counseling**.
- **Blood and blood plasma**, including administration of blood and blood plasma.
- **Oxygen**, including administration of oxygen.
- **Home healthcare services**, limited to a total of 100 visits per person each year. General housekeeping services or custodial care is not covered.
- Inpatient and outpatient **hospice** services and supplies if you are terminally ill.
- **Anesthesia**, including administration of anesthesia.
- **Durable medical equipment**, and supplies, for all non-disposable devices or items prescribed by a healthcare provider, such as wheelchairs, hospital-type beds, respirators and associated support systems, infusion pumps, home dialysis equipment, monitoring devices, home traction units, and other similar medical equipment or devices.
 - Rental fees are covered if the DME can only be rented, and the purchase price is covered if the DME can only be bought.
 - However, if DME can be either rented or bought, and if the rental fees for the course of treatment are likely to be more than the equipment's purchase price, benefits may be limited to the equipment's purchase price.
 - If DME is bought, costs for repair or maintenance are also covered.
- **Habilitative therapy** for children with autism spectrum disorder (only for treatment that begins before May 31, 2018). *You must get prior authorization for habilitative therapy before the Plan pays benefits.* Benefits are limited to 30 hours per person each week, and to a total of 36 months. "Habilitative therapy" includes applied behavioral analysis (ABA) therapy and similar types of treatment. It does not include physical, speech, or occupational therapy.
 - Your child must be at least 2 years old, but no more than 8 years old.
 - Your child must have a diagnosis of autism spectrum disorder, and have a prorated mental age of at least 11 months.
 - The provider supervising the habilitative therapy must be certified by the Behavioral Analyst Certification Board (BACB) as a Board Certified Behavior Analyst or Board Certified Behavior Analyst Doctorate (or is otherwise licensed to supervise this type of supervision).
 - The person providing the habilitative therapy must be certified by the BACB as a Board Certified Assistant Behavioral Analyst or Registered Behavioral Technician (or is otherwise licensed to provide this type of treatment).
 - Benefits will only be paid for services supplemental to any therapy for which your child is eligible through his or her school or school district. No benefits will be paid for therapy provided through the school or school district.

Medical benefits under the EPO

- ▶ The habilitative therapy and treatment plan must get prior authorization from the Fund before treatment begins. The treatment notes and treatment plan must be reviewed by the Fund at least twice a year, and must show that:
 - Your child is demonstrating improvement.
 - You are trained to, and do, participate in the habilitative therapy.
 - You follow the treatment plan.
- ▶ *No Plan benefits will be paid for a course of habilitative therapy that starts on or after June 1, 2018.*
- **Medical foods** if you have an inborn error of metabolism (IEM). *You must get prior authorization for your medical food costs before the Fund will reimburse you.* The Fund will reimburse 100% of your costs for medical foods. To be reimbursed, the medical food must be: (1) ordered by and used under the supervision of a healthcare provider; (2) the primary source of your nutrition; and (3) labeled and used for dietary management of your IEM.
- Outpatient rehabilitation services for **physical and occupational therapy**.
- Outpatient **speech therapy services**.
- **Radiation therapy**.
- **Chemotherapy and infusion** services.
- **Kidney dialysis** services.
- **Repair of sound natural teeth** and their supporting structures, if the covered expenses are the result of an injury. Treatment must be received while you are covered under the Fund. You may have additional dental coverage under your dental benefits—see the applicable dental benefit section.
- **Sterilization procedures** for employees and spouses. For female dependent children, FDA-approved sterilization procedures considered preventive healthcare (*see page H-6*) are also covered.
- **Surgical supplies and surgical dressings**, including casts, splints, and trusses.
- **Orthotics and prosthetics**.
- Treatment of **tumors, cysts and lesions** not considered a dental procedure.
- Oral surgery for the **removal of bony impacted teeth**.

Medical benefits under the EPO

Employee Assistance Program

Beacon provides an Employee Assistance Program (EAP) for you and your family. The EAP provides confidential, professional counseling, education, and referral services.

Beacon Health Options

(844) 376-8085

www.beaconhealthoptions.com

Be sure to call the EAP if you need help with things like:

- Alcohol or substance use concerns
- Balancing work and family, including:
 - Adoption
 - Adult and child care
 - Emergency dependent care
 - End of life issues
 - Health and wellness
 - Moving
 - Parenting and child development
 - Pet care
 - Retirement
- Career transitions and work-related concerns
- Financial and legal problems
- Financial coaching
- Grief or loss
- Identity theft recovery services
- Marital, family, or other relationship issues
- Mediation
- Personal growth and development
- Referral to legal services

The EAP will try to help you resolve your issues. The EAP can also refer you to live or web-based educational materials, or help you find someone to talk to if you need more help. The EAP may also be able to help you find local resources or agencies that can help you and your family.

Reimbursement for travel, lodging and meals

If you are covered under the EPO, UNITE HERE HEALTH may reimburse you for certain **travel, lodging, and meal costs**. Reimbursement may be available if you need treatment more than 50 miles away from your home (as long as you travel within the United States). *You must get prior authorization from the Fund, not from EHS, for these expenses before the Fund will reimburse you.* **Call (855) 844-5262 for help with this benefit.**

Covered expenses only include travel, lodging and meal costs related to: (1) transplants, (2) cancer-related treatments, and (3) congenital heart defect care. The following rules apply:

- The travel, lodging, and meal costs of one other person will also be covered. (Two other people will be covered if the patient is a minor child.)

Medical benefits under the EPO

- Reimbursement is limited to \$10,000 per episode of care for you and your traveling companion(s) combined. Up to \$250 each day will be reimbursed for lodging and meal costs.
- You must provide the Fund with your original receipts.
- You must participate in any case management programs required by the Fund.
- You cannot get reimbursed for expenses related to your participation in a clinical trial, or for an organ transplant if you are donating an organ instead of getting an organ.

The Fund may prearrange or prepay certain travel or lodging costs instead of requiring you to pay yourself and then file for reimbursement.

What's not covered

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

- Ambulatory surgical facility fees for procedures normally performed in a provider's office.
- Prescription drugs and medications, other than those used where they are dispensed. Prescription drugs may be covered under the prescription drug benefit shown on page C-13.
- Cosmetic, plastic, or reconstructive surgery, unless that surgery is either: (1) to treat an injury, or (2) breast reconstruction following a mastectomy.
- Services of a specialist if EHS does not approve the specialist care.
- Non-network providers, unless EHS approves the non-network care, or unless the non-network care is specifically stated as covered.
- Dental services for or in connection with routine care of the teeth and supporting oral tissues, or restorative services to replace natural teeth lost as a result of injury.

However, charges made by a hospital or other facility for dental procedures covered under the dental benefit provisions (see the dental benefits sections), will be covered if the procedure requires the patient to be treated in an institutional setting to safely receive the care. For example, if you suffer from a medical or behavioral condition, such as autism or Alzheimer's, that severely limits your ability to cooperate with the dentist providing the care, charges made by a hospital or other facility will be considered a covered expense. Benefits for other types of dental care may be covered under the dental benefit (see page C-27).

- Treatment of temporomandibular joint (TMJ) disorders, craniofacial disorders, or orthognathic disorders.
- Surgery to modify jaw relationships including, but not limited to, osteoplasty and

Medical benefits under the EPO

genioplasty procedures. However, Le Fort-type operations are covered when primarily to repair birth defects of the mouth, conditions of the mid-face (over or under development of facial features), or damage caused by injury.

- 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.
- Oral contraceptives or over-the-counter FDA-approved female contraceptive drugs, devices or supplies. These may be covered under the prescription drug benefit (*see page C-13*).
- Private duty nursing care.
- Supplies or equipment for personal hygiene, comfort or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, tanning beds, or water beds.
- Eye or hearing exams, except as specifically stated as covered, or unless the exam is for the diagnosis or treatment of an accidental bodily injury or an illness. However, eye exams may be covered under the vision benefits (*See page C-51*).
- Eye refractions, eyeglasses, or contact lenses. However, these expenses may be covered under the vision benefits (*See page C-51*).
- Hearing aids.
- Routine podiatry. Routine podiatry includes but is not limited to care of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain.
- Chiropractic treatment.

Prescription drug benefits under the EPO

Learn about your drug benefits if you chose the EPO benefit option:

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

This section only applies to you if you choose the EPO option through EHS. If you choose one of the HMO benefit options, please see the section starting on [page C-23](#) for information about your medical and prescription drug benefits.

Prescription drug benefits under the EPO

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

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

Important Phone Numbers		
If you want to:	Call:	At:
Find a network pharmacy	Hospitality Rx	(844) 484-4726
Get prior authorization for prescription drugs	Hospitality Rx	(844) 484-4726
Get a free glucometer	One Touch (LifeScan products) <i>use order number 739WDRX01</i>	(888) 883-7091
	True Test (Nipro products)	(866) 788-9618
Order from the mail-order pharmacy	WellDyneRx Home Delivery (through Hospitality Rx)	(844) 813-3860
Order from the specialty pharmacy	Walgreens Specialty Pharmacy	(877) 647-5807

What you pay

You must pay the applicable amount shown below for each fill of a prescription drug. You must also pay any expenses that are not considered covered expenses (*see page C-19* for information about excluded expenses).

Prescription Drugs under the EPO option	Your Cost for Each Fill or Refill	
	Retail <i>up to a 34-day supply</i>	Mail Order <i>up to a 60-day supply</i>
Preventive Prescription Drugs or Supplies on the Formulary (<i>see page H-6</i>), including immunizations	\$0	\$0
Generic Drugs on the Formulary	\$5	\$5
Brand Name Drugs on the Formulary	\$15	\$15
Specialty and Biosimilar Drugs on the Formulary	25% up to \$15 total copay per fill or refill	

Drugs and supplies on the formulary are safe, effective and high-quality. No benefits are paid for drugs not on the formulary unless the Fund approves the drug. Ask your healthcare provider to prescribe a drug that is on the formulary. Prescription drugs and supplies may be added to or

Prescription drug benefits under the EPO

removed from the formulary from time to time. Contact Hospitality Rx at (844) 484-4726 if you or your healthcare provider have questions about which prescription drugs and supplies are on the formulary.

