



## Monterey Culinary Health Plan

*Plan Unit 175*



## Summary Plan Description

*Your Health and Welfare Benefits*



# **UNITE HERE HEALTH**

## **Summary Plan Description**

### **Monterey Culinary Health Plan Plan Unit 175**

*Effective October 1, 2017*

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

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# ***Using this book***

## Learn:

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

### Please take some time to review this book.

**If you have dependents, share this information with them, 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 Monterey Culinary Health Plan (Plan Unit 175), 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) 483-4373**. They can help you understand how your benefits work.

Read your SPD for important information about what your benefits are (*see page B-2*), how your benefits are paid, and what rules you may need to follow. You can find more information about a specific benefit in the applicable section. For example, if you want to know more about your life or

AD&D benefits, read the section titled “Life and AD&D Benefits.” If you want more information about your medical benefits, read the medical benefits section.

Some terms are defined for you in the section titled “Definitions” starting *on page I-2*. The SPD will also explain what some commonly used terms mean. When you have questions about what certain words or terms mean, contact the Fund at **(855) 483-4373**.





# ***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"> <li>• Find out about your benefits</li> <li>• Ask questions about your eligibility</li> <li>• Update your address</li> <li>• Request forms or ID cards</li> <li>• Get help filing a vision claim</li> <li>• Get help filing a life or AD&amp;D claim</li> </ul>	<p><b>UNITE HERE HEALTH</b>  <b>(855)-483-4373</b>  <a href="http://www.uhh.org">www.uhh.org</a></p>
<ul style="list-style-type: none"> <li>• Find a network pharmacy</li> <li>• Get information about your prescription drug benefits</li> </ul>	<p><b>Hospitality Rx</b>  <b>(844) 813-3860</b>  <a href="http://www.hospitalityrx.org">www.hospitalityrx.org</a></p>
<p><b>Get help with your dental benefits</b></p> <ul style="list-style-type: none"> <li>• Find a network dentist</li> <li>• Get help filing a claim</li> </ul>	<p><b>MetLife</b>  <b>(800) 942-0854</b>  <a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></p>
<p><b>Get help with your life/AD&amp;D benefits</b></p> <ul style="list-style-type: none"> <li>• Convert to an individual life insurance policy</li> </ul>	<p><b>Dearborn National</b>  <b>(800) 348-4512</b></p>

*This booklet contains a summary in English of your plan rights and benefits under UNITE HERE HEALTH. If you have difficulty understanding any part of this booklet, you can visit or contact the Monterey regional office at 702 Forest Avenue, Suite B, Monterey, California 93950. 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) 483-HERE (TTY: (855) 386-3889 or (855) FUNDTTY) for assistance.*

*Este folleto contiene un resumen en inglés de sus derechos y beneficios de su plan bajo UNITE HERE HEALTH. Si tiene dificultad para comprender cualquier parte de este folleto, puede visitar o contactar a la oficina regional de Monterey en 702 Forest Avenue, Suite B, Monterey, California 93950. Los horarios de oficina son de 8:30 a.m. a 4:30 p.m. (hora estándar del Pacífico), de Lunes a Viernes. También puede llamar a UNITE HERE HEALTH al (855) 483-HERE (TTY: (855) 386-3889 o (855) FUNDTTY) para obtener asistencia.*

# ***How do I get the most from my benefits?***

## Learn:

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

## How 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.

- ✓ Call the Fund at **(855) 483-4373** to get help finding a PCP or a specialist.

### Get preventive healthcare

Your Plan pays 100% for most types of preventive healthcare when you use network providers. Getting preventive healthcare helps you stay healthy by looking for signs of serious medical conditions. If preventive healthcare or tests show there is a problem, the sooner you get diagnosed, the sooner you can start treatment. Be sure to use a network provider. The Plan won't pay for preventive healthcare if you use a non-network provider. *See page D-3 and page I-6* for more information about preventive healthcare.

