



Los Angeles Plan

Plan Unit 178



Summary Plan Description

Your Health and Welfare Benefits

This booklet contains a summary in English of your plan rights and benefits under UNITE HERE HEALTH. If you have difficulty understanding any part of this booklet, you can visit or contact the Los Angeles regional office at 130 S. Alvarado Street, 2nd Floor, Los Angeles, California 90057. Office hours are from 8:30 a.m. to 4:30 p.m. (Pacific Time), Monday through Friday. You may also call UNITE HERE HEALTH at (855) 484-8480 (TTY: (855) 386-3889 or (855) FUNDTTY) for assistance.

Este folleto contiene un resumen en inglés de los derechos y beneficios de su plan en UNITE HERE HEALTH. Si tiene dificultades para comprender alguna parte de este folleto, puede visitar o comunicarse con la oficina regional de Los Ángeles en 103 S. Alvarado St, 2ª piso, Los Ángeles, California 90057. El horario de atención es de 8:30 a.m. a 4:30 p.m. (hora del Pacífico), de lunes a viernes. También puede llamar a UNITE HERE HEALTH al (855) 484-8480 (TTY: (855) 386-3889 o (855) FUNDTTY) para obtener ayuda.

UNITE HERE HEALTH

Summary Plan Description

Los Angeles Plan

Plan Unit 178

Effective October 1, 2018

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

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Using this book

Learn:

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

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 the Los Angeles Plan (Plan Unit 178), 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) 484-8480**. We can help you understand how your benefits work.

Read your SPD for important information about what your benefits are, how your benefits are paid, and what rules you may need to follow. You can find more information about a specific benefit in the applicable section. For example, if you want to know more about your dental benefits, read the section titled “Dental benefits.”

Some terms are defined for you in the section titled “Definitions” starting *on page H-1*. 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) 484-8480**.

How can I get help?

Learn:

- ▶ Where to call for help.

How can I get help?

Important Phone Numbers	
If you want to:	Contact:
<ul style="list-style-type: none"> • Find out about your benefit options • Ask questions about your eligibility for enrollment or benefits • Update your address 	<p>UNITE HERE HEALTH (855) 484-8480 www.uhh.org</p>
<i>If you are in a Kaiser HMO benefit option</i>	
<p>If you are in a Kaiser HMO:</p> <ul style="list-style-type: none"> • Find a network PCP • Find a network pharmacy • Get information about your benefits 	<p>Kaiser (800) 464-4000 (888) 576-6225 <i>(nurse advice line)</i> www.kp.org</p>
<i>If you are in the PPO benefit option</i>	
<ul style="list-style-type: none"> • Get information about your medical or pharmacy benefits • Get help with a claim • Find a network pharmacy 	<p>UNITE HERE HEALTH (855) 484-8480 www.uhh.org</p>
<i>For help with your dental benefits</i>	
<ul style="list-style-type: none"> • Make an appointment • Get information about your benefits 	<p>LA Dental Center (213) 484-9660 www.uhhdental.org <i>After-hours emergencies:</i> (800) 436-3702</p>
<i>For help with your vision benefits</i>	
<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 	<p>UnitedHealthcare (800) 638-3120 www.myuhcvision.com</p>

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 find network providers.
- ▶ 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.

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

If you are in a Kaiser option: your PCP has to arrange specialist care for you. **Your PCP also has to get approval for most types of services or supplies.**

- ✓ 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.

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

Use network providers

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 a 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.
- ✓ **Remember, except in emergencies, the Plan will only pay benefits for services and supplies provided by network providers. Only your vision benefit has non-network benefits.**

- **If you are in the PPO option,**
 - ▶ **Blue Cross Blue Shield of Illinois (BCBSIL)** provides access to a network of doctors, hospitals, and other healthcare professionals through **Blue Cross of California**. To find a network provider, call **(800) 810-BLUE (2583)** or visit www.bcbsil.com.
 - ✓ *Blue Shield of California providers are non-network providers.*
 - ▶ **Hospitality Rx** provides access to a network of retail pharmacies. To find a network pharmacy, call UNITE HERE HEALTH at **(855) 484-8480** or visit www.hospitalityrx.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) 638-3120** or visit www.myuhcvision.com.
- For dental benefits, **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.

How do I get the most from my benefits?

Workshop leaders

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

Support along the way

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

Contact the Fund Office at **(855) 484-8480** 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 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) 484-8480** for more information about the copay reimbursement program or for help getting reimbursed for your prescription drug copays.

HMO options

Learn about your benefits if you are in a Kaiser HMO:

- ▶ How your HMO option works.
- ▶ Using this SPD if you chose the HMO option.
- ▶ Getting more information if you chose a Kaiser HMO benefit option.

This section only applies to you if you are in one of the Kaiser HMOs. If you are in the PPO, please see the sections starting on [page C-1](#) and [page C-17](#) for information about your medical and prescription drug benefits.

HMO options

Depending on your employee classification, you have a choice of Kaiser HMO options (*see page F-4* for more information about your HMO choices). If you have questions about your HMO benefits, 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 are in one of the Kaiser HMOs

If you are in one of the Kaiser HMOs, 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.

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 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).

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same cost share applicable to other medical and surgical benefits provided under your HMO benefits.

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 are in one of the Kaiser HMOs

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 enrollment book you get when you enroll in a Kaiser HMO benefit option 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 PPO
- Prescription drug benefits under the PPO
- Coordination of benefits under the PPO

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
- Subrogation
- General claim provisions
- Definitions

Getting more information if you are in one of the Kaiser HMOs

The Kaiser enrollment book, which is part of your SPD, will give you more information about your medical management programs, your medical and prescription drug 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

Learn about your dental benefits:

- ▶ What you pay for your covered dental care.
- ▶ What types of dental care are covered.
- ▶ What types of dental care are not covered.
- ▶ What the retiree dental self-pay program is and how to enroll.

Dental benefits

UNITE HERE HEALTH operates the LA Dental Center out of the UNITE HERE HEALTH Los Angeles regional office. **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
www.uhhdental.org

In case of a true dental emergency after hours:

(800) 436-3702

*For all other calls, please wait for office hours,
or leave a voice mail 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.

DENTAL BENEFITS—What you pay		
Description of Services	Dental2+	Dental+
Maximum Benefit Payable Each Calendar Year	n/a	
Calendar Year Deductible		
What You Pay for Dental Care		
Diagnostic & Preventive Services		
Emergency Services— <i>including to treat severe pain</i>	\$0	
Diagnostic X-ray Services		
Minor Restorative Services		
Periodontic Services	10%	15%
Endodontic Services		
Major Restorative Services		
Oral Surgery	15%	25%
Prosthodontic Services & Repairs		

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.

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 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.

Dental benefits

- 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 one of the medical benefit options.
- Placement of an additional appliance in the same dental arch less than 60 months following placement of the initial appliance.

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.

Retiree self-pay dental program

If you retire and you were eligible for dental benefits immediately prior to retirement, you may apply for the retiree self-pay dental program. You must apply no later than 90 days following the date you lose eligibility for dental benefits as an active employee. Contact UNITE HERE HEALTH if you want to enroll, or with questions about the quarterly rates.

You and your enrolled dependents will be eligible for the Dental2+ benefits described earlier in this section. Benefits are only paid if you use the Dental Center for your dental care.

In order to be eligible to enroll in the program, you must meet both of the following requirements:

- You must be qualified to receive retirement income from the Los Angeles Hotel-Restaurant Employer-Union Retirement Fund; and

- You retired after age 62, and have 10 or more years of combined coverage under the Los Angeles Hotel-Restaurant Employer-Union Welfare Fund and/or UNITE HERE HEALTH.

Quarterly payments are due 15 days before the beginning of each quarter. UNITE HERE HEALTH will attempt to mail you a reminder notice before the next payment is due. However, quarterly payments are due regardless of whether or not you receive a reminder notice. If you don't make a timely payment, you and your dependents will cease to be eligible under the retiree self-pay dental program on the last day of the quarter for which a timely payment was made. You will not be able to make future payments for coverage, including payments for COBRA continuation coverage.