If your healthcare provider wants you to take a drug that is not on the formulary, he or she should reach out to Hospitality Rx at (844) 484-4726 for a formulary exception. The formulary exception allows your healthcare provider to ask for approval for you to get coverage for a prescription drug not on the formulary. Remember, though, that the Fund will not consider a non-formulary drug for coverage until you have tried all of the formulary prescription drug alternatives that are medically appropriate to your situation.

You must use the specialty pharmacy to get specialty and biosimilar prescription drugs. *See page C-19* for more information about the specialty pharmacy.

Out-of-Pocket limit for covered network expenses

Your out-of-pocket cost sharing for most covered network prescription drug is limited to \$1,200 per person (\$2,400 per family) each calendar year. Once your out-of-pocket costs for covered network prescription drugs meet these limits, the Plan will usually pay 100% for your (or your family's) covered network prescription drugs during the rest of that calendar year. Amounts you pay out of pocket for medical covered expenses under the section titled "Medical benefits under the EPO" do **not** count toward this out-of-pocket limit.

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

Generic prescription drug policy for retail pharmacies

If you or your provider chooses a covered brand name prescription drug when you could get a generic equivalent instead, you pay the difference in cost between the brand name prescription drug and the generic equivalent. For example, if the brand name prescription drug costs \$80 at retail, and the Fund's cost for the generic equivalent is \$30, you must pay the \$50 difference. You will also have to pay the \$5 generic prescription drug copay.

The generic prescription drug policy does not apply to certain prescription drugs that need to be closely monitored, or if very small changes in the dose could be harmful. The prescription drugs that are not subject to the generic prescription drug policy change from time to time. You can get up-to-date information by calling Hospitality Rx at (844) 484-4726. This rule will also not apply if the prior authorization program makes an exception to the rule. Your healthcare provider will need to get prior approval for this exception to apply to your prescription drugs.

If you have an exception to the generic prescription drug policy, you will still have to pay the formulary brand name drug copay.

Prescription drug benefits under the EPO

What's covered

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

- Formulary FDA-approved prescription drugs which can legally be purchased only with a written prescription from a healthcare provider. This includes formulary oral and injectable contraceptives and formulary drugs mixed to order by a pharmacist, as long as at least one part of the mixed-to-order drug is a formulary FDA-approved prescription drug.
- The following formulary diabetic supplies: insulin, diabetic test strips, control solution for glucometers, disposable syringes and needles, and lancets.
- Formulary prescription and non-prescription (over-the-counter) preventive healthcare services and supplies, including immunizations.
- The following single-source formulary vitamins: ferrous sulfate, vitamin D, cyanocobalamin, vitamin K, potassium chloride, bicarbonate, phosphate, calcium acetate, niacin, and Galzin (zinc).

Free glucometers

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

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

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

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

Safety and cost containment programs for prescription drugs

The Fund provides extra protection through several safety and cost containment programs. These programs may change from time to time, and the prescription drugs or types of prescription drugs that are part of these programs may also change from time to time. You and your healthcare provider can always get the most current information by contacting Hospitality Rx at **(844) 484-4726** or visiting www.hospitalityrx.org.

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

Prescription drug benefits under the EPO

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

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

Prior authorization

If your healthcare provider prescribes certain drugs, he or she will need to give Hospitality Rx your medical records to show that the prescription drug is clinically appropriate for your medical situation. The list of prescription drugs that require prior authorization changes from time to time. Call **(844) 484-4726** for a list of drugs on the prior authorization list, or to get prior authorization for a drug.

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

Step therapy

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

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

The list of prescription drugs that require step therapy changes from time to time. Contact Hospitality Rx with questions about which prescription drugs require prior authorization.

Case management

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

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

Prescription drug benefits under the EPO

Fill and refill limits

Quantity limits

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

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

You generally cannot refill a prescription until you have used most of your prescription, but in some cases, you may be able to refill a prescription sooner than is usually allowed. For example, you may get an early refill if:

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

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

Call Hospitality Rx at (844) 484-4726 if you need an early refill of a drug.

Exceptions to the standard quantity limits

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

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

Mail-order pharmacy

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

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

WellDyneRx Home Delivery

(844) 813-3860

www.mywdrx.com

Specialty pharmacy

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

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

Walgreens Specialty Pharmacy

(877) 647-5807

What's not covered

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

- Prescription drugs that have not been approved by the FDA. However, the Fund may cover prescription drugs not approved by the FDA in certain situations. You or your healthcare professional may ask for an exception through the Fund's prior authorization program.
- Drugs or supplies not on the formulary. Your healthcare provider can ask for an exception. However, you must try all of the medically appropriate drugs on the formulary before Hospitality Rx will review a request for coverage for a non-formulary drug.
- Specialty prescription drugs, other than those used to treat HIV/AIDS, if you do not use the specialty pharmacy.

Prescription drug benefits under the EPO

- Experimental or investigational drugs.
- Fertility drugs.
- Prescriptions or refills in amounts over the quantity limits (*see page C-18*).
- Non-sedating antihistamines or histamine receptor blockers.
- Prescription drugs that have an over-the-counter equivalent or are otherwise available over-the-counter (unless the drugs or supplies are preventive healthcare—*see page H-6*). However, prescription drugs that have a higher dosage than their over-the-counter equivalents will be covered.
- Vitamins, dietary supplements, or dietary aids, except those specifically listed as a covered.
- New-to-market prescription drugs until the Fund or its representative has reviewed and approved the prescription drug.
- Any prescription drugs that are not self-administered, meaning a prescription drug that you cannot give to yourself. However, this type of prescription drug may be covered under the medical benefits.
- High-cost “me too” drugs, unless the Fund or its representative approves the drug for purchase. “Me-too” drugs usually have only very small differences in how they work, but are considered “new” drugs with no generic equivalent. Often, the manufacturer charges high prices for these drugs even though there are other drugs available that work just as well for a lower cost. You can find out if a “me too” drug is covered by contacting Hospitality Rx.
- Drugs that require review under a safety or cost containment program (such as a drug that requires prior authorization, or a drug subject to the step therapy program) if that safety or cost containment program is not followed, or does not approve the drug.
- Drugs, medications, or supplies that are not for an FDA-approved indication, that are not covered under the Plan’s or Plan’s designee’s claims processing guidelines or any other internal rule, including but not limited to any national guidelines used by the medical community.
- Glucometers, other than those the Fund gives to you for free. You may be able to get a glucometer through the medical benefits if you do not want one of the free ones, but you will usually have to pay part or all of the cost.
- Rogaine and other drugs to prevent hair loss.
- Any prescription drugs that are considered a lifestyle prescription drug. Lifestyle prescription drugs are not primarily intended to prevent, treat, or cure a disease or manage pain. Examples of lifestyle drugs include but are not limited to prescription drugs used to treat erectile dysfunction, acne, or wrinkles. The Fund or its representative determines whether a prescription drug is considered a lifestyle prescription drug.

Prescription drug benefits under the EPO

- Drugs or medications used, consumed or administered at the place where it is dispensed, other than preventive healthcare supplies. (These drugs may be covered under your medical benefits. *See page C-5.*)
- Diagnostics or biologicals.
- Drugs used for cosmetic reasons.
- Weight control drugs, unless for the treatment of morbid obesity under the direct supervision of a healthcare provider, and authorized in writing by the Fund.
- Human growth hormone, except to treat emaciation due to AIDS.
- Drugs or other covered supplies not purchased from a network pharmacy.
- Medical foods (medical foods may be covered under the medical benefit—*See page C-8.*)

C-22

HMO options

Learn about your benefits if you chose one of the HMO options:

- How your HMO option works.
- Using this SPD if you chose the HMO option.
- Getting more information if you chose one of the HMO options.

This section only applies to you if you choose one of the HMO benefit options. If you choose the EPO option through EHS, please see the sections starting on *page C-1* and *page C-13* for information about your medical and prescription drug benefits.

HMO options

Depending on how long you have been working in covered employment, you may be entitled to choose from one of the two Kaiser HMO options: either the Kaiser+ HMO option, or the Long Beach HMO option. *See page F-4* for more information about what your medical benefit options are.

If you have questions about your HMO option, how to pick a primary care provider, or have any questions about how your benefits work, contact Kaiser:

Kaiser Permanente:

www.kp.org

Member Services
(800) 464-4000

Kaiser Advice Nurse
(888) KPONCALL (576-6225)

Using your benefits if you chose one of the Kaiser HMO options

If you enroll in either of the Kaiser HMO options, 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, you will need a referral from a Kaiser provider to see most specialists. Your PCP can do this for you. 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 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.

Kaiser 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.

Using this SPD if you chose one of the Kaiser HMO options

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 evidence of coverage you get when you enroll in one of the Kaiser options will explain the rules that apply to your benefits.

Some sections of this SPD do not apply to you if you are enrolled in the Kaiser HMO option, including:

- Medical benefits under the EPO option
- Prescription drug benefits under the EPO option

If you are enrolled in either of the Kaiser HMO options, the following sections of this SPD do not apply to benefits Kaiser provides (but may apply other benefits the Plan provides):

- General exclusions and limitations
- Coordination of benefits
- Subrogation
- General claim provisions
- Definitions

Health Net HMO

Certain grandfathered employees and their dependents may also chose the Health Net HMO. The Health Net HMO is not open to employees who are not currently enrolled in this HMO option. You may move to a different medical option if you want; however, if you leave the Health Net HMO, you cannot change your mind and go back into the Health Net HMO.

Health Net:

www.healthnet.com

Member Services
(800) 400-8987

Member Services (if you are in Mexico)
(011-52-664) 683-29-02

If you are in the Health Net HMO, you can get help understanding or using your HMO benefits, including finding a network provider, by contacting Health Net:

The parts of this SPD described above that don't apply to Kaiser benefits, like the subrogation or claim and appeal sections, also don't apply to your Health Net HMO benefits.