### 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.**

### Get prior authorization for your care

You or your provider must call Nevada Health Solutions before you get certain types of care. *See page C-2* for information about the prior authorization program. You will pay a \$150 penalty each time you don't call for prior authorization. If you don't call first, your claim may be denied until you or your provider submit medical records showing the care was medically necessary. If your care is not considered medically necessary, you have to pay all of the cost. Be sure you call first to avoid surprise medical bills!

Nevada Health Solutions  
**(855) 487-0353**

### Use network providers

#### Reduce your costs with a network provider

You generally pay less out-of-pocket if you choose a network provider than if you choose

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

Here is a sample medical claim to show how using a network provider usually saves you money. You can see how staying in the network means less money out of your pocket.

Example of Your Costs for Outpatient Surgery		
	PPO Network Provider	Non-Network Provider
A. Total charge	\$10,000	\$20,000
B. Network discount	-\$4,000	n/a
C. Allowable charge ( <i>See page I-2</i> )	\$6,000	\$6,000
What you pay		
D. Amount over allowable charge	\$0	\$14,000 (A minus C)
E. Deductible	\$400	\$400
F. Your cost sharing (coinsurance)	\$1,120 (20% after C minus E)	\$2,800 (50% after C minus E)
Your total payment	<b>\$1,520</b> (D plus E plus F)	<b>\$17,200</b> (D plus E plus F)

Network benefits will be applied to non-network emergency treatment, and to treatment provided by non-network healthcare providers who specialize in emergency medicine, radiology, anesthesiology, or pathology, as well as for in-hospital consultations with non-network providers, or non-network specialists if there is no network specialist available. However, the allowable charge will be based on whether or not the provider is in the network. **You must still pay the difference between the allowable charge and what the non-network provider charges.**

### How do I stay in the network?

- Blue Cross Blue Shield of Illinois provides access to a national network of doctors, hospitals, and other healthcare providers. Your network is the Participating Provider Organization (PPO) network.
- ✓ Only BlueCross of California providers are considered network providers.
- ✓ **BlueShield of California providers are not in your network.**

## *How do I get the most from my benefits?*

- Hospitality Rx provides access to a national network of participating pharmacies that you must use in order to get benefits for prescription drugs.
- MetLife provides access to a national network of dental providers. You get the highest benefits if you use a network provider.

If you have questions about your benefits, or if you need help finding a network provider, call the Fund at **(855) 483-4373** or go to [www.uhh.org](http://www.uhh.org).

# ***Summary of benefits***



## Summary of benefits

Please call the Fund with questions about your benefits: (855) 483-4373.

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### Medical Benefits

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 I-2*).

If you do not call Nevada Health Solutions (NHS) for prior authorization, you will have to pay a \$150 penalty. Your claim could also be denied entirely. *See page C-2* for more information.

*See page D-28* for information about Medicare supplement benefits for retired employees and their spouses.

### Medical Benefits—What You Pay

	Network Provider	Non-Network Provider
<b>Additional Accident Benefit Maximum</b>		
Maximum Plan Payment	\$0 Plan pays up to \$300 per person per year	
<b>Calendar Year Deductibles</b>		
Calendar Year Deductibles	\$400 per person \$1,200 per family	
<b>Annual Out-of-Pocket Limits</b>		
For Network Medical Care and Prescription Drugs	\$6,350/person \$12,700/family	n/a
<b>Office Visits</b>		
Preventive Healthcare Services	\$0	Not covered
Primary Care Provider (PCP) Office Visit	\$25 copay/visit	50% after deductible