There is no guarantee that dental treatment will be completed during any certain period of time. Dental treatment started during one quarter will be continued during the next quarter only if a timely quarterly payment is received.

If, after you retire, you earn eligibility as an active employee, you will need to re-enroll in the retiree dental self-pay program once you retire again.

You may continue to make self-payments until you die. If you die while continuing your and your dependents' eligibility under this program, your surviving dependents enrolled in the retiree self-pay dental program may continue to make self-payments for dental coverage.

Coverage for a dependent child under the retiree self-pay dental program will terminate if the child ceases to meet the definition of a child (*see page F-3*).

The retiree self-pay dental program is not a vested benefit. The program may be modified, terminated, or amended at any time, and will apply to anyone currently participating in the program, as well as to any persons who participate in the future.

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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

B

UnitedHealthcare provides your vision benefits through a fully insured contract with UNITE HERE HEALTH. You get vision benefits through UnitedHealthcare regardless of which 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.

<i>What You Pay for Your Vision Care Benefits</i>		
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

Benefits are available every once every 24 months, based on your last date of service.

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.

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, you won't pay anything for: standard scratch resistant coatings, ultraviolet coating, fashion, sun, or gradient tinted lenses, or polycarbonate lenses for children under age 19.
- 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 to get standard contacts, the fitting/evaluation, and up to two follow-up visits are covered. The \$105 allowance for non-standard contacts does not include charges for fitting or evaluation.

- Medically necessary contacts, with prior authorization from UnitedHealthcare.

What's not covered

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 eye wear 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 insurance 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.
- ▶ How to tell the Fund who should get your life benefit if you die.

Life insurance benefits

You and your dependents must be enrolled in medical benefits under Plan Unit 178 in order to be eligible for the life insurance benefits.

Event	Benefit	Who Receives
Life Insurance—Employees	\$10,000	Your beneficiary
Life Insurance—Dependents	\$10,000	You

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.

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

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

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

Life insurance benefit

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

In addition, the life insurance benefit is available for your covered dependents. The amount of the benefit is shown in the table above. If a dependent dies while he or she is eligible for coverage, the amount of the life insurance benefit will be paid to you.

Continuation if you become totally disabled

If you become totally disabled before age 62 and while you are eligible for coverage, your life ben-

Benefits will continue if you provide proof of your total disability. Your benefits will continue until the earlier of the following dates:

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

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

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

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

Converting to individual life insurance coverage

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

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

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

Terminal illness benefit

If you have a terminal illness (an illness so severe that you have a life expectancy of 24 months or less or if you are continuously confined in an eligible institution, as defined by Dearborn National, because of a medical condition and you are expected to remain there until your death), your life insurance pays a cash lump sum up to 75% of the death benefit in force on the day you were diag-

Life insurance benefits

nosed with a terminal illness. The remaining portion of your death benefit will be paid to your named beneficiaries after your death. Certain exceptions may apply. See your certificate or call Dearborn National for more details.

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. 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 Morneau Shepell, a nationwide organization utilizing qualified and accessible grief counselors and legal and financial consultants. Services are provided via telephone, face-to-face contact, and referrals to local support resources. Free online will preparation is also included. Call **(800) 769-9187** for more information or go to www.beneficiaryresource.com and enter the username: Dearborn National.
- **Travel Resource Services**—Europ Assistance USA, Inc. provides 24-hour emergency medical and related services for short-term travel more than 100 miles from home. Services include: assistance with finding a doctor, medically necessary transportation, and replacement of medications or eyeglasses. Other non-medical related travel services are also available. Europ Assistance USA, Inc. arranges and/or pays for certain covered services up to the program maximum. While in the US or Canada, call **(877) 715-2593** for more information. From other locations, call **(202) 659-7807**.

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

Medical benefits under the PPO

Learn about your benefits if you are in the PPO:

- ▶ What you pay for your medical healthcare.
- ▶ When and how to get prior authorization.
- ▶ How the out-of-pocket limits protect you from large out-of-pocket expenses.
- ▶ What types of medical healthcare are covered.
- ▶ What types of medical healthcare are not covered.

This section only applies to you if you are in the PPO benefit option. If you are in a Kaiser HMO, please see the section starting on [page B-1](#) for information about your medical and prescription drug benefits.

The PPO is closed to employees not already enrolled in this option as of March 1, 2018. If you choose to move into an HMO option, you cannot move back to the PPO.

Medical benefits under the PPO

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PPO BENEFIT OPTION

This section only applies if you are enrolled in the PPO benefit option. *See page B-1* for information about your medical benefits if you are in the HMO benefit option.

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

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

If you do not call NHS for prior authorization, you will have to pay a \$150 penalty. Your claim could also be denied entirely. *See page C-6* for more information.

PPO BENEFIT OPTION—What You Pay

	Network Provider	Non-Network Provider
Calendar Year Deductibles		
Calendar Year Deductibles	\$300/person & \$600/family	
Annual Out-of-Pocket Limits		
Basic Out-of-Pocket Limit for Network Medical Coinsurance	\$700/person	Not applicable
Safety Net Out-of-Pocket Limit for Network Medical Care and Prescription Drugs Combined	\$6,350/person & \$12,700/family	Not applicable
Office Visits		
Preventive Healthcare (<i>see page H-6</i>)	\$0	50% (<i>\$0 for non-hospital grade breast pumps and related supplies</i>)

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.

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Medical benefits under the PPO

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PPO BENEFIT OPTION—What You Pay		
	Network Provider	Non-Network Provider
Primary Care Provider (PCP) Office Visit	10% after deductible	50% after deductible
Specialist Visit		
Mental Health/Substance Abuse Office Visit		
Chiropractic Treatment— <i>up to 40 total visits per person per year</i>	10% after deductible	50% after deductible
Acupuncture Treatment— <i>up to 40 total visits per person per year, and benefits are limited to a \$50 maximum benefit payment per visit</i>	20% after deductible	
Non-Routine Podiatry Visit	10% after deductible	
Allergy Injections in an Office		
Urgent and Emergency Care		
Urgent Care Center	10% after deductible	50% after deductible
Hospital Emergency Room for Emergency Care	\$100 copay/visit <i>waived if admitted</i>	\$100 copay/visit <i>waived if admitted</i>
Hospital Emergency Room for Non-Emergency Care	50% after deductible and \$100 copay/visit	50% after deductible and \$100 copay/visit
Professional Ambulance Services	20% after deductible	20% after deductible
Outpatient Services		
Laboratory Services	10% after deductible	50% after deductible
Radiology Services		
Diagnostic Imaging		
Outpatient Surgery		
Physical, Speech, or Occupational Therapy— <i>up to 60 total visits per person per year</i>		
Habilitative Therapy for Children with Autism Spectrum Disorder — <i>certain limits apply (see page C-11)</i>	\$10 copay/day of treatment	

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Medical benefits under the PPO

PPO BENEFIT OPTION—What You Pay		
	Network Provider	Non-Network Provider
Inpatient Treatment		
Inpatient Hospitalization	10% after deductible	50% after deductible
Inpatient Hospitalization for Mental Health/Substance Abuse Treatment <i>(including residential treatment)</i>		
Skilled Nursing Facility — <i>up to 60 total days per person each year</i>		
	\$0	
Other Services and Supplies		
Diabetes Education	\$0	Not covered
Nutritional Counseling— <i>up to \$200 per person per year</i>		
Home Healthcare Services — <i>up to 60 total days per person each year</i>	\$0	50% after deductible
Hospice Care— <i>up to 60 total days per person each year</i>	\$0	\$0
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment	10% after deductible	50% after deductible
Durable Medical Equipment	20% after deductible	20% after deductible
Travel and Lodging— <i>See page C-14 for information</i>	Reimburse 100% up to \$250/day and \$10,000/episode	
Medical Foods— <i>See page C-14 for information</i>	Reimburse 100%	
All Other Covered Expenses	10% after deductible	50% after deductible

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Network providers

Benefits are paid based on whether you use a network provider or a non-network provider. Treatment by a non-network provider is generally reimbursed at a lower level. To find a network provider, contact:

Blue Cross and Blue Shield of Illinois (BCBSIL)—PPO Network

toll-free: **(800) 810-BLUE (2583)**

www.bcbsil.com

(Go to the Provider finder, and select the “Participating Provider Organization (PPO)” network)

✓ **BlueShield of California providers are not in your network.**

Only BlueCross of California providers are considered network providers.