Getting more information if you chose one of the Kaiser HMO options

The Kaiser enrollment materials will give you more information about your medical management programs, your medical and prescription drug benefits, coordination of benefits, exclusions and limitations, subrogation, and claims provisions, including how to file claim appeals. You are also entitled to a copy of the Kaiser evidence of coverage for your benefits. You can get a copy by contacting UNITE HERE HEALTH or Kaiser.

Dental benefits under the LIBERTY DHMO option

Learn about your benefits if you chose the LIBERTY DHMO:

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

*This section only applies to you if you choose the LIBERTY DHMO option.
If you choose the LIBERTY dental PPO, please see the section starting on [page C-35](#) for information
about your dental benefits. If you choose the LA Dental Center option, please see the section
starting on [page C-45](#) for information about your dental benefits.*

Dental benefits under the LIBERTY DHMO option

Retirees and their dependents are **not** eligible for dental benefits.

LIBERTY Dental provides the DHMO benefits to you and your dependents.

<i>If You Choose the LIBERTY DHMO Option</i>		
Description of Services	LIBERTY DHMO Network Dentist	Non-Network Provider
Dental Services		
Maximum Benefit Payable Each Calendar Year	n/a	Not covered *
Calendar Year Deductible	n/a	Not covered
	What You Usually Pay for Selected Dental Care <i>copays apply to certain services—see your LIBERTY DHMO charge sheet for more information</i>	
Routine Exams	\$0	Not covered
Routine X-Rays	\$0	Not covered
Routine Cleanings	\$0	Not covered
Fluoride Treatment for a Child	\$0	Not covered
Space Maintainers	\$0	Not covered
Amalgam Fillings	\$0	Not covered
Crowns	\$0	Not covered
Deep Cleaning (periodontal scaling & root planing)	\$0	Not covered
Complete Upper Denture (maxillary denture)	\$0	Not covered
Orthodontic Services		
Comprehensive Orthodontic Services	\$1,550 <i>Plan benefits limited to 24 months of treatment</i> <i>Additional copays may apply for x-rays and casts</i>	Not covered

* LIBERTY Dental will reimburse you up to \$75 per person each year for emergency dental treatment provided by a non-network provider.

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 DHMO option

Using your LIBERTY DHMO benefits

Your dental benefits are provided through a dental health maintenance organization (DHMO). Under a DHMO, you must follow certain rules in order to get dental benefits. If you don't follow these rules, you may have to pay the entire cost of the dental care yourself. If you have any questions about how to use your dental benefits, please contact LIBERTY at **(888) 442-4585**.

Except in emergencies, you must use a network dentist. If you don't use a network dentist, you will have to pay the full cost of your dental care.

If you have an emergency, such as excessive bleeding, acute infection, or severe pain, try to reach your primary dentist. Your primary dentist should handle any emergency within 24 hours. If you are outside the LIBERTY service area, or you cannot reach your primary dentist, you can go to any dentist to get treatment. (You should follow-up with your primary dentist if you go to a non-network dentist.) If you use a non-network dentist, you should file a claim with LIBERTY. LIBERTY will pay you back up to \$75 each year for your costs to get emergency treatment from a non-network dentist. You will still be responsible for: any copays for your care, charges in excess of the \$75 maximum reimbursement, and any charges that LIBERTY does not cover.

You can always get a second opinion regarding proposed dental care. Just contact LIBERTY to get a referral to another dentist.

Your primary dentist

You must pick a primary dentist to provide your and your whole family's dental care. Your primary dentist will also refer you to a specialist, if necessary. Benefits will only be paid for a specialist if LIBERTY has approved the specialist care. The only exception is that you don't need a referral to see a network orthodontist.

You can change your primary dentist any time you want (as long as you don't have an outstanding bill from your current dentist), and as often as you want. However, you must wait to see your new primary dentist until LIBERTY has processed your request to change primary dentists. Usually, if you request a change by the 20th of the month, the change will be effective by the first day of the next month. LIBERTY can tell you whether your change in primary dentists has been made.

You can log in to www.libertydentalplan.com or contact LIBERTY at **(888) 442-4585** to choose a primary dentist or to change a primary dentist.

Dental benefits under the LIBERTY DHMO option

What you pay

You pay any required copay for your dental care (these are listed in LIBERTY's schedule of benefits booklet). If you need a copy of your schedule of benefits, contact LIBERTY or UNITE HERE HEALTH.

Many types of routine dental care, such as routine exams, cleanings, and x-rays, have no copays. Copays may apply to other types of dental care.

You also have to pay for any dental care that isn't covered, including dental care you get more often than is covered.

What's covered under the LIBERTY DHMO

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

LIBERTY's benefit schedule and certificates of coverage contain more specific information about the circumstances under which dental care is covered.

- **Diagnostic and preventive services and procedures**, including but not limited to exams and cleanings.
 - Routine cleanings (prophylaxis), limited to once every six consecutive months. Additional cleanings may be permitted under certain circumstances; you will usually pay a copay for each additional approved cleaning.
 - Complete series of x-rays (full-mouth) or panoramic films, limited to one set every 36 consecutive months.
 - Topical application of fluoride, limited to once every six consecutive months.
 - Sealants for children under age 14, limited to once per tooth every 36 consecutive months. Sealants are covered only for first and second permanent molars, and only if the tooth has no cavities (caries).
- **Emergency palliative care** to temporarily relieve pain and discomfort.
- **Diagnostic x-rays** to diagnose a specific condition.
- **Restorative services**, including but not limited to inlays, onlays, crowns, and labial veneers.
 - Fabricated crowns, onlays, and inlays may be covered when a tooth with a good prognosis needs to be restored but there isn't enough of the tooth left to retain a filling. These services will only be covered if you are 16 or older.

Dental benefits under the LIBERTY DHMO option

- ▶ Replacement of crowns and labial veneers are limited to once every five consecutive years.
- **Endodontic services and procedures** to treat teeth with diseased or damaged nerves, including but not limited to pulp caps, pulpal therapy, root canals, apicoectomy, or endodontic therapy.
- **Periodontic services** to treat diseases of the gums and supporting structures of the teeth, including but not limited to gingivectomy or gingivoplasty, clinical crown lengthening, osseous surgery, grafts, and splinting.
 - ▶ Deep cleaning (periodontal scaling and root planing) is limited to once every 24 consecutive months.
 - ▶ Periodontal scaling and root planing is limited to two quadrants for each appointment per day.
 - ▶ Surgical periodontal services are limited to once in a 36-month period.
 - ▶ Full mouth debridement to remove extensive plaque and tartar is limited to once in a 24-month period.
- **Prosthodontics**, including but not limited to dentures and tissue conditioning, and repairs to prosthodontics (such as relining and rebasing).
 - ▶ Fixed partial dentures are covered when replacing a “like-for-like” fixed partial denture with identical pontics and abutment teeth.
 - ▶ Replacement of a full or partial denture is covered once per arch every 5 years, but only if the denture can’t be made to work through relining or repair.
 - ▶ Denture relining is limited to once every 12 consecutive months.
 - ▶ Replacement of crowns, labial veneers, or fixed partial dentures is limited to one unit every five-year period.
- **Oral surgery**, extractions and other surgical procedures, including pre-operative and post-operative care, and general anesthesia. No coverage is provided if you are under age 15.
- **Orthodontic treatment**, limited to 24 months of active treatment, plus a further 24 months of office visits to maintain the active treatment.

What's not covered under the LIBERTY DHMO

The following types of treatments, services, and supplies are not covered.

- Services or supplies provided by a non-network dentist without LIBERTY's prior approval, except in the case of an emergency.
- Procedures that are not dentally necessary in accordance with professionally recognized standards of dental practice.
- Procedures performed on natural teeth solely to increase vertical dimension or restore occlusion.
- Services or supplies provided by a specialist if your primary dentist has not referred the specialist, or if LIBERTY has not approved the specialist.
- Services or supplies provided outside your primary dentist's office, except in the case of an emergency.
- Services not covered under the terms of LIBERTY's contract.
- Procedures that have a poor prognosis, as determined by LIBERTY.
- Services or supplies provided more frequently than allowed.
- Treatment started prior to coverage, or after termination of coverage, unless allowed by LIBERTY.
- Cosmetic services, or services for conditions due to hereditary developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth, and teeth that are discolored or lacking enamel.
- General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist unless specifically covered by LIBERTY.
- Procedures, appliances, or restorations to treat temporomandibular joint (TMJ) dysfunctions, congenital or developmental situations, or medically induced dental disorders, including but not limited to myofunctional treatment, or myoskeletal dysfunctions, unless covered as an orthodontic benefit.
- Removal of asymptomatic, unerupted teeth, including third molars, that appear to have an unimpeded pathway to eruption and no active pathology.
- Procedures or appliances that are provided by a dentist who specializes in prosthodontic services.
- Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding occlusion or maintaining chewing surfaces, for teeth that are out of alignment, or for stabilizing teeth.

Dental benefits under the LIBERTY DHMO option

- Any routine dental services performed by a dentist or dental specialist in an inpatient or outpatient hospital setting.
- Consultations for non-covered services.
- With respect to orthodontic treatment, any of the following:
 - Replacement of lost, stolen, or broken orthodontic appliances.
 - Extractions for orthodontic purposes. However, this exclusion does not apply to extractions consistent with professionally recognized standards of dental practice or that arise in the context of an emergency dental condition.
 - Surgical orthodontics for TMJ syndrome.
 - Myofunctional therapy.
 - Treatment of cleft palate, micrognathia, or macroglossia.
 - Changes in orthodontic treatment caused by an accident of any kind.
- Treatment started before you become eligible for dental benefits.
- The replacement of an amalgam or resin restoration less than 12 months after the same contracted dentist or office performed the original restoration.
- Replacement of lost or stolen prosthetics or appliances, including orthodontics, partial dentures, full dentures, and orthodontic appliances.