#### 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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<b>Medical Benefits—What You Pay</b>		
	<b>Network Provider</b>	<b>Non-Network Provider</b>
Specialist Visit	\$25 copay/visit	50% after deductible
Mental Health/Substance Abuse Office Visits		
Acupuncture	20% after deductible	
Chiropractic Care — <i>up to \$500 per person per year</i>		
<b>Urgent and Emergency Care</b>		
Urgent Care Center	\$25 copay/visit	50% after deductible
Hospital Emergency Room for Emergency Care— <i>see page I-4</i>	20% after deductible	20% after deductible
Hospital Emergency Room for Non-emergency Care	50% after deductible	50% after deductible
Professional Ambulance Services	20% after deductible	20% after deductible
<b>Laboratory Services</b>		
Laboratory Services at Quest Diagnostics	\$0	n/a
All Other Laboratory Services and Radiology	20% after deductible	50% after deductible
Alpha-Fetoprotein Screening	\$0	Not covered
<b>Outpatient Services</b>		
Hospital Outpatient Treatment	20% after deductible	50% after deductible
Physical, Speech, Occupational, or Massage Therapy— <i>up to 60 total visits per person per year; no more than 30 non-network visits</i>		
Habilitative Therapy for Children with Autism Spectrum Disorder — <i>for treatment starting before June 1, 2018; certain other limits apply (see page D-2)</i>		
Diabetes Education	\$0	Not covered
Nutritional Counseling — <i>up to \$200 per person per year</i>	\$0	Not covered

## Summary of benefits

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<i>Medical Benefits—What You Pay</i>		
	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Inpatient Treatment</b>		
<b>Inpatient Hospitalization</b>	20% after deductible	50% after deductible
<b>Inpatient Hospitalization for Mental Health/Substance Abuse Treatment</b> <i>(including residential treatment)</i>		
<b>Skilled Nursing Facility —</b> <i>up to 60 total days per person each year</i>		
<b>Other Services and Supplies</b>		
<b>Podiatric Care—</b> <i>Non-routine podiatry only</i>	20% after deductible	50% after deductible
<b>Home Healthcare Services —</b> <i>up to 60 total visits per person each year</i>		
<b>Hospice Care</b>		
<b>Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment</b>		
<b>Durable Medical Equipment</b>		
<b>Travel and Lodging—</b> <i>see page D-7 for information</i>	Reimburse 100% up to \$250/day and \$10,000/episode	
<b>Medical Foods—</b> <i>see page D-7 for information</i>	Reimburse 100%	
<b>Other Covered Expenses</b>	20% after deductible	50% after deductible

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## Summary of benefits

B

<i>Medical Benefits—What You Pay</i>		
	Network Provider	Non-Network Provider
<b>Prescription Drug Benefits</b>		
	Retail (up to a 34-day supply)	Mail Order (up to a 90-day supply)
Preventive Healthcare Prescription Drugs and Supplies, Including Immunizations <i>See page D-3</i>	\$0	
Generic Drugs	\$10	\$20
Preferred Brand Name Drugs	\$25	\$50
Non-Preferred Brand Name Drugs	\$60	\$120
Specialty Brand and Biosimilar Prescription Drugs	25%, up to a maximum of \$50	

<b>Dental benefits</b>		
Description of Services	Network Dentists	Non-Network Dentists
<b>Dental Services</b>		
Calendar Year Maximum Benefit— <i>does not apply to exams for persons under age 19</i>	\$1,000 per person per year	\$800 per person per year
Calendar Year Deductible	\$0	\$50 per person \$50 per family
<b>What You Pay for Your Covered Dental Care</b>		
Diagnostic and Preventive Services	\$0	20%
Minor Restorative Services	20%	30% after deductible
Major Restorative Services	50%	60% after deductible

<i>Vision Care Benefits—What the Plan Pays</i>	
<b>Vision Care Services and Supplies— available every 24 months</b>	Plan pays 100% up to \$200 per person every 24 months <i>Maximum benefit does not apply to the following services for persons under age 19: eye exams or lenses</i>