In some special circumstances, the plan will pay for non-network services at the network cost share. The circumstances are:

- Non-network emergency treatment.
- Treatment provided by non-network healthcare providers who specialize in emergency medicine, radiology, anesthesiology, or pathology.
- In-hospital consultations with non-network providers.
- Services if you live outside of the PPO network.

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

Prior authorization program

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

Nevada Health Solutions (NHS) works with you to help you find a provider, understand your treatment plan, and coordinate your healthcare and the information flow between your providers.

To get prior authorization, call toll free:

NHS
(855) 487-0353

Medical benefits under the PPO

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

Get prior authorization for medical and surgical treatment

You and your healthcare provider must get prior authorization before you get any of the types of care listed below. If you or your provider don't get prior authorization before you receive these types of care, a \$150 penalty may apply, and your claim may be denied. NHS will ask for more information to decide whether the claim should be re-processed and paid. Making sure NHS is called first helps you avoid surprise medical bills. If you get treatment, services, or supplies that are not covered or are not medically necessary, you pay 100% of your care.

NHS toll free: (855) 487-0353

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

When to call for prior authorization

You or your healthcare provider should contact NHS before any of the following:

- Air ambulance transportation.
- Clinical trials.
- The following radiology services:
 - ▶ CT or CTA scans (computed tomography or computed tomography angiography).
 - ▶ Discography.
 - ▶ MRA or MRI (magnetic resonance imaging or magnetic resonance angiography).
 - ▶ PET-Scan (positron emission tomography scintiscan).
- Durable medical equipment rentals or purchases over \$500. (This includes breast pumps costing over \$500.)
- Genetic testing.
- Gender reassignment surgical services and certain hormone therapy.

Medical benefits under the PPO

- Skilled services provided in a home setting, including home healthcare and home infusion.
- Habilitative therapy for children with autism spectrum disorder.
- Hyperbaric treatment.
- Inpatient admissions, other than for treatment of mental health/substance abuse, admissions following observation or an emergency room visit, and admissions for skilled nursing facility care, acute rehabilitation care, and long-term acute facility care.
- Medical foods for inborn errors of metabolism.
- Oncology and hematology services.
- Orthotic and prosthetic appliance rentals or purchases of over \$500.
- Orthognathic surgery.
- Outpatient surgery or procedures performed in an ambulatory surgical center, and surgery or invasive diagnostic procedures performed in the outpatient hospital surgery area. However, colonoscopies or sigmoidoscopies do not require prior authorization.
- Sleep studies.
- TMJ procedures.
- Transplant services, including consultations.
- Travel and lodging.
- Varicose vein procedures.

Additionally, you should also get prior authorization for the types of care listed in the next section. NHS may reach out to you or your healthcare professional to make sure that this care is received at the most cost-effective location and is medically appropriate.

- Dialysis.
- Physical, speech, or occupational therapy

Finally, you are required to notify NHS for the following types of care listed below. Again, NHS may reach out to you or your healthcare professional to make sure that this care is received at the most cost-effective location and is medically appropriate.

- All inpatient and residential mental health/substance abuse treatment

You should contact NHS before receiving any of the above types of services and supplies. This list changes from time to time. Contact the Fund at **(855) 484-8480** for the most up-to-date information.

If you need emergency care, you should contact NHS as soon as possible, but no later than the

Medical benefits under the PPO

next business day, after you get the service or supply. If you are hospitalized because you are having a baby, you must call NHS if your stay will be longer than 48 hours for normal childbirth, or 96 hours for a Cesarean section. No prior authorization is required for emergency medical treatment you get in an emergency room or while you are in observation in the hospital.

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).

You do not need prior authorization in order to access obstetrical or gynecological care from a healthcare provider who specializes in obstetrics or gynecology. The healthcare provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For help finding network providers who specialize in obstetrics or gynecology, call the Fund at **(855) 484-8480**.

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

Case management program

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

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

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

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

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

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

What you pay

You must pay any cost share (such as copays, deductibles, and coinsurance) for your share of covered expenses. You must also pay any expenses that are not covered expenses (*see page C-15* for information about what's not covered), including any amounts over the allowable charge when you use non-network providers, or charges once a maximum benefit or limitation has been met.

Deductibles

Your calendar year deductible applies to both network and non-network expenses. 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 \$300 individual deductible applies to each person covered by the Plan. However, once your family deductible has been satisfied, no one else in your family has to pay deductibles for the rest of that year.

Your \$300 individual and \$600 family deductibles only apply to the medical benefits. Amounts you pay for prescription drugs, vision care, or dental care will not apply toward the deductibles. In addition, the deductibles do not apply to certain medical benefits. See the summary of benefits at the beginning of this section to see which services require the deductible and which services are covered before you satisfy the deductible.

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 for emergency care, the \$100 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 for network expenses

There are two types of out-of-pocket limits that limit how much you pay for network services.

Basic out-of-pocket limit

The most coinsurance you pay for network medical services, including mental health and sub-

Medical benefits under the PPO

stance abuse services, in one calendar year is \$700 per person. However, your out-of-pocket costs for non-emergency medical treatment in an emergency room don't count toward your basic out-of-pocket limit, and the Plan won't pay 100% for these charges even if you have met the basic limit.

The 50% coinsurance you pay for non-network services does not count toward your basic out-of-pocket limit.

Safety net out-of-pocket limit

Your out-of-pocket cost-sharing (deductibles, coinsurance, and copays) for most covered network medical (including mental health/substance abuse) and prescription drug expenses is limited to \$6,350 per person (\$12,700 per family) each calendar year. Once your out-of-pocket costs for covered expenses meet these limits, the Plan will usually pay 100% for your (or your family's) network medical and prescription drug covered expenses during the rest of that calendar year.

Amounts you pay out-of-pocket for prescription drug expenses under the section titled "Prescription drug benefits under the PPO benefit option" count toward this out-of-pocket limit, too.

<i>Network Care Only</i>	<i>Basic Out-of-Pocket Limit</i> \$700 per Person	<i>Safety Net Out-of-Pocket Limit</i> \$6,350 per Person & \$12,700 per Family
Medical Deductible		✓
Medical Coinsurance	✓	✓
Medical Copays		✓
Pharmacy Copays and Coinsurance		✓

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.

- **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. Although medical care provided by non-network providers is generally not covered, non-hospital grade breast pumps (limited to one per pregnancy) and breast pump supplies will be covered when obtained from a non-network provider.
 - ▶ PSA tests are covered annually.
 - ▶ 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.

Medical benefits under the PPO

- ▶ Screening mammography is covered: once every 5 years for women age 35 but less than 40, annually for women age 40 through age 64; every 2 years for women age 65 and older.

- **Professional services of 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.
- **Chiropractic services**, up to a total of 40 visits per person each year.
- **Acupuncture treatment**, up to a total of 40 visits per person each year. The Plan's maximum benefit payment for each visit is \$50.
- **Podiatric care**, excluding x-rays and routine care. Routine podiatric care, such as treatment of corns and callouses, care of nail conditions, or care for dermatological conditions of the feet is not covered.
- **Injectable medications**, including immunizations provided by a healthcare provider.
- Outpatient treatment in a clinic or **urgent care center**.
- Transportation by a **professional ambulance service** to an area medical facility that is able to provide the required treatment.

If you have no control over whether the ambulance was called, for example when the ambulance is called by a healthcare professional, employer, law enforcement, school, etc., the ambulance will be considered medically necessary. Contact the Fund if you had no control over an ambulance being called.