Dental benefits under the LIBERTY DHMO after eligibility ends

Benefits will only be paid for covered services and supplies incurred before your coverage ends. However, benefits will continue to be paid for root canals, crowns, or dentures started before your coverage ends as long as treatment is completed within 60 days of the date you lose coverage.

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

Contract with LIBERTY governs your DHMO benefits

The contract between UNITE HERE HEALTH and LIBERTY determines what your benefits are. If there is any conflict between any information the Plan prepares (such as your SPD) and the contract, the terms of the LIBERTY contract govern. The parts of your SPD that talk about coordination of benefits, subrogation, general exclusions and limitations, claim filing and appeal provisions, and definitions do not apply to the DHMO benefits provided by LIBERTY.

Dental benefits under the LIBERTY DHMO option

You generally don't need to file a claim for dental care. If you do need to file a claim for dental care (which will usually only happen if you need emergency treatment), you can get a claim form from LIBERTY by calling **(888) 442-4585** or visiting www.libertydentalplan.com. You will need to provide all the information LIBERTY needs to process the claim.

Contact LIBERTY if you need a copy of the evidence of coverage, or if you need more information about LIBERTY, including more information about claim filing, processing, or appeal procedures.

C

Dental benefits under the LIBERTY dental PPO option

Learn about your benefits if you chose the LIBERTY dental PPO:

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

This section only applies to you if you choose the LIBERTY dental PPO option. If you choose the LIBERTY DHMO, please see the section starting on [page C-27](#) for information about your dental benefits. If you choose the LA Dental Center option, please see the section starting on [page C-45](#) for information about your dental benefits.

Dental benefits under the LIBERTY dental PPO option

Retirees and their dependents are **not** eligible for dental benefits.

LIBERTY Dental administers the dental PPO benefits for you and your dependents.

<i>If You Choose the LIBERTY Dental PPO Option</i>		
Description of Services	LIBERTY Dental PPO Provider	Non-Network Provider
Dental Services		
Maximum Benefit Payable Each Calendar Year	\$1,500/person	
Calendar Year Deductible	\$50/person & \$150/family	
What You Pay for Dental Care		
Diagnostic & Preventive Services	\$0 (no deductible)	30% (no deductible)
Emergency Services— <i>including to treat severe pain</i>	\$0 (no deductible)	30% (no deductible)
Diagnostic X-ray Services	\$0 (no deductible)	30% (no deductible)
Minor Restorative Services	20%, after deductible	40%, after deductible
Periodontic Services	20%, after deductible	40%, after deductible
Endodontic Services	20%, after deductible	40%, after deductible
Oral Surgery	20%, after deductible	40%, after deductible
Major Restorative Services	50%, after deductible	60%, after deductible
Prosthodontic Services & Repairs	50%, after deductible	60%, after deductible
Orthodontic Services		
Orthodontic Services	50% (no deductible) <i>Plan benefits limited to a lifetime maximum of \$2,500/person</i>	

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

Dental benefits under the LIBERTY dental PPO option

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 or 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.

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

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.

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:

Dental benefits under the LIBERTY dental PPO option

- 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.

- **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. Panoramic x-rays (including bitewings) are considered a full mouth x-ray.
 - Topical application of fluoride if you are under age 19—once 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).

Dental benefits under the LIBERTY dental PPO option

- ▶ 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 benefit 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 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 four surfaces are limited to the benefits provided for amalgam or resin restorations.
- **Prosthetic 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 six 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.

Dental benefits under the LIBERTY dental PPO option

- ▶ 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.

Dental benefits under the LIBERTY dental PPO option

- 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 six 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.

Dental benefits under the LIBERTY dental PPO option

- 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 by the Plan.

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. However, if your coverage ends after your treatment starts for root canals, crowns, and dentures, the Plan continues to pay benefits for these, as long as treatment is completed within 60 days of your loss of coverage.

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

C-44

LA Dental Center benefits

Learn about your benefits if you chose the LA Dental Center:

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

This section only applies to you if you choose the LA Dental Center dental option. If you choose the LIBERTY DHMO option, please see the section starting on [page C-27](#) for information about your dental benefits. If you choose the LIBERTY dental PPO option, please see the section starting on [page C-45](#) for information about your dental benefits.

LA Dental Center benefits

Retirees and their dependents are **not** eligible for dental benefits.

UNITE HERE HEALTH operates the LA Dental Center out of the UNITE HERE HEALTH Los Angeles regional office. Under this option, your dental care is only covered if you use the LA Dental Center, unless the LA Dental Center refers you to another dentist.

LA Dental Center
130 S. Alvarado St.
Los Angeles, CA 90057
(213) 484-9660

In case of a true dental emergency:

(800) 436-3702

*For all other calls, please wait for office hours,
or leave a voicemail message on the main phone number.*

If you are outside the LA Dental Center's service area and you have an emergency, contact the LA Dental Center for instructions.

<i>If You Choose the LA Dental Center Option</i>		
Description of Services	LA Dental Center	Care Not Provided at the LA Dental Center
Dental Services Only		
Maximum Benefit Payable Each Calendar Year	n/a	Not covered
Calendar Year Deductible	n/a	Not covered
What You Pay for Dental Care		
Diagnostic & Preventive Services	\$0	Not covered
Emergency Services— <i>including to treat severe pain</i>	\$0	Not covered
Diagnostic X-ray Services	\$0	Not covered
Minor Restorative Services	10%	Not covered
Periodontic Services	10%	Not covered
Endodontic Services	10%	Not covered
Major Restorative Services	15%	Not covered
Oral Surgery	15%	Not covered
Prosthodontic Services & Repairs	15%	Not covered

You usually will have to pay your share of the dental cost at the end of your visit. However, services requiring laboratory work (such as dentures, bridges, crowns, etc.) must be paid in advance of the final appointment and delivery. Future appointments may not be made if your account has an unpaid balance.

If you schedule a dental appointment for a procedure(s) expected to last 90 minutes or more, you will need to make a \$50 non-refundable advance deposit. This deposit will be credited to your costs for the procedure(s). However, if you do not call the LA Dental Center at least 24 hours before your appointment to reschedule or cancel, the \$50 deposit will not be refunded. You will have to pay a new \$50 deposit when you re-schedule the appointment.

A \$25 missed appointment fee applies to any missed scheduled appointment unless you call the LA Dental Center at least 24 hours before your appointment.

The LA Dental Center performs certain dental treatments that are not considered covered expenses, such as implants or cosmetic procedures, at discounted fees. If you choose treatment that is not covered, you are responsible for the entire cost.

What's covered

Covered expenses mean the allowable charges made by the LA Dental Center for the following services and supplies, if determined by the LA Dental Center to be based on a valid dental need and performed according to accepted standards of dental practice:

- **Diagnostic and preventive services:** services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease, including examinations, routine cleanings and consultations with a non-treating dentist.
- **Emergency palliative treatment:** nonspecific treatment by a dentist to temporarily relieve pain and discomfort.
- **Radiographs:** x-rays as required or as part of the diagnosis of a specific condition.
- **Oral surgery services:** extractions and other surgical dental procedure, including preoperative and post-operative care, and general anesthesia.
- **Endodontic services:** services and procedures for the treatment of teeth with diseased or damaged nerves (for example, root canals).
- **Periodontic services:** services and procedures for the treatment of diseases of the gums and supporting structures of the teeth.
- **Restorative services:** services and procedures to rebuild, repair, or reform the tissues of the teeth, including but not limited to:
 - Minor restorative services: amalgam or resin restorations.
 - Major restorative services: crowns and restorations involving gold when the teeth cannot be restored with another filling.
- **Prosthodontic services:** services and appliances that replace missing natural teeth, including bridges, partial dentures, and complete dentures.
- **Prosthodontic repairs:** repairs and relines to prosthetic appliances.

What's not covered

In addition to the Plan's general exclusions and limitations shown in your SPD, no benefits are provided for the following, unless the LA Dental Center deems such care to be necessary and appropriate:

- Services and supplies provided outside of the LA Dental Center, unless such services or supplies are provided in accordance with a referral made by the LA Dental Center.
- Space maintainers unless used as a passive appliance due to the loss of primary teeth.
- Repair of space maintainers, or recementing by the same office within six months of initial placement.
- Pulpal therapy on non-vital deciduous teeth.
- Replacement of a cast restoration within 60 months after initial placement of an existing restoration.
- Crown buildup when there is radiographic evidence of sufficient vertical height to support a cast restoration.
- Repair of cast restorations.
- Periodontal surgery or therapy in the absence of radiographic evidence of bone loss.
- Replacement or repair of an existing prosthodontic appliance within 60 months after initial placement or repair.
- Implants.
- Prosthodontic appliances connected to implants.
- Services for injuries or conditions compensable 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.

- Services of anesthetists or anesthesiologists.
- Services performed on primary teeth when loss is imminent.
- Major oral maxillofacial surgery.
- Charges for completion of forms.
- Sealants for persons age 16 or older.
- Orthodontic services.
- 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.
 - That are experimental or investigational in nature.
 - That are otherwise limited or excluded according to the processing procedures developed by the LA Dental Center.
- 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 anyone other than a healthcare professional, except for the scaling or cleaning of teeth and topical application of fluoride by a licensed dental hygienist (or other licensed provider) under the supervision and guidance of a dentist in accordance with generally accepted dental standards.
- Services performed as a component of another procedure.
- Services and supplies covered under a medical HMO.
- Placement of an additional appliance in the same dental arch less than 60 months following placement of the initial appliance.

LA Dental Center benefits

Pre-estimate of dental needs

Before any treatment other than cleanings and x-rays is performed, the LA Dental Center will provide an estimate of your dental needs, including a written estimate of the cost of the proposed dental treatment and your approximate share of the cost.