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## Summary of benefits

B

<i>Life and Accidental Death &amp; Dismemberment (AD&amp;D) Benefit What the Plan Pays</i>	
<b>Active Employees</b>	
Life Insurance—Active Employees	\$1,000—Basic \$2,500—Supplemental
AD&D Insurance ( <i>full amount</i> )—Active Employees	\$1,000—Basic \$2,500—Supplemental
<b>Dependents of Active Employees</b>	
Life Insurance—Dependents:	
Spouse	\$1,000
Child from 14 days to age 26	\$1,000
Child from live birth to age 14 days	\$500
<b>Former Employees—Who Were Hired before January 1, 2011 (This benefit continues even if you are no longer covered under Plan Unit 175)</b>	
Life Insurance—Former Employees	\$2,500
<b>Retirees</b>	
Life Insurance—Retirees	\$2,500

# ***Prior authorization program***

Learn when you should call Nevada Health Solutions:

- ▶ To get prior authorization for your care.
- ▶ To sign up for the case management program.

## 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 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:

**Nevada Health Solutions**

**(855) 487-0353**

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 don't get prior authorization before you receive these types of care, a \$150 penalty may apply, and your claim may be denied. Nevada Health Solutions will ask for more information to decide whether the claim should be re-processed and paid. Making sure Nevada Health Solutions 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.

**Nevada Health Solutions**

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 Nevada Health Solutions 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.
- 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. Nevada Health Solutions 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.

## Prior authorization program

Finally, you are required to notify Nevada Health Solutions for the following types of care listed below. Again, Nevada Health Solutions 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 Nevada Health Solutions before receiving any of the above types of services and supplies. If you need emergency care, you should contact Nevada Health Solutions as soon as possible, but no later than the next business day, after you get the service or supply. If you are hospitalized because you are having a baby, you must call Nevada Health Solutions if your stay will be longer than 48 hours for normal childbirth, or 96 hours for a Cesarean section.

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

*See page H-4* for information about when Nevada Health Solutions 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, Nevada Health Solutions will look for patients who may benefit from case management services. Nevada Health Solutions 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.



## *Prior authorization program*

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.



# ***Medical benefits***

Learn about your medical benefits:

- ▶ How to use your medical benefits.
- ▶ What you pay for medical healthcare.
- ▶ 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.

## Medical benefits

### Network providers

Benefits are paid based on whether you use a network provider or a non-network provider. 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](http://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.

*See page A-8* for more information about how staying in the network can help you save money.

### Additional accident benefit

If you or a dependent are accidentally injured, the Plan pays 100% up to \$300 for covered services for that injury. The allowable charges must exceed any medical benefits paid by the Fund, and be incurred within 90 days of the injury.

### What you pay

You must pay any cost share (such as copays, coinsurance, or deductibles) for your share of covered expenses. You must also pay any expenses that are not covered expenses (*see page D-8* 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.

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

### 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 \$400 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 \$400 individual and \$1,200 family deductibles only apply to the medical benefits (including mental health and substance abuse 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 page B-2* to see which services require the deductible and which services are covered before you satisfy the deductible.

Any allowable charges applied to your calendar year deductible during October, November, or December will also apply to your deductible for the next calendar year.

When two or more persons covered as members of the same family are injured in the same accident, only one deductible will be applied in the calendar year in which the accident occurs and the next following calendar year to all allowable charges incurred for covered expenses for that accident.

### Copays

The copay covers your cost sharing for all of the healthcare you receive at the time of the service. For example, you only pay one office visit copay for all healthcare you receive during the office visit, even if you received other services at the same time. However, depending on how your provider bills for services, you might have to pay an office visit copay, plus deductible and coinsurance for any bloodwork (laboratory services) you get.

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

### Out-of-Pocket limit for covered network expenses

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 of this SPD titled "Prescription drug benefits" (*see page D-10*) count toward this out-of-pocket limit, too.