- **Laboratory services.**
- **Radiology**, including but not limited to x-rays, ultrasounds, and fetal monitoring.
- **Ambulatory surgical facility services**, including general supplies, anesthesia, drugs, and operating and recovery rooms but excluding professional services, for surgical procedures not normally performed in a healthcare professional's office. If you have multiple surgeries, covered expenses are limited to charges for the primary surgery.
- Outpatient rehabilitation services for **physical, speech, occupational therapy**, up to a total of 60 visits per person each year.
- **Habilitative therapy** for children with autism spectrum disorder. *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.

Medical benefits under the PPO

- ▶ 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.
 - ▶ 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.
- **Hospital charges** for room and board, and other inpatient or outpatient services.
 - **Anesthesia**, including administration of anesthesia.
 - **Pregnancy** and pregnancy-related conditions for employees and spouses, including childbirth, miscarriage, abortion, and preventive healthcare (*see page C-10*). No benefits are payable for pregnancy or pregnancy-related conditions for a dependent child, unless the care is considered preventive healthcare. Non-preventive healthcare services for a dependent child's pregnancy, including but not limited to ultrasounds, charges associated with a high-risk pregnancy, abortions, and delivery charges will not be covered.
 - **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 benefits under the PPO

- **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**, up to a total of 60 days per person each year, as long as you are under the care of a doctor, and are confined as a regular bed patient.
- Professional services for **diabetes education** and training for the care, monitoring, or treatment of diabetes. Non-network services are not covered.
- Professional services for **nutrition counseling**, up to \$200 per person each year. Non-network services are not covered.
- **Blood and blood plasma**, including administration of blood and blood plasma.
- **Home healthcare services**, up to a total of 60 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, up to a total of 60 days per person each year.
- **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.

Medical benefits under the PPO

- Reimbursement for **travel, lodging, and meal costs** for transportation to get certain treatment more than 50 miles away from your home (as long as you travel within the United States). You must get prior authorization for these expenses before the Plan will reimburse you. Covered expenses only include travel, lodging and meal costs related to: (1) transplants, (2) cancer-related treatments, and (3) congenital heart defect care. The following rules apply:
 - ▶ The travel, lodging, and meal costs of one other person traveling with you will also be covered. (Two other people will be covered if the patient is a minor child.)
 - ▶ Reimbursement is limited to \$10,000 per episode of care for you and your traveling companion(s) combined. This includes up to \$250 each day for lodging and meal costs.
 - ▶ You must provide the Plan with your original receipts.
 - ▶ You must participate in any case management programs required by the Fund.
 - ▶ You cannot get reimbursed for expenses related to your participation in a clinical trial, or for an organ transplant if you are donating an organ instead of getting an organ.

The Fund may prearrange or prepay certain travel or lodging costs. More details about the benefit are available upon request.

- **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.
- **Chemotherapy and radiotherapy.**
- **Repair of sound natural teeth** and their supporting structures, if the covered expenses are the result of an injury and treatment is received while you are covered under the Fund.
- **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.
- Treatment of **tumors, cysts and lesions** not considered a dental procedure.
- Oxygen, **including administration of oxygen.**
- **Dental procedures** for treatment otherwise covered under a dental benefit, including charges made by a hospital, or other facility, when those procedures require treatment in an institutional setting to safely administer the care, including for treatment if you are suffering from medical or behavioral conditions, such as autism or Alzheimer's, that severely limit your ability to cooperate with the necessary care.

- **Gender reassignment surgery** for individuals with a diagnosis of gender dysphoria and related charges (e.g., laboratory work, x-rays, office visits, etc.). The Plan will cover surgical procedures, including medically necessary corrective surgeries, to change your gender once (for example, if the Plan covers procedures changing your gender from male to female, the Plan will not then pay to change your gender back to male). You must be at least 18 years of age and obtain prior authorization for surgical services. Infused hormone therapy will also be covered with no age limit. However, if you are using puberty-suppressing hormones, your healthcare professional must document that you have begun puberty (Tanner stage 2 or higher).

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:

- 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-17.
- Procedures for the treatment of temporomandibular joint dysfunction, craniofacial disorders or orthognathic disorders, unless prior approval has been received in writing from UNITE HERE HEALTH.
- Unless specifically listed as covered, other than LeFort procedures, surgery to modify jaw relationships including, but not limited to, osteoplasty and genioplasty procedures.
- Unless specifically listed as covered, alveolar ridge augmentation or implant procedures, dental extractions, 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.
- Private duty nursing care.
- Oral contraceptives or over-the-counter birth control devices.
- Eye refractions, eyeglasses, or contact lenses. However, these expenses may be covered under the vision benefits (see page B-13).
- Except as specifically covered under the Plan, non-healthcare items or services, including but not limited to oral nutrition or supplements, and disposable supplies, such as bandages, antiseptics, and diapers.

Prescription drug benefits under the PPO

Learn about your drug benefits if you are in the PPO:

- ▶ 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 are in the PPO benefit option. If you are in a Kaiser HMO, please see the section starting on [page B-1](#) for information about your medical and prescription drug benefits.

The PPO is closed to employees not already enrolled in this option as of March 1, 2018. If you choose to move into an HMO option, you cannot move back to the PPO.

Prescription drug benefits under the PPO

The Plan has contracted with Hospitality Rx, LLC (Hospitality Rx) to administer your prescription drug benefits.

Hospitality Rx provides access to a select national network of participating pharmacies (called the True Choice network) that you must use in order to get benefits for prescription drugs. *Not all pharmacies are in your pharmacy network. Walgreens is in your network.* CVS and Wal-Mart, are **not** in your network. Because this list changes from time to time, contact UNITE HERE HEALTH at **(855) 484-8480** or go to www.hospitalityrx.org to get the most current list of network pharmacies.

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

Important Phone Numbers

If you want to:	Call:	At:
Find a network pharmacy or ask questions about your benefits	UNITE HERE HEALTH	(855) 484-8480
Get prior authorization for prescription drugs or to ask which drugs require prior authorization	Hospitality Rx	(844) 813-3860
Get a free glucometer	TrueMetrix (by Trividia)	(866) 788-9618
	One Touch (by LifeScan) use order code 739WDRX01	(888) 883-7091 www.OneTouch.orderpoints.com
Order from the mail-order pharmacy	WellDyneRx Home Delivery (through Hospitality Rx)	(844) 813-3860
Order from the specialty pharmacy	AllianceRx Walgreens Prime	(877) 647-5807

You can also visit www.hospitalityrx.org for more information.

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.

Prescription drug benefits under the PPO

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

Prescription Drugs - (<i>Network Retail Pharmacies & Mail Order</i>)	Your Cost for Each Fill or Refill	
	Retail Pharmacy <i>up to a 34-day supply</i>	Mail Order <i>up to a 60-day supply</i>
Formulary Prescription Drug Benefits		
Preventive Healthcare Prescription Drugs, including immunizations (<i>see page H-6</i>)	\$0	
Generic Drugs	\$10	
Preferred Brand Name Drugs	\$30	
Non-Preferred Brand Name Drugs	\$50	
Specialty and Biosimilar Drugs	25%, up to a maximum of \$50	
Non-Formulary Prescription Drugs and Supplies	Not covered	
Safety Net Out-of-Pocket Limit for Network Medical Care and Prescription Drugs Combined	\$6,350 per person & \$12,700 per family	

Drugs and supplies on the formulary are safe, effective, high-quality drugs. 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 removed from the formulary from time to time. Contact Hospitality Rx at (844) 813-3860 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) 813-3860 for a formulary exception. The formulary exception allows your healthcare provider to ask for approval for you to get coverage for a prescription

You must use the specialty pharmacy to get specialty and biosimilar prescription drugs. *See page C-24* for more information about the specialty pharmacy.