Dental benefits after eligibility ends

If coverage ends because of the loss of eligibility for reasons other than termination of UNITE HERE HEALTH, benefits will only be determined for allowable charges incurred for covered expenses before coverage ends. However, if coverage ends after covered treatment begins for crowns, jackets, bridges, complete dentures, or partial dentures, benefits for the completion of that treatment will be paid, provided the treatment is completed within 60 days of the date coverage ends.

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

Vision benefits

Learn:

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

Vision benefits

Retirees and their dependents are **not** eligible for vision benefits.

UnitedHealthcare provides your vision benefits through a fully insured contract with UNITE HERE HEALTH. You get vision benefits through UnitedHealthcare regardless of which medical benefit option you choose. If there are any conflicts between the UnitedHealthcare insurance contract and the plan documents, the contract shall govern.

The sections of this SPD titled “General Plan Exclusions”, “Subrogation”, and “Coordination of Benefits” do not apply to vision benefits you get through UnitedHealthcare.

What You Pay for Your Vision Care Benefits

Description of Services <i>Covered once every 24 months</i>	UnitedHealthcare Provider	Non-Network Provider
Exam	\$15 copay	\$0 copay Plan benefits limited to \$40
Lenses	\$10 copay Plan benefits limited to \$130 for frames (lenses are covered in full)	\$0 copay Plan benefits limited to: \$40 for single vision lenses \$60 for bifocal lenses \$80 for trifocal lenses \$125 for lenticular lenses
Frames		\$0 copay Plan benefits limited to \$45
Elective Contact Lenses (instead of glasses)	\$10 copay Plan benefits limited to \$105 for non-standard contacts like toric and gas permeable lenses (copay does not apply to non- standard contacts)	\$0 copay Plan benefits limited to \$105
Medically Necessary Contact Lenses	\$10 copay	\$0 copay Plan benefits limited to \$210

Services are covered once every 24 months, regardless of whether you use a network or a non-network provider.

Network and non-network vision providers

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

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 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 will be covered 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.
- Medically necessary contacts, with prior authorization from UnitedHealthcare.

What's not covered

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

- The fitting or evaluation of contact lenses if you use a non-network provider.
- Non-prescription lenses.
- Any type of lenses, frames, services, supplies, or options that are not specifically listed as covered, or that are not specified as covered under the contract with UnitedHealthcare.
- Services not actually performed.
- Two or more pairs of glasses during the same 24-month period instead of bifocals or trifocals.
- Contacts and eyeglasses during the same 24-month period.
- Replacement or repair of lost or broken lenses or frames before the beginning of a 24-month benefit period.
- Low vision services.
- Exams or eyewear required for employment.
- Medical/surgical treatment for eye disease.
- Missed appointment charges.
- Services or supplies that are cosmetic, other than elective contact lenses.
- Orthoptics or vision training.
- Malign or congenital malformations of the eye.

Life and AD&D benefits

Learn:

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

Life and AD&D benefits

Life and AD&D benefits are for employees only. Dependents of active employees, and retirees and their dependents, are not eligible for life and AD&D benefits.

You, the employee, must be enrolled in medical benefits under Plan Unit 278 in order to be eligible for the life and AD&D benefits.

Event	Benefit	Who Receives
Life Insurance	\$1,000	Your beneficiary
Accidental Death & Dismemberment Insurance (<i>full amount</i>)	\$1,000	You (or your beneficiary if you die)

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

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

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

Life insurance benefit

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

Continuation if you become totally disabled

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

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

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

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

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

Converting to individual life insurance coverage

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

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

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

Accidental death & dismemberment insurance benefit

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

Your AD&D Benefit for a loss (death or dismemberment) within 365 days of an accident		
Event	Benefit	Who Receives
Death	\$1,000	Your beneficiary
Loss of both hands or feet	\$1,000	You
Loss of sight in both eyes	\$1,000	You
Loss of one hand and one foot	\$1,000	You
Loss of one hand and sight in one eye	\$1,000	You
Loss of one hand or one foot	\$500	You

Life and AD&D benefits

Your AD&D Benefit for a loss (death or dismemberment) within 365 days of an accident

Loss of the sight in one eye	\$500	You
Loss of index finger and thumb on same hand	\$250	You

AD&D exclusions

AD&D benefits do not cover losses caused by:

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

See your certificate for complete details.

Additional accidental death & dismemberment insurance benefits

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

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

death and an air bag deployed, your additional AD&D coverage pays a benefit equal to 5% of the amount of your life insurance benefit, with a minimum benefit of \$1,000 and a maximum benefit of \$5,000. If it is not clear that the air bag deployed, your additional AD&D coverage will only pay a benefit of \$1,000.

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

Naming a beneficiary

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

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

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

Additional services

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

- **Beneficiary Resource Services**—Beneficiary Resource Services is available to beneficiaries of an insured person who dies, and to participants who qualify for the terminal illness benefit. The program combines grief and financial counseling, funeral planning, and legal support provided by Bensinger, DuPont & Associates, a nationwide organization utilizing qualified and accessible grief counselors and legal and financial consultants. Services are provided via telephone, face-to-face contact, and referrals to local support resources. Free online will preparation is also included. Call **(800) 769-9187** for more information or go to www.beneficiaryresource.com and enter the username: Dearborn National.
- **Travel Resource Services**—Europ Assistance USA, Inc. provides 24-hour emergency medical and related services for short-term travel more than 100 miles from home.

Life and AD&D benefits

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

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

C

General exclusions and limitations

Learn:

- The types of care not covered by the plan.

General exclusions and limitations

Each specific benefit section has a list of the types of treatment, services, and supplies that are not covered. In addition to those lists, the following types of treatment, services and supplies are also excluded for all medical care under the EPO benefit, prescription drugs under the EPO benefit, dental care under the LIBERTY dental PPO, and dental care under the LA Dental Center benefit. No benefits will be paid under this Plan for charges incurred for or resulting from any of the following:

- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a healthcare provider.
- Any injury, sickness, or dental or vision treatment which arises out of or in the course of any occupation or employment, or for which you have gotten or are entitled to get benefits under a workers' compensation or occupational disease law, whether or not you have applied or been approved for such benefits.
- Any treatment, services, or supplies:
 - For which no charge is made.
 - For which you, your spouse or your child is not required to pay.
 - Which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish, or municipal hospital when there is no legal requirement to pay for such treatment, services, or supplies.
- Any charge which is more than the Plan's allowable charge (*see page H-2*).
- Treatment, services, or supplies not recommended or approved by your healthcare provider, or not medically necessary in treating the injury or sickness as defined by UNITE HERE HEALTH (*see page H-5*).
- Experimental treatment (*see page H-4*), or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH.
- Any treatment, service, or supply that is denied or not covered because prior authorization was not obtained when prior authorization is required as a condition of coverage.
- Preventive care, unless specifically considered preventive healthcare (*See page H-6*), 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

General exclusions and limitations

D

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.
- Any treatment, services, or supplies for or in connection with the child of your dependent child, unless such child meets the definition of a dependent (*see page F-2*).
- Sex transformation for any reason.
- Home construction for any reason.
- Treatment for or in connection with infertility, other than for diagnostic services, including but not limited to in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and fertility drugs and medications of any kind.
- 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, nutrition counseling, or preventive healthcare services).
- Any smoking cessation treatment, drug, or device to help you stop smoking or using tobacco, other than preventive healthcare services.
- 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.
- Massage therapy, rolfing, acupressure, or biofeedback training.
- Naturopathy or naprapathy.

D-3

General exclusions and limitations

- 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.
- 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 any maximum benefit, or any expense incurred before eligibility for coverage begins or after eligibility terminates, unless specifically provided for under this Plan.
- Charges or claims incurred as a result, in whole or in part, of fraud, false information, or misrepresentation.

Coordination of benefits under the EPO medical option

Learn:

- How benefits are paid if you are covered under the EPO medical option and you are covered under other plan(s).

Coordination of benefits under the EPO medical option

These coordination of benefits provisions only apply to medical benefits under the EPO benefit option. If you have questions about how your benefits are coordinated, contact the Fund.

No coordination of benefits applies to prescription drug benefits under the EPO benefit option, to any benefits provided through an HMO, to any dental benefits, or to the vision benefits.

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

This Plan coordinates benefits with the following types of plans:

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

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

Which plan pays first

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

Order of payment

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

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

Coordination of benefits under the EPO medical option

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

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

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

COB and prior authorization

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

Coordination of benefits under the EPO medical option

Special rules for Medicare

The Plan pays secondary to Medicare for non-active employees and their dependents who are Medicare-eligible, whether or not they enroll in Medicare. The Plan won't pay amounts that could have been paid by Medicare.

For example, if you have retiree or COBRA coverage, and you fail to enroll in both Medicare Part A (Hospital Benefits) and Part B (Doctor's Benefits) when you are 65, you will have to pay 100% of the costs that Medicare would have paid.

For the first 30 months you or your dependent are eligible for Medicare because of end stage renal disease (ESRD), the Plan pays primary. After that, the Plan pays secondary, whether or not the individual with ESRD has enrolled in Medicare. This means individuals with ESRD should enroll in Medicare.

If the Fund is secondary to Medicare

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

If you and your spouse are both employees under this Plan

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

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

Subrogation

Learn:

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

Subrogation

This section does not apply to benefits provided under any HMO (either medical HMO or dental HMO), to the dental PPO benefits, or to 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 medical expenses as a result of an accident or act for which someone other than UNITE HERE HEALTH is financially responsible. For benefit repayment purposes, "subrogation" means that UNITE HERE HEALTH, or an entity acting on behalf of UNITE HERE HEALTH, takes over the same legal rights to collect money damages that a participant had.

Typical examples include injuries sustained:

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

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

Agreement to repay benefits

In order to determine benefits for an injury caused by another party, you may be required to submit additional information or complete additional forms even if benefits have already been paid on your behalf.

If you decide to pursue legal action or file a claim in connection with the accident, you and your attorney (if one is retained) may also be required to agree to help the Plan enforce its right to be repaid and give 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.

You and your attorney may also be required to allow 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, or the entity performing subrogation on its behalf, to obtain the total amount of medical bills paid. Upon settlement, UNITE HERE HEALTH is entitled to reimbursement for the amount of the benefits it has paid or the full amount of the settlement or other recovery you or a dependent receive, whatever is less.

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

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

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:

EHS Medical Group
1600 Corporate Center Drive
Monterey Park, CA 91754

Eligibility for coverage

Learn:

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

Eligibility for coverage

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

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

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

Who is eligible for coverage

Employees

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

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

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

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

Dependents

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

You can add dependents after your coverage starts. See "Dependent coverage" starting **on page F-8** for more information.

Who your dependents are

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

- Your legal spouse.
- *If and only if you are enrolled in one of the HMO options, 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.

If you enroll a domestic partner, you will have to pay any federal, state, or local taxes owed on the value of the domestic partner benefits to UNITE HERE HEALTH on a quarterly basis. Contact UNITE HERE HEALTH with questions about covering domestic partners.

- 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.

Eligibility for coverage

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.

Choice of benefit options

UNITE HERE HEALTH offers different benefit options for medical benefits and prescription drug coverage. Your medical and prescription drug benefit options are based on when you were hired, and how long you have been reported to UNITE HERE HEALTH. Your employee contribution (EC payment), if any, is based on which benefit option you choose and the terms of your CBA. You can also choose between any of the dental benefits options.

If you choose to enroll, you must enroll in all coverages. You can't choose medical but not vision, for example.

Your enrolled dependents will automatically be covered under the same medical and dental benefits options you select. If you and your spouse are both employees, you must choose the same medical and dental benefits options.

In some cases you may be allowed to waive coverage if you have other medical coverage. Please contact UNITE HERE HEALTH for more information, including information about when your coverage would begin if you elect to enroll after waiving coverage.

Medical Options (including prescription drug coverage)

If you were hired before April 1, 2017

You can choose between:

- The EHS EPO option (*see page C-1* for more information). No EC payment applies.
- The Long Beach Kaiser HMO (*see page C-23* for more information). No EC payment applies unless your CBA requires a payment.

Certain grandfathered employees and their dependents may also choose to stay in the Health Net HMO. The Health Net HMO is not open to employees who are not currently enrolled in this HMO option. You may move to a different medical option if you want; however, if you leave the Health Net HMO, you cannot change your mind and go back into the Health Net HMO.

If you were hired on or after April 1, 2017

- **For the first 2 years, you get:**
 - The EHS EPO option (*see page C-1* for more information). No EC payment applies.
- **For the next 3 years, you can choose either:**
 - The EHS EPO option (*see page C-1* for more information). No EC payment applies.
 - The Kaiser+ HMO option (*see page C-23* for more information). A \$50 monthly EC payment applies.
- **After 5 years, you can choose either:**
 - The EHS EPO option (*see page C-1* for more information). No EC payment applies.
 - The Long Beach Kaiser HMO (*see page C-23* for more information). No EC payment applies, unless your CBA requires a payment.

Dental Options

Regardless of your medical and prescription drug coverage, you can choose between any of the dental benefit options. Your choice of dental benefit options does not affect the amount of your EC payment.

- LIBERTY dental health maintenance organization (DHMO). *See page C-27* for more information about the LIBERTY DHMO.
- LIBERTY dental preferred provider organization (dental PPO). *See page C-35* for more information about the LIBERTY dental PPO.
- LA Dental Center. *See page C-45* for more information about the LA Dental Center.

Vision benefits

Regardless of your medical option or dental option choices, you and your enrolled dependents will also be eligible for the vision benefits. *See page C-52* for more information about your vision benefits.

Enrollment requirements

Employees

Once you become eligible, you must fill out and submit an enrollment form before the Plan pays benefits for you. If you don't enroll, you are considered to have waived your coverage. You can enroll later. Your coverage will begin on the first day of the coverage period following the coverage period during which the Fund gets your enrollment materials. For example, if you submit your enrollment materials on August 15, your coverage will start on September 1.

Dependents

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

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

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

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

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.

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

When your coverage begins (initial eligibility)

Your coverage begins at 12:01 a.m. on the coverage period corresponding to the work period for which contributions are required on your behalf. You must also make any required payments for your share of your coverage.

For purposes of establishing initial eligibility:

Work period means the three-calendar-month period for which your employer must make contributions to UNITE HERE HEALTH on your behalf, and you make any required EC payment. You must meet the eligibility requirements each month of the work period.

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

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

Example: Establishing Initial Eligibility

Work Period	Lag Period	Coverage Period
July, August, September	October	November, December

Suppose you work the required hours during each of July, August, and September. Your employer must make contributions on your behalf for each of these three months. Your coverage begins November 1, and continues through December 31.

The number of hours you must work depends on whether your employer is a hotel or not.

- If your employer is in the hotel industry, you must work 90 hours each month.
- If your employer is not in the hotel industry, you must work 80 hours each month.

If you work for both an employer in the hotel industry and an employer which is not in the hotel industry, your eligibility requirements will be based on the employer for which you worked the most hours. For example, if you work 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 worked 90 hours each month, meeting the 90-hour rule that applies to employers in the hotel industry.

Eligibility for coverage

Continuing eligibility

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

For purposes of establishing initial eligibility:

Work period means the calendar month for which your employer must make contributions to UNITE HERE HEALTH on your behalf, and you make any required EC payment. You must meet the eligibility requirements during the work period.

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

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

Example - Continuing Eligibility		
Work Month	Employer Contribution Due	Coverage Period
October	November, December	January
November	December, January	February
December	January, February	March

You have already become eligible. Suppose your employer is required to contribute on your behalf for October. If a contribution is made, your coverage continues during January. A contribution for November continues your coverage for February, December will continue your coverage for March, and so on.

The number of hours you must work depends on whether your employer is a hotel or not.

- If your employer is in the hotel industry, you must work 90 hours each month.
- If your employer is not in the hotel industry, you must work 80 hours each month.

If you work for both an employer in the hotel industry and an employer which is not in the hotel industry, your eligibility requirements will be based on the employer for which you worked the most hours. For example, if you work 60 hours during October for an employer in the hotel industry, and 30 hours during October for an employer which is not in the hotel industry, you will be considered to work for the employer in the hotel industry during the month of October. You will continue your eligibility during the January coverage period because you met the 90-hour rule that applies to employers in the hotel industry.

Dependent coverage

Dependent coverage cannot start before your coverage starts. Dependent coverage cannot continue after your coverage ends. There is no cost to you to cover your dependents.

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

Once you are enrolled, you can enroll an existing dependent any time. The dependent's coverage will start the first day of the coverage period during which UNITE HERE HEALTH receives the completed enrollment form. For example, if your child's enrollment form is received on October 10, your child will become eligible on October 1. (*See page F-10* for the special enrollment rules for adding a *new* dependent.)

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

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 the remodeling or restoration is finished. However, you may only make self-payments for up to 18 months from the date your workplace began remodeling or restoration.

Self-payments during a strike

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

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

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

Vacation Hours

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

- Vacation hours can only be used in blocks of 8 hours.
- Vacation hours can not be used to continue eligibility during coverage periods before the hours were earned.

Eligibility for coverage

- You will lose any vacation hours that are not used within 12 months.

Contact UNITE HERE HEALTH with questions about vacation hours.

Enrollment periods

Open enrollment periods

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

Special enrollment periods

In a few special circumstances, you do not need to wait for the open enrollment period to change your benefit options, and special rules apply to adding new dependents. You qualify for a special enrollment period by contacting the Fund within 60 days after any of the following events:

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

If you get married, or the other coverage terminates (including coverage for Medicaid or CHIP plan), or you or a dependent become eligible for state financial assistance under a Medicaid or CHIP, coverage for your new dependent begins the first day of the month following that date.

If a child is born, if you adopt a child, if a child is placed with you for adoption, or if a dependent comes to the United States to take up residence with you, coverage for your new dependent begins the date the person meets the definition of a dependent, or the date the person comes to the United States to take up residence with you.

If you change your benefit options during a special enrollment period, contact UHH for help understanding when your coverage under the new benefit option will start. If you do not notify the Fund within 60 days of a special enrollment period, you will have to wait until the next open enrollment or special enrollment period to change your benefit options.

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. The medical benefits offered to retired employees are the same medical benefits as offered to active employees. 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 benefits. The Trustees have the right to change, modify or terminate benefits for retirees, or to add, change or eliminate retiree contributions towards the cost of coverage.

Termination of coverage

Learn:

- When your coverage and your dependents' coverage ends.

Termination of coverage

Your and your dependents' coverage continues as long as you maintain your eligibility as described *on page F-8*. However, your coverage ends if one of the events described below happens. If your coverage terminates, you may be eligible to make self-payments to continue your coverage (called COBRA continuation coverage). *See page F-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 for which you were last credited with the minimum work requirements requiring your employer to make contributions on your behalf during the corresponding work period. *Meeting "minimum work requirements" includes paying your share of the cost of 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.

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 first day of the month in which your dependent no longer meets the Plan's definition of a dependent (*see page F-2*).

The effect of severely delinquent employer contributions

The Trustees may terminate eligibility for employees of an employer whose contributions to the Fund are severely delinquent. Coverage for affected employees will terminate as of the last day of

the coverage period corresponding to the last work period for which the Fund grants eligibility by processing the employer's work report. The work report reflects an employee's work history, which allows the Fund to determine his or her eligibility.

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

Special termination rules

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

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

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

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

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

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

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

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

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

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

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.

Reestablishing eligibility

Portability

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

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

Family and Medical Leave Act (FMLA)

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

If you are making monthly employee contributions for your coverage when your FMLA leave starts, you can continue your coverage during your leave by making any required payments to your employer. If you stop making payments, your coverage under the Plan will end. However, your coverage will start again on the first day of the month for which your employer must make a contribution on your behalf after you return to work, provided you make your monthly EC payment as soon as you return to work.