Out-of-pocket limit

Your cost-sharing for most network medical and prescription drug covered expenses is limited to \$6,350 per person (\$12,700 per family) each calendar year under the safety net out-of-pocket limit. Once your out-of-pocket costs for covered expenses meet these limits, the Plan will usually pay 100% for your (or your family's) network medical and prescription drug expenses 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 PPO benefit option" count toward this out-of-pocket limit, too.

Certain prescription drug expenses don't count toward your out-of-pocket limit. This includes any amounts you must pay in addition to your copay when you or your doctor chooses a brand name drug when a generic equivalent is available (see "Generic prescription drug policy" below), and any surcharge amounts you pay for early refills. These expenses do not count toward your out-of-pocket limit and you will continue to be responsible for these expenses even if you have met the out-of-pocket limit for the year.

You can get more information about your out-of-pocket limits on [page C-10](#) and [page H-6](#).

Generic prescription drug policy

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

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

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

What's covered

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

- FDA-approved prescription drugs which can legally be purchased only with a written prescription from a healthcare provider. This includes oral and injectable contraceptives and drugs mixed to order by a pharmacist, as long as at least one part of the mixed-to-order drug is an FDA-approved prescription drug.

Prescription drug benefits under the PPO

- The following diabetic supplies: insulin, diabetic test strips, control solution for glucometers, disposable syringes and needles, and lancets.
- Prescription and non-prescription (over-the-counter) preventive healthcare services and supplies, including immunizations (*see page H-6*).
- The following single-source vitamins: ferrous sulfate, vitamin D, cyanocobalamin, vitamin K, potassium chloride, bicarbonate, phosphate, calcium acetate, niacin, and Galzin (zinc).
- Hormone therapy as long as the hormones are FDA approved and only available by prescription. Prior authorization is required for certain hormone therapy. Hormone therapy for individuals with gender dysphoria is not subject to an age restriction; however, the prior authorization process for individuals under age 18 will include an additional requirement that the treating physician have documentation showing sexual maturity of Tanner stage 2 or more.

Free glucometers

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

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

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

If you don't want to use one of the Fund's free glucometers, you have to pay the full cost of the glucometer upfront. You may submit a claim under the medical benefits for the glucometer, but you may not be reimbursed 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 health-care provider can always get the most current information by contacting Hospitality Rx at **(844) 813-3860** or visiting www.hospitalityrx.org.

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

The programs also can help make sure your money is not wasted on prescription drugs that do not work for you. For example, some prescription drugs cause serious side effects in some pa-

Prescription drug benefits under the PPO

tients. 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-8 for information about appealing a denied request for prior authorization or appealing a denial of prescription drug benefits.

Prior authorization

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

Prior authorization is also required for any requests for early refills, and 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 over-the-counter, generic, or preferred formulary versions of prescription drugs first. If the first level of prescription drugs does not work for you, or causes serious side effects, you are “stepped up” to another level of prescription drugs.

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

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

Case management

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

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

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.
- Male impotency drugs are limited to 6 applications per month and to a 3-month initial supply.
- 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 earlier than allowed under any applicable guidelines, safety or cost containment programs, or other Plan rules, 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 will be out of the country when you will run out of a prescription drug.
- Your drug is lost or stolen.
- You run out of a drug too soon because you misunderstood the instructions or accidentally used too much (limited to one 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 of up to \$50 (or the cost of the drug, if less) in addition to the applicable copay after the first early refill of a drug each year, and you may be required to participate in the pharmacy case management program.

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

Exceptions to the standard quantity limits

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

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

Prescription drug benefits under the PPO

Mail-order pharmacy

You can save money by using Hospitality Rx's mail-order pharmacy: WellDyneRx Home Delivery. If you need a prescription drug to treat a chronic, long-term health condition, you can order these prescription drugs through the mail-order pharmacy. You can get up to a 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 the mail-order pharmacy by mail, by phone, or on the internet.

WellDyneRx Home Delivery

(844) 813-3860

www.mywdrx.com

(Registration is required)

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 these drugs 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.

AllianceRx Walgreens Prime

(877) 647-5807

(TTY) 866-830-4366

www.alliancerxwp.com

AllianceRx Walgreens Prime specialty pharmacy is different than Walgreens retail pharmacies.

What's not covered

See page D-2 for a list of the 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 prior authorization program.

Prescription drug benefits under the PPO

- Specialty prescription drugs, other than those used to treat HIV/AIDS, if you do not use the specialty pharmacy.
- Experimental or investigational drugs.
- Fertility drugs.
- Prescriptions or refills in amounts over the quantity limits (*see page C-23*).
- Non-sedating antihistamines or histamine receptor blockers.
- Over-the-counter proton pump inhibitors.
- Vitamins, dietary supplements, or dietary aids, except those specifically listed as a covered expense.
- New-to-market prescription drugs until the Fund or its representative has reviewed and approved the prescription drug.
- High-cost “me too” drugs, unless the Fund or its representative approves an exception through the prior authorization program. “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.
- 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 to use one of the free ones, but you will usually have to pay part or all of the cost.
- Rogaine and other drugs to prevent hair loss.
- Drugs or medications used, consumed or administered at the place where it is dispensed, other than immunizations. (These drugs may be covered under your medical benefits.)
- Birth control devices and implants other than non-legend (over-the-counter) FDA-approved female contraceptive drugs, devices, or supplies that have been prescribed by a healthcare provider.
- Drugs used for cosmetic reasons.

Prescription drug benefits under the PPO

- Weight control drugs, unless for the treatment of morbid obesity under the direct supervision of a healthcare provider, and authorized in writing by the Plan.
- 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-11*).

Coordination of benefits under the PPO

Learn:

- ▶ How benefits are paid if you are in the PPO and you are covered under other plan(s).

This section only applies to you if you are in the PPO benefit option. If you are in a Kaiser HMO, please see the section starting on [page B-1](#) for information about your medical and prescription drug benefits.

The PPO is closed to employees not already enrolled in this option as of March 1, 2018. If you choose to move into an HMO option, you cannot move back to the PPO.

Coordination of benefits under the PPO

These coordination of benefits provisions only apply to medical benefits under the PPO 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 PPO benefit option, to any benefits provided through an HMO, to the dental benefits, or to the vision benefits.

If you or your dependents are covered under the PPO 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.

Coordination of benefits under the PPO

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

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

COB and prior authorization

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

Coordination of benefits under the PPO

Special rules for Medicare

I am an active employee

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

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

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

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

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

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

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

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

I have COBRA coverage or retiree coverage

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

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

How to get help with Medicare

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

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

If you and your spouse are both employees under this Plan

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

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

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General exclusions and limitations

Learn:

- ▶ The types of care not covered by the Plan.

The exclusions and limitations in this section do not apply to any benefits provided through a Kaiser HMO benefit option or to the vision benefits. Call the Fund at (855) 484-8480 if you have questions about this section.

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 PPO benefit option, prescription drugs under the PPO benefit option, and for dental benefits. No benefits will be paid under this Plan for charges incurred for or resulting from any of the following:

- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a 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 by an HMO for the cost of any services provided.
- 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

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its Territories), unless for a medical emergency. The decision of the Trustees in determining whether an emergency existed will be final.

- Any charges incurred while you are confined in a hospital, nursing home, or other facility or institution (or a part of such facility) which are primarily for education, training, or custodial care.
- Any treatment, services or supplies for or in connection with the pregnancy of a dependent child except for preventive healthcare services. For example, ultrasounds, treatment associated with a high-risk pregnancy, non-preventive care, and delivery charges are not covered with respect to the pregnancy of a dependent child.
- Hospital charges for personal comfort items, including but not limited to telephone, television, cosmetics, guest trays, magazines, and bed or cots for family members or other guests.
- Supplies or equipment for personal hygiene, comfort, or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, tanning bed, or water bed.
- Home construction for any reason.
- Routine podiatry, including but not limited to treatment of corns and calluses, care of nail conditions, and care of dermatological conditions of the feet.
- Treatment for or in connection with infertility, other than for diagnostic services, including but not limited to in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and fertility drugs and medications of any kind.
- Any dental treatment of teeth or their supporting structures, or services or supplies associated with such treatment, unless specifically listed as a covered expense.
- 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.
- Hearing aids.
- Eyeglasses or hearing aids, except as specifically stated as covered.
- 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 B-13*).
- Any expense or charge by a rest home, old age home, or a nursing home.