The effect of uniformed service

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

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

Reestablishing eligibility

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

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

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

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

If your dependents lose eligibility due to your leave of absence governed by the Uniformed Services Employment and Reemployment Rights Act (USERRA), your dependents' coverage will be reinstated at the same time your coverage starts again.

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 ([page F-8](#)). If your loss of eligibility lasts for 12 or more months you must again satisfy the Plan's initial eligibility rules.

Reestablishing eligibility for dependents

For losses of eligibility for reasons other than termination of employment, your dependents' coverage will be reestablished when your (the employee's) coverage is reestablished.

COBRA continuation coverage

Learn:

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

COBRA continuation coverage

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

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

Who can elect COBRA continuation coverage?

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

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

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

What is a qualifying event?

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

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

What coverage can be continued?

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

How long can coverage be continued?

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

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

However, you may be able to continue coverage for yourself and your dependents for up to an additional 11 months, for a total of 29 months. The Social Security Administration must determine that you or a covered dependent are disabled according to the terms of the Social Security Act of 1965 (as amended) any time during the first 60 days of continuation coverage.

- Up to 36 months from the date coverage would have originally ended for all other qualifying events (*see page F-22*), as long as those qualifying events would have resulted in a loss of coverage despite the occurrence of any previous qualifying event.

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

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

COBRA continuation coverage

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

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

Notifying UNITE HERE HEALTH when qualifying events occur

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

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

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

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

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

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

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

- For divorce or legal separation: spouse's/partner's name, Social Security number, address, telephone number, date of birth, and a copy of one of the following: a divorce decree or legal separation agreement.

COBRA continuation coverage

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

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

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

Election and payment deadlines

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

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

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

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

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

COBRA continuation coverage

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

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

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

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

Termination of COBRA continuation coverage

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

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

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

COBRA continuation coverage

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

To get more information

If you have any questions about COBRA continuation coverage, your rights, or the Plan's notification procedures, please call UNITE HERE HEALTH at **(855) 844-5262**.

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

Claim filing and appeal provisions

Learn how you file claims and appeal a denied claim:

- 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.

Claim filing and appeal provisions

This section does not apply to claims for benefits provided through any of the HMOs (either medical HMO or dental HMO). See the applicable HMO booklet for more information about filing claims and appeals for these types of claims.

Filing a benefit claim

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

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

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

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

Claims for life or AD&D benefit claims must include a certified copy of the death certificate. All claims for benefits must be made as shown in this section. If you need help filing a claim, contact your regional Fund office at **(855) 844-5262**.

Medical/surgical claims under the EPO benefit option

Network providers will generally file the claim for you. However, if you need to file a medical/surgical claim, for example because you used a non-network provider, mail it to EHS.

EHS Medical Group
ATTN: Claims Department
1600 Corporate Center Drive
Monterey Park, CA 91754

Claim filing and appeal provisions

Mental health/substance abuse claims under the EPO benefit option

Network providers will generally file the claim for you. However, if you need to file a mental health/substance abuse claim, for example because you used a non-network provider, mail it to Beacon Health Options.

Beacon Health Options/Claims

P.O. Box 1850, Hicksville
New York 11802-1850

Prescription drug claims under the EHS EPO benefit option

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

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

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

LA Dental Center claims

You don't need to file a claim if you use the LA Dental Center. Remember, dental care provided outside the LA Dental Center is not normally covered. However, if the LA Dental Center directs you to use a dentist outside of the LA Dental Center, the LA Dental Center will handle the bill from the provider—you should not have a claim to file.

Vision claims

Network vision providers will generally file vision claims for you. However, if you need to file a claim, for example because you used a non-network vision provider, the claim should be sent to UnitedHealthcare. You need to include your unique member 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 in order to get reimbursed for covered vision benefits.

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

Claim filing and appeal provisions

Life and AD&D insurance claims

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

UNITE HERE HEALTH
P.O. Box 6020
Aurora, IL 60598-0020
(855) 405-FUND (3863)

After you have contacted the Fund about an employee's death or dismemberment, Dearborn National will contact you to complete the claim filing process.

All other benefit claims

Claims for all other services or supplies, including services and supplies denied because you are not eligible should be mailed to

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

Deadlines for filing a benefit claim

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

Deadline for filing a claim	
Type of claim	Deadline to file
Life insurance	Within a reasonable amount of time
AD&D insurance	<ul style="list-style-type: none">• Written <i>notice</i> must be received within 31 days of loss (or as soon as possible).• Written <i>proof</i> 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.
LIBERTY dental PPO claims	365 days following the date the claim was incurred
Vision claims	12 months following the date the claim was incurred.
All other claims (including claims under the EPO benefit option—medical, mental health/substance abuse, and prescription drug claims)	18 months following the date the claim was incurred

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

Claim filing and appeal provisions

Individuals who may file a benefit claim

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

Who is an authorized representative?

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

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

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

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

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

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

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

Determination of claims

Post-service healthcare claims not involving concurrent care decisions

You will be notified of the decision within a reasonable period of time appropriate to your medical circumstances, but no later than 30 days after getting your claim. In general, benefits for medical/surgical services will be paid to the provider of those services.

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

Claim filing and appeal provisions

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

Concurrent care decisions

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

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

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

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

Life and AD&D benefit claims

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

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

Rules for prior authorization of benefits

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

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

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

Claim filing and appeal provisions

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

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

Special rules for decisions involving urgent concurrent care

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

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

If a request for prior authorization is denied

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

Appealing a benefit prior authorization denial

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

If a benefit claim is denied

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

Claim filing and appeal provisions

Life and AD&D claims

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

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

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

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

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

One level of appeal for vision care claims

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

Two levels of appeal for healthcare claims under the EPO option (including prior authorization denials) other than prescription drug claims

First level of appeal

All appeals for healthcare claims other than prescription drug claims under the EPO option, including prior authorization denials or denials for extensions of treatment beyond limits previously approved, must be sent within 12 months of your receipt of the claim denial to:

Claim filing and appeal provisions

For medical and surgical treatment:

EHS Medical Group
ATTN: Union Appeals
1600 Corporate Center Drive
Monterey Park, CA 91754

For mental health/substance abuse treatment:

Beacon Health Options, Inc.
Appeals and Grievance Department
P.O. Box 6065
Cypress, CA 90630
Fax number: (855) 861-0314

Second level of appeal

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

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

Two levels of appeals for prescription drug claim denials under the EPO option

First level of appeal

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

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

Second level of appeal

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

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

Claim filing and appeal provisions

Two levels of appeal for LIBERTY dental PPO claims

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 Drive
Aurora, Illinois 60504

One level of appeal for most other claims

If you disagree with all or any part of a LA Dental Center claim denial, vision claim denial, or healthcare claim denial other than those that go to EHS or Beacon Health Options (for example a denial for the travel and lodging reimbursement), and you wish to appeal the decision, you must follow the steps in this section.

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

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

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

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

Claim filing and appeal provisions

Appeals involving urgent care claims

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

- (866) 293-0134 for urgent medical/surgical appeals.
- (844) 376-8085 for urgent mental health/substance abuse appeals.
- (630) 699-4372 for urgent prescription drug appeals.

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

Appeals under the sole authority of the plan administrator

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

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

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

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

Review of appeals

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

- Upon request, examine and obtain copies, free of charge, of all Plan documents, records and other information that affect your claim.
- Submit written comments, documents, records, and other information relating to your claim.
- Information identifying the medical or vocational experts whose opinion was obtained on behalf of UNITE HERE HEALTH in connection with the denial of your claim. You are entitled to this information even if this information was not relied on when your appeal was denied.
- Designate someone to act as your authorized representative (*see page G-5* for details).

Claim filing and appeal provisions

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

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

Notice of the decision on your appeal

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

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

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

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

Independent external review procedures

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

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

- You must have been eligible for benefits at the time you incurred the medical expense.
- Your claim must relate to an issue that involved medical judgment or rescission of coverage.
- You must have exhausted your internal appeal rights, unless you are deemed to have exhausted all levels of the internal appeals process.

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

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

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

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

Claim filing and appeal provisions

Internal Appeal Exception

In certain situations, if the Plan fails to follow its claims procedures, you are deemed to have exhausted the Plan's internal appeals process and may immediately seek an independent external review or pursue legal action under Section 502(a) of ERISA. Please note this exception does not apply if the Plan's failure is de minimis; non-prejudicial; based on good cause or matters beyond the Plan's control; part of a good faith exchange of information between you and the Plan; and not reflective of a pattern or practice of plan non-compliance.

If you believe the Plan violated its own internal procedures, you may ask the Plan for a written explanation of the violation. The Plan will provide you with an answer within ten (10) days. To use this exception, you must request external review or commence a legal action no later than 180 days after receipt of the initial adverse determination.

If the court or external reviewer rejects your request for immediate review, the Plan will notify you (within 10 days) of your right to pursue internal appeal. The applicable time limit for you to now file your internal appeal will begin to run when you receive that notice from the Plan.

Non-assignment of claims

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

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

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

Commencement of legal action

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

If you finish all internal appeals and decide to file a lawsuit against the Plan, that lawsuit must be

Claim filing and appeal provisions

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.

G-16

Definitions

Learn:

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

The definitions in this section do not apply to any benefits provided through an HMO (either a medical HMO or a dental HMO) or to the vision benefits. Call the Fund if you aren't sure what a word or phrase means.

Definitions

Allowable charges

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

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

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

Copay or copayment

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

Your medical **copays** apply to your medical out-of-pocket limits (*see page C-5*), and your prescription drug **copays** count toward your prescription drug out-of-pocket limits (*see page C-15*).

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

Coinsurance

Your share of the costs of a covered expense, calculated as a percent (for example, 20%) of the allowable charge for the service. You pay your **coinsurance** plus any deductibles or copays. For example, if you are enrolled in the LA Dental Center dental benefit option, if your oral surgery through the LA Dental Center costs \$1,000, your 15% **coinsurance** equals \$150. The Fund pays the rest of the allowable charge.