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General exclusions and limitations

- 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.
- Athletic training.
- Education or training, unless specifically stated as covered.
- Cosmetic services.
- 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.
- Prescription drugs not purchased from a network provider, other than those consumed at the location in which they are dispensed.
- 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.

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 only applies to members enrolled in the PPO Plan option, and, for members enrolled in one of the Kaiser options, to those benefits not provided through Kaiser. If you are enrolled in Kaiser, see your Kaiser booklet for additional information about subrogation.

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.

Statement of facts and repayment agreement

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

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

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

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

Settling your claim

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

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

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

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

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

Eligibility for coverage

Learn:

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

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 make any employee contribution (EC) payment required by your CBA or by UNITE HERE HEALTH.
- You meet the Plan's eligibility rules.

If you are required to make an EC 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

130 S. Alvarado Street

2nd Floor

Los Angeles, CA 90057

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. Coverage for your dependents is provided at no cost to you.

Your dependents will be eligible for the same benefit option you choose for yourself.

You can add dependents after your coverage starts. See “Dependent coverage” starting *on page F-13* 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 Kaiser HMOs, 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.
 - ▶ Your unmarried grandchild under age 19, provided he or she lives with you, and you provide his or her principal support.

If your child is age 26 or older and disabled, his or her coverage may be continued under

Eligibility for coverage

the Plan. In order to continue coverage, the child must have been diagnosed with a physical or mental handicap, must not be able to support himself or herself, and must continue to depend on you for support. Coverage for a child with a disability will continue as long as all of the following rules are met:

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

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

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 your employee classification (hotel, event center, or cafeteria). Your EC payment, if any, is based on which benefit option you choose.

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 benefit option you select. If you and your spouse are both employees, you and your spouse will also be covered under the same medical benefit option.

Medical options (including prescription drug coverage)

Your medical benefit options, and the dental benefit that goes with each medical option, are shown in the following tables. The amount of your EC payment, which is what you owe the Fund each month for your share of your coverage, is also shown.

Your Benefit Options and Monthly EC Payments			
	Hotel Employees	Event Center Employees	Cafeteria Employees
Kaiser+ HMO (with Dental+)	\$0	\$25	\$25
Kaiser2+ HMO (with Dental2+)	\$25	\$50	\$50
Kaiser3+ HMO (with Dental2+)	\$50	not available	not available
For employees who were enrolled in the PPO before March 1, 2018 only: <i>If you move out of the PPO into one of the HMOs, you cannot re-elect the PPO</i>			
PPO (with Dental2+)	\$50	\$50	\$50

You can enroll yourself and/or your dependents at any time while you are eligible for benefits. However, if you do not enroll when first eligible to do so, you will only be able to enroll in the Kaiser+ option until the next open or special enrollment period.

Enrollment requirements

Employees

You or your employer must provide the Fund with any required information before benefits will be paid on your behalf. This may include providing a signed enrollment form.

Dependents

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

In order to enroll your dependents, you must provide any requested information about them to UNITE HERE HEALTH.

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). If you are enrolling a grandchild, your tax return should show that you claimed the grandchild as a dependent.
- 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.

Eligibility for coverage

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

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

No benefits of any kind will be provided for your dependents until they are properly enrolled.

When your coverage begins (initial eligibility)

Your coverage begins at 12:01 a.m. on the first day of the coverage period corresponding to the first work period for which contributions are required on your behalf, and for which you make any applicable EC payment for the last month of the work period.

For purposes of establishing initial eligibility:

- **Work period** means the 5-calendar-month period for which your employer must make contributions to UNITE HERE HEALTH on your behalf, including any EC payment or any amount you are required to contribute under the terms of your CBA, and during which you meet the required eligibility requirement each month.
- **Lag period** means the 2-calendar-month period between the end of a work period and the beginning of the corresponding coverage period.
- **Coverage period** means the calendar month for which coverage is in force as determined by the corresponding work period.

Example: Establishing Initial Eligibility

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

Suppose you work the required hours, and your employer makes the required contributions, during each of July, August, September, October, November. Your coverage begins February 1—as long as you make any required EC payment.

Work requirements

- ✓ In order to become eligible, you must also make any required monthly EC payment.
- ✓ For the purposes of determining your work requirements, you are a “grandfathered employee” if, between March 1, 2010 and May 31, 2011, you EITHER worked at least one

Eligibility for coverage

hour OR you were covered for at least one month under the Los Angeles Hotel-Restaurant Employer-Union Welfare Fund.

Monthly Work Requirements			
	Hotel Employees	Event Center Employees	Cafeteria Employees
Grandfathered Employees	80 hours	60 hours	80 hours
All Other Employees	80 hours	100 hours - <i>first 5 years of employment</i>	120 hours - <i>first 5 years of employment</i>
		80 hours - <i>after 5 years of employment</i>	80 hours - <i>after 5 years of employment</i>

Special rule for Dodger's Stadium event center employees

If the season begins after the 5th day of the month, or ends prior to the 25th day of the month, that month is considered a “short month.” If you work at least 40 hours during a “short month,” you will be considered to meet the hours requirement for eligibility.

For example, if the season ends on October 15, you only need to work 40 hours in October in order to meet the work requirement for October.

Continuing eligibility

Once you establish eligibility, you maintain eligibility when you continue to meet work requirements described below during the corresponding work periods, and you make any applicable monthly employee contribution.

For purposes of continuing eligibility:

- **Work period** means a calendar month for which your employer must make a contribution to UNITE HERE HEALTH on your behalf, including any EC payment or any amount you are required to contribute under the terms of your Collective Bargaining Agreement.
- **Lag period** means the 2-calendar-month period between the end of a work period and the beginning of the corresponding coverage period.
- **Coverage period** means the calendar month during which coverage is in force as determined by the corresponding work periods.

Eligibility for coverage

Example: Continuing Eligibility		
Work Month	Lag Period	Coverage Period
December	January - February	March
January	February - March	April
February	March - April	May

Suppose you have already become eligible, and your employer is required to contribute on your behalf for December. If you meet the continuing eligibility rule described below, and you make any required EC payment, your coverage continues during March. Contributions for January continue your coverage for April, and so on.

Work requirements

- ✓ In order to maintain your eligibility, you must also make any required monthly EC payments.
- ✓ For the purposes of determining your work requirements, you are a “grandfathered employee” if, between March 1, 2010 and May 31, 2011, you EITHER worked at least one hour OR you were covered for at least one month under the Los Angeles Hotel-Restaurant Employer-Union Welfare Fund.

Monthly Work Requirements			
	Hotel Employees	Event Center Employees	Cafeteria Employees
Grandfathered Employees	80 hours	60 hours	80 hours
All Other Employees	80 hours	100 hours - <i>first 5 years of employment</i> 80 hours - <i>after 5 years of employment</i>	120 hours - <i>first 5 years of employment</i> 80 hours - <i>after 5 years of employment</i>

Special rule for Dodger’s Stadium event center employees

If the season begins after the 5th day of the month, or ends prior to the 25th day of the month, that month is considered a “short month.” If you work at least 40 hours during a “short month,” you will be considered to have met the hours requirement for eligibility.

For example, if the season ends on October 15, you only need to work 40 hours in October (instead of 60 hours) in order to meet the work requirement for October.

Once you become eligible, if you work more than the required number of hours during a work period, these extra hours can be saved. These extra hours will help you continue your eligibility under the Dodger's Stadium rules if you do not have the required number of hours in future months. You can use these extra hours to continue your eligibility for up to 2 months after the season ends. However, extra hours you earn during one calendar year cannot be continued during the next calendar year. However, you cannot combine banked hours with hours you work for other employers.