Your prescription drug **coinsurance** counts toward your prescription drug out-of-pocket limits.

Cosmetic or reconstructive surgery

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

Mastectomies, and reconstruction following a mastectomy, will not be considered **cosmetic or reconstructive surgery** (*see page C-7*).

Covered expense

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

Deductible

The amount you owe for covered expenses before the Fund begins paying benefits. For example, if you are enrolled in the LIBERTY dental PPO benefit option, LIBERTY will not start paying dental benefits on your behalf until you meet your \$50 individual **deductible** or \$150 family **deductible**.

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

Durable medical equipment (DME)

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

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

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

Definitions

Emergency medical treatment

Emergency medical treatment means covered medical services used to treat a medical condition displaying acute symptoms of sufficient severity (including severe pain) that an individual with average knowledge of health and medicine could expect that not receiving immediate medical attention could place the health of a patient, including an unborn child, in serious jeopardy or result in serious impairment of bodily functions or bodily organs or body parts.

Experimental, investigational, or unproven (experimental or investigational)

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

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

Healthcare provider

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

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

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

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

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

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

A **healthcare provider** is not:

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

Injuries and sicknesses

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

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

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

Medically necessary

Medically necessary services, supplies, and treatment are:

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

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

Definitions

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

Out-of-Pocket limit for network care and treatment

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

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

You can get more information about your **out-of-pocket limits** for medical care *on page C-5*. You can get more information about your **out-of-pocket limits** for prescription drugs *on page C-15*.

Plan Document

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

Preventive healthcare

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

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

Certain **preventive healthcare** may be covered more liberally (for example, more frequently or at earlier/later ages) than required.

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

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

H-8

Other important information



Other important information

Who pays for your benefits?

Employers participating in the Plan are required to make contributions for their employees. These contributions are controlled by the terms of the Collective Bargaining Agreements negotiated by your local union. Depending on the plan of benefits you select and your Collective Bargaining Agreement, you may also be required to contribute towards the cost of coverage. The Plan is supported by employer contributions and any required contributions you make.

What benefits are provided through insurance companies?

This Plan provides the following benefits on a self-funded basis. Self-funded means that none of these benefits are funded through insurance contracts. Benefits and associated administrative expenses are paid directly from UNITE HERE HEALTH.

- EPO medical benefit option: EHS administers these benefits, as well as managing specialist referral services, prior authorization and other utilization review services.
- EPO prescription drug benefits: These benefits are administered by Hospitality Rx, LLC, a wholly owned subsidiary of UNITE HERE HEALTH.
- LIBERTY dental PPO benefits: LIBERTY Dental Plans of California, Inc. administers the LIBERTY dental PPO dental benefit option.
- LA Dental Center dental benefits.

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.

- Life and accidental death & dismemberment (AD&D) benefits through Dearborn National.
- Kaiser HMO medical benefit options through Kaiser Foundation Health Plan, Inc. Southern California Region.
- Health Net HMO medical benefit option through Health Net of California, Inc.
- LIBERTY DHMO benefit option through LIBERTY Dental Plans of California, Inc.
- Vision benefits through UnitedHealthcare Insurance Company.

Interpretation of Plan provisions

- For claims subject to independent external review (*see page G-13*), the IRO has the authority to make decisions about benefits, and decide all questions about claims, submitted for independent external review.
- For benefits provided on a fully insured basis, the insurer has the sole authority to make decisions about benefits and decide all questions or controversies of whatever character with respect to the insured policy

Other important information

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

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

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

Amendment or termination of the Plan

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

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

Other important information

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 health-care providers is voluntary, and the Fund makes no recommendation as to which specific provider you should use, even when benefits may only be available for services furnished by providers designated by the Fund. You should select a provider or treatment based on all appropriate factors, only one of which is coverage under the Fund.

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

Workers' compensation

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

Type of Plan

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

Employer and employee organizations

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

Plan administrator and agent for service of legal process

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

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

Employer identification number

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

Plan number

The Plan number is 501.

Plan year

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

Other important information

Remedies for fraud

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

Limited retroactive terminations of coverage allowed

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

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

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

Your rights under ERISA



Your rights under ERISA

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

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

Receive information about your Plan and benefits

ERISA provides that all Plan participants shall be entitled to:

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

Continue group health Plan coverage

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

Prudent actions by Plan fiduciaries

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

Enforce your rights

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

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

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

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

Assistance with your questions

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

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

Important phone numbers and addresses

Beacon Health Options

P.O. Box 1850
Hicksville, NY 11802-1850
(844) 376-8085

ConsejoSano

169 11th St.
San Francisco, CA 94103
(855) 785-7885

Dearborn National

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

EHS Medical Group

(844) 480-8444
Claims:
Attn: Claims Department
1600 Corporate Center Drive
Monterey Park, CA 91754
All Other Issues:
Attn: Union Department
1600 Corporate Center Drive
Monterey Park, CA 91754

LA Dental Center

130 S. Alvarado Street
Los Angeles, CA 90057
(213) 484-9660
(800) 436 - 3702 (emergency number)

Health Net of California

(800) 400-8987
Claims
P.O. Box 14702
Lexington, KY 40512

All Other Issues, Including Appeals & Grievances

P.O. Box 9103
Van Nuys, CA 91409-9103

Kaiser Permanente

(800) 464-4000

Member Service Address

Kaiser Permanente California Service Center
P.O. Box 23250
San Diego, CA 92193-3250

Emergency Claims Address

Kaiser Foundation Health Plan, Inc.
Claims Administration Dept.
P.O. Box 7004
Downey, CA 90242-7004

LIBERTY Dental Plan

340 Commerce, Suite 100
Irvine, CA 92602
(888) 442-4585

Hospitality Rx

P.O. Box 6020
Aurora, IL 60598-0020
(844) 813-3860

UnitedHealthcare Vision

Liberty 6, Suite 200
6220 Old Dobbin Lane
Columbia, Maryland 21045
(800) 638-3120

UNITE HERE HEALTH
Board of Trustees



UNITE HERE HEALTH Board of Trustees

Union Trustees

Chairman of the Board

D. Taylor

President

UNITE HERE
1630 S. Commerce Street
Las Vegas, NV 89102

Geoconda Arguello-Kline

Secretary/Treasurer

Culinary Union Local 226
1630 S. Commerce Street
Las Vegas, NV 89102

William Biggerstaff

UNITE HERE International Executive Vice President/Financial Secretary-Treasurer

UNITE HERE Local 450
7238 West Roosevelt Road
Forest Park IL 60130

Donna DeCaprio

Financial Secretary Treasurer

UNITE HERE Local 54
1014 Atlantic Avenue
Atlantic City, NJ 08401

Jim DuPont

Director, Food Service Division

UNITE HERE
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

Bill Granfield

President

UNITE HERE Local 100
275 Seventh Avenue, 10th Floor
New York, NY 10001

Terry Greenwald

Secretary-Treasurer

Bartenders Local 165
4825 W. Nevso Drive
Las Vegas, NV 89103

Connie Holt

Connecticut Director

UNITE HERE Local 217
425 College Street
New Haven, CT 06511

Karen Kent

President

UNITE HERE Local 1
218 S. Wabash Avenue, 7th floor
Chicago, IL 60604

Rev. Clete Kiley

UNITE HERE International Union

218 S. Wabash Avenue, 7th Floor
Chicago, IL 60604

Brian Lang

President

UNITE HERE Local 26
33 Harrison Avenue, 4th floor
Boston, MA 02111

C. Robert McDevitt

President

UNITE HERE Local 54
1014 Atlantic Avenue
Atlantic City, NJ 08401

Leonard O'Neill

UNITE HERE Local 483
702C Forest Avenue
Pacific Grove, CA 93950

Tom Walsh

President

UNITE HERE Local 11
464 S. Lucas Avenue, Suite 201
Los Angeles, CA 90017

UNITE HERE HEALTH Board of Trustees

Employer Trustees

Secretary of the Board

Arnold F. Karr

President

Karr & Associates
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

Paul Ades

Senior Vice President Labor Relations

Hilton Worldwide
7930 Jones Branch Drive
McLean, VA 22102

M Christine Andrews

VP Human Resources

Hostmark Hospitality Group
1300 East Woodfield Road
Suite 400
Schaumburg IL 60173

Richard Betty

c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

James L. Claus

Executive Vice President

Tishman Hotel Corporation
100 Park Avenue, 18th Floor
New York, NY 10017

Richard Ellis

Vice President/Labor Relations
ARAMARK

1101 Market Street, 6th Floor
Philadelphia, PA 19107

George Greene

Vice President Labor Relations

Starwood Hotels and Resorts
715 W. Park Avenue, Unit 354
Oakhurst, NJ 07755

Cynthia Kiser Murphey

President & Chief Operating Officer

New York-New York
3790 Las Vegas Blvd. South
Las Vegas, NV 89109

Robert Kovacs

VP Total Rewards North America

Compass Group
2400 Yorkmont Road
Charlotte, NC 28217

Russ Melaragni

Vice President of Associate & Labor Relations

Hyatt Hotels & Resorts
71 S. Wacker Drive
Chicago, IL 60606

Cynthia Moehring

VP Human Resources

The Mirage
3400 Las Vegas Blvd., South
Las Vegas, NV 89109

Frank Muscolina

Vice President Corporate Labor Relations

Caesars Palace
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

William Noonan

Senior Vice President - Administration

Boyd Gaming
3883 Howard Hughes Parkway
9th Floor
Las Vegas, NV 89118

Michael O'Brien

Vice President Corporate HR Services

Caesars Palace
1 Caesars Palace Drive
Las Vegas, NV 89109

James Stamas

Dean Emeritus

Boston University School of Hospitality
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

Harold Taegel

Senior Director Labor Relations

Sodexo
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

George Wright

c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

UNITE HERE HEALTH

P.O. Box 6020

Aurora, IL 60598-0020

(630) 236-5100