- *For example, you **are** a grandfathered employee:* if you earn a total of 80 hours in August 2018, you have 20 extra hours. If you only earn 50 hours in September you can use 10 of your extra hours to meet the 60-hour rule. This leaves you with a total of 10 extra hours. The 10 extra hours will not carry over into 2019.
- *For example, you **are not** a grandfathered employee and you have less than five years of experience:* if you earn a total of 120 hours in August 2018, you have 20 extra hours. If you only earn 90 hours in September you can use 10 of your extra hours to meet the 100-hour rule. This leaves you with a total of 10 extra hours. The 10 extra hours will not carry over into 2019.

Eligibility for employees who work for more than one employer

If you work for more than one employer, your employer may not payroll deduct any required EC payment, for example if you do not earn enough hours for eligibility with that employer. You may have to make your EC payment directly to UNITE HERE HEALTH. Call the Fund with questions about making your EC payment.

Contact the Fund at **(855) 484-8480** with questions about your eligibility if you work for more than one employer.

Eligibility for employees who work in more than one employee group

If you work in more than one employee group (hotel, event center, and cafeteria), your eligibility will be determined based on the hours you earn. If you do not meet the eligibility requirements for one employee group, but you do for a second employee group, your eligibility will continue based on the second employee group's rules. This means that the second employee group's eligibility rules, benefit options, and EC payments, if any, will apply.

- *For example, assume you are a grandfathered employee.* During August 2018, you work 65 hours as a hotel employee, and 15 hours as an event center employee. You need 80 hours to continue eligibility as a hotel employee, or 60 hours to continue eligibility as an event center employee. You do not have enough hours to continue coverage as a hotel employee, but you do have enough hours to continue coverage as an event center employee because you worked the 60-hour-minimum for event center employee coverage.

Eligibility for coverage

You will be eligible during November 2018 as an event center employee if you make any required EC payment. The hours you work during September 2018 will determine your eligibility for December 2018. If you work at least 80 hours as a hotel employee during September, you will again be covered as a hotel employee during December.

If you are eligible as a cafeteria employee or an event center employee, and you were covered under Kaiser3+ as a hotel employee, you will automatically be moved to Kaiser2+ coverage even if you had some hours as a hotel employee.

- However, you have the option to buy-up coverage to continue your Kaiser3+ benefit option. If you want to buy-up to Kaiser3+, you must pay the difference in cost between 80 hours as a hotel employee and the hours you actually worked.
- If you decide to buy-up to Kaiser3+, you must continue to buy-up to Kaiser3+ each month you are eligible as a cafeteria or event center employee. If you don't buy-up to the Kaiser3+ benefit option, you will not be allowed to choose Kaiser3+ again until you regain eligibility as a hotel employee.

If you are eligible as a cafeteria employee or an event center employee, and you were covered under Kaiser2+ as a hotel employee, you will continue to be covered under the Kaiser2+ benefit option. The same rule applies if you are covered under Kaiser+ or the PPO option.

Contact the Fund at **(855) 484-8480** with questions about your eligibility if you work in more than one employee group, or to buy up to Kaiser3+ (if available).

Vacation hours

If you do not work enough hours to continue your eligibility, vacation hours your employer pays to you will be automatically applied to help maintain your eligibility. Vacation hours can be applied in any increment(s) necessary.

Vacation hours not applied within 12 months may not be carried forward

Disability credit hours

- ✓ For the purposes of this section, totally disabled means that you are prevented by injury or sickness from working in an occupation for which you are qualified.
- ✓ Disability credit hours will not be applied until you have exhausted any leave available to you under the Family and Medical Leave Act. Talk to your employer if you have questions about such leave.

Disability credit hours help you continue eligibility for your current level of coverage if you become totally disabled. If your eligibility continues due to disability credit hours, you will be eligible for the same benefits for which you were eligible before you became totally disabled.

Eligibility for coverage

If you qualify for eligibility during disability, you will be given disability credits for 8 hours for each day that you are disabled.

To qualify for disability credit hours you must meet all of the following rules:

- You work for a contributing employer during the work period during which your total disability begins.
- You have worked for a contributing employer during the work period prior to the work period in which your total disability begins.
- You have been eligible for benefits due to working for at least 9 of the 12 work periods immediately prior to the work period in which your total disability begins.

The maximum length of time you can continue eligibility using disability credit hours depends on your employee classification:

Maximum time you can earn disability credit hours		
Hotel Employees	Event Center Employees	Cafeteria Employees
up to 6 months during any 12-consecutive-month period	up to 3 months during any 12-consecutive-month period	up to 3 months during any 12-consecutive-month period

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

Extended disability credits for hotel employees

If you are covered as a hotel employee, you will be eligible for extended disability credits for up to 12 months after exhausting your disability credit hours if you meet all of the following rules:

- You were at least age 50 prior to becoming totally disabled.
- You were eligible under the Plan for at least 120 of the 150 months immediately prior to becoming totally disabled.
- You remain totally disabled and unable to work.

After exhausting your extended disability credits, you have the option to make individual payments for up to an additional 6 months. You will be eligible for the same benefits as you were while an active employee.

Contact UNITE HERE HEALTH with questions about continuing your eligibility while disabled.

Eligibility for coverage

Self-payments

If you choose to make a self-payment (or cash payment), you will also be required to make any applicable monthly employee contribution.

Self-payments to continue coverage

You can make self-payments (sometimes called cash payments) to continue your coverage if you do not meet the minimum hours to continue your eligibility. The work period for which you are making a self-payment must immediately follow one for which you were credited with enough hours to continue your eligibility. This includes making self-payments or receiving disability credit hours.

The amount of the required self-payment depends on the amount of hours you worked, and the employee group(s) in which you worked. If you choose to make a self-payment (or cash payment), you will also be required to make any applicable monthly employee contribution.

Self-payments are due by the 15th day of the month immediately before the applicable coverage period. You must also pay any applicable EC payment.

You can make self-payments for up to 12 consecutive work periods. You will cease to be eligible to make self-payments if your employment ends, or if a timely self-payment and applicable monthly employee contribution is not made.

The number of months for which you can make self-payments is reduced by the number of months for which you are eligible based on disability coverage (see “Disability Credit Hours”). For example, if you get 3 months of disability credits, you will only be eligible to make 9 months of self-payments. If you are eligible for 12 or more months due to disability, you will not be entitled to make 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.

Dependent coverage

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

Your dependents will become eligible when your coverage starts. If you get a new dependent, the new dependent will become eligible on the date he or she meets the definition of a dependent. However, you must enroll each dependent according to the Plan's enrollment rules. No benefits of any kind will be provided for your dependents until they are properly enrolled.

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

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 must submit the required enrollment material and arrange to make any required EC payments.

You can enroll yourself and/or your dependents at any time while you are eligible for benefits. However, if you do not enroll when first eligible to do so, you will only be able to enroll in the Kaiser+ option until the next open or special enrollment period.

Special enrollment periods

In a few special circumstances, you do not need to wait for the open enrollment period to change your benefit options. (Remember, you can add dependents at any time.) 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.

Eligibility for coverage

- 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 change your benefit options during a special enrollment period, contact the Fund at **(855) 484-8480** for help understanding when your coverage under your 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.

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-7*. 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-24*.

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) 484-8480**.

When employee coverage ends

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

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

When dependent coverage ends

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

- The date the Plan is terminated.
- Your (the employee's) coverage ends.
- The dependent enters any branch of the uniformed services.
- The first day of the month in which your dependent no longer meets the Plan's definition of a dependent (*see page F-3*).

You may also ask the Fund to stop covering your dependent (or dependents). Contact the Fund at **(855) 484-8480** for more information about how to stop covering a dependent, or how to re-enroll a dependent if you change your mind.

The effect of severely delinquent employer contributions

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

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

Special termination rules

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

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

Then: Your coverage ends on the last day of the month during which the decertification 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.

Termination of coverage

Certificate of creditable coverage

You or your dependent may request a certificate of creditable coverage within the 24 months immediately following the date your or your dependents' coverage ends. The certificate shows the persons covered by the Fund and the length of coverage applicable to each. The Fund will only send a certificate of creditable coverage if you or your dependent request it.

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

Reestablishing eligibility

Learn:

- ▶ 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.
- ▶ How you can reestablish your and your dependents' 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 EC payments for your coverage when your FMLA leave starts, you can continue your coverage during your leave by making any required EC payments to your employer. If you stop making EC payments, your coverage under the Plan will end. Generally, 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:
 - 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.

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-7](#)). 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-3*).
- 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. COBRA continuation coverage includes medical/prescription drug benefits, vision benefits, and dental benefits. **Life insurance benefits cannot be continued under COBRA.** However, you may be able to convert your life insurance to an individual policy. Contact 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-24*), 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 809328
Chicago, IL 60680-9328

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 the Fund at **(855) 484-8480**.

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 a Kaiser 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 insurance 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) 484-8480**.

Prescription drug claims under the PPO 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

Claim filing and appeal provisions

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

Life 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, including healthcare claims under the PPO medical benefit option

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

Claim filing and appeal provisions

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
Vision claims	12 months following the date the claim was incurred.
All other claims (including dental claims, and healthcare and prescription drug claims under the PPO benefit option)	18 months following the date the claim was incurred

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

Individuals who may file a benefit claim

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

Who is an authorized representative?

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

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

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

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

- Your spouse (or domestic partner).

Claim filing and appeal provisions

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

Concurrent care decisions

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

For example, if you are approved for a 30-day stay in a skilled nursing facility, but your 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.

Claim filing and appeal provisions

Life insurance claims

In general, you will be notified of the decision on your claim for life insurance claims no later than 90 days after your claim is received.

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

Rules for prior authorization of benefits

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

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

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

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

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

Special rules for decisions involving urgent concurrent care

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

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

If a request for prior authorization is denied

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

Appealing a benefit prior authorization denial

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

If a benefit claim is denied

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

Life insurance claims

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

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

Appealing claim denials (other than life insurance claims)

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

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

Claim filing and appeal provisions

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 prior authorization denials made by NHS

First level of appeal

All appeals for benefit claims that are denied by NHS (prior authorization denials or extensions of treatment beyond limits previously approved) must be sent within 180 days of your receipt of the claim denial to:

NHS
Attn: Appeals Department
P.O. Box 61440
Las Vegas, NV 89160

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, IL 60504

Two levels of appeals for prescription drug claim denials under the PPO 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, IL 60504-4197

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, a healthcare claim under the PPO benefit option, or any other healthcare claim, 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, IL 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:

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

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

Appeals under the sole authority of the plan administrator

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

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

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

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

Review of appeals

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

- Upon request, examine and obtain copies, free of charge, of all Plan documents, records and other information that affect your claim.
- Submit written comments, documents, records, and other information relating to your claim.
- Information identifying the medical or vocational experts whose opinion was obtained on behalf of UNITE HERE HEALTH in connection with the denial of your claim. You are entitled to this information even if this information was not relied on when your appeal was denied.
- Designate someone to act as your authorized representative (*see page G-4* 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.

Claim filing and appeal provisions

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.

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

Claim filing and appeal provisions

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 all of its rights and defenses in that regard.

Commencement of legal action

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

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

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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 a Kaiser HMO benefit option or to the vision benefits. Call the Fund at (855) 484-8480 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. Except where a different allowable charge is required by federal law for non-network emergency medical treatment, the Plan calculates benefits (if any) 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, a \$15 **copay** applies to each eye exam under the vision benefit.

If you are in the PPO, your medical **copays** apply to your medical out-of-pocket limits (*see page C-10*), and your prescription drug **copays** count toward your prescription drug out-of-pocket limits (*see page C-20*).

You can get more information about your 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 in the dental2+ benefit option, your 15% **coinsurance** for a \$1,000 oral surgery equals \$150. The Fund pays the rest of the allowable charge.

If you are in the PPO, your prescription drug **coinsurance** counts toward your prescription drug out-of-pocket limits.

Cosmetic services

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

Mastectomies, and reconstruction following a mastectomy, will not be considered a **cosmetic service** (*see page H-3*).

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.

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.

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

Emergency medical treatment

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

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

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

Injuries and sicknesses

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

Sickness also includes mental health conditions and substance abuse. For employees and spouses only, sickness also includes pregnancy and pregnancy-related conditions, including abortion.

The PPO benefit option only pays benefits for preventive healthcare for a pregnant dependent child. *Generally, maternity charges for a pregnant dependent child that are not preventive health-care (see page H-6) are not covered by the Plan.* “Non-preventive maternity care” includes but is not limited to ultrasounds, care for a high-risk pregnancy, and the actual childbirth and delivery. No benefits are payable for the child of your child (unless the child meets the Plan’s definition of a dependent—*see page F-3*).

The Plan will also consider voluntary sterilization procedures for you, your spouse, and your female children who meet the definition of a dependent, to be 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.

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.

Out-of-pocket costs for non-network care or treatment do not count toward your out-of-pocket limit, except for emergency medical treatment, professional ambulance transportation, treatment provided by non-network healthcare providers who specialize in emergency medicine, radiology, anesthesiology, or pathology, inpatient consultations with non-network providers, and when the network doesn't have a provider in the required specialty. The Plan will not pay 100% for services or supplies that are not covered, or that are provided by a non-network provider, even if you have met your out-of-pocket limit(s) for the year.

You can get more information about your **out-of-pocket limits** for medical care *on page C-9*. You can get more information about your **out-of-pocket limits** for prescription drugs *on page C-20*.

Plan Document

The rules and regulations governing the Plan of benefits provided to eligible employees and dependents participating in Plan Unit 178 (Los Angeles Plan).

Preventive healthcare

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

- Services rated “A” or “B” by the United States Preventive Services Task Force (USPSTF).
- 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. The Plan also considers routine PSA screening tests (prostate-specific antigen tests) to be preventive healthcare.

Contact the Fund 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 include 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.

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Other important information



Other important information

Who pays for your benefits?

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

What benefits are provided through insurance companies?

This Plan provides the following benefits on a self-funded basis. 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.

- PPO medical benefits. Nevada Health Solutions (NHS) provides prior authorization and other utilization review services, case management and chronic condition management.
- PPO prescription drug benefits are administered by Hospitality Rx, LLC, a wholly owned subsidiary of UNITE HERE HEALTH.
- 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 insurance benefits through Dearborn National.
- Kaiser HMO benefit options through Kaiser Foundation Health Plan, Inc. Southern California Region.
- Vision benefits through UnitedHealthcare Insurance Company.

Interpretation of Plan provisions

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

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

With respect to claims for benefits provided through the Dental Center, the contracted dental provider has the sole authority to make decisions about dental benefits and decide all questions or controversies of whatever character with respect to the Dental Center.

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

Plan administrator and agent for service of legal process

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

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

Employer identification number

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

Plan number

The Plan number is 501.

Plan year

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

Remedies for fraud

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

Other important information

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.

Creditable coverage under Massachusetts law

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

If you live in Massachusetts and need help understanding how the Plan meets Massachusetts' rules for minimum creditable coverage, or to get a copy of your MA Form HC-1099, please call the Fund at **(855) 484-8480**.

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

Blue Cross and Blue Shield of Illinois

300 East Randolph Street
Chicago, IL 60601-5099
(800) 810-2583
www.bcbsil.com

Dearborn National

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

LA Dental Center

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

Kaiser Permanente

(800) 464-4000
www.kp.org

Member Service Address

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

Emergency Services (Non-Plan) Claims Address

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

Hospitality Rx

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

Nevada Health Solutions

P.O. Box 61440
Las Vegas, NV 89160
(855) 487-0353
www.nevadahealthsolutions.org

UnitedHealthcare Vision

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

UNITE HERE HEALTH

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

UNITE HERE HEALTH
Board of Trustees



Important phone numbers and addresses

Union Trustees

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