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

### What's covered

The Plan will only pay benefits for injuries or sicknesses that are not related to your job. Benefits are determined based on allowable charges for covered services resulting from medically necessary care and treatment prescribed or furnished by a healthcare provider.

- **Preventive healthcare services** (*see page I-6*). Certain limits or rules may apply to when and how you get preventive healthcare based on your gender, age, and health status. However, breast pumps purchased through a non-network provider will be considered a covered expense.
  - ▶ PSA tests for men are covered according to the following schedule:
    - Once at age 40

## Medical benefits

- Every 2 years ages 41 through 50
- Annually from age 51
- Cervical cancer screening (pap smear) is covered once every 36 months for just the pap smear, or once every 60 months if both a pap smear and human papillomavirus screening are done together. Cervical cancer screenings are only covered for women from age 21 to age 65.
- Screening mammography is covered for women according to the following schedule:
  - Once at age 40
  - Every 2 years ages 41 through 50
  - Annually from age 51
- **Professional services** of a healthcare provider.
- **General nursing services.**
- **Injectable medications**, including immunizations provided by a healthcare provider.
- Treatment of **mental health conditions and substance abuse**, including inpatient and residential treatment, outpatient care, partial hospitalization, intensive outpatient care, and ambulatory detoxification.
- **Acupuncture services.**
- **Non-routine podiatry.**
- **Chiropractic care**, subject to the maximum benefits shown on the Schedule of Benefits.
- **Outpatient services** in a clinic or urgent care center.
- Hospital **emergency room** services.
- Transportation by a **professional ambulance service** to an area medical facility that is able to provide the required treatment.

If you have no control over whether the ambulance was called, for example 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.
- **Ambulatory surgical facility services**, including general supplies, anesthesia, drugs, and operating and recovery rooms. If you have multiple surgeries, covered expenses are limited to charges for the primary surgery.
- **Radiology.**

- **Diagnostic imaging**, including but not limited to MRIs, MRAs, CT scans, PET scans.
- **Laboratory services.**
- **Radiation therapy.**
- **Chemotherapy.**
- **Hospital charges** for room and board, and other inpatient or outpatient services. The Plan's benefits for a private room will be limited to the semi-private room rate. Hospital charges include intensive care unit accommodations, and routine nursery charges for a covered newborn child.
- **Pregnancy** and pregnancy-related conditions for employees and spouses, including childbirth, miscarriage, abortions, and preventive healthcare (*see page I-6*). No benefits are payable for pregnancy or pregnancy-related conditions for a dependent child, unless the care is considered preventive healthcare.
- **Mastectomies**, including reconstruction of the breast upon which the mastectomy is performed, surgery and reconstruction on the other breast to produce a symmetrical appearance, breast implants, and treatment of physical complications resulting from a mastectomy, including swollen lymph glands.
- **Medical services for organ transplants** if the following rules are all met:
  - ▶ The transplant must be covered by Medicare, including meeting Medicare's clinical, facility, and provider requirements.
  - ▶ You must use any case management program recommended by the Fund or its representative.
  - ▶ You must get prior authorization for the transplant.
  - ▶ Donor expenses for your transplant are only covered if the donor has no other coverage.
  - ▶ Transplant coverage does not include your expenses if you are giving an organ instead of getting an organ.
- **Dental procedures** for treatment otherwise covered under the dental benefit (*see page D-18*), 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.
- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- **Skilled nursing facility care**, subject to the limits shown on the benefits summary, as long as you are under the care of a doctor, and are confined as a regular bed patient.

## Medical benefits

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



the Fund at least twice a year, and must show that:

- Your child is demonstrating improvement.
- You are trained to, and do, participate in the habilitative therapy.
- You follow the treatment plan.

▶ *No Plan benefits will be paid for a course of habilitative therapy that starts on or after June 1, 2018.*

- Outpatient rehabilitation services for **physical, speech, occupational, and massage therapy**, subject to the maximum benefits show on the summary of benefits.
- Professional services for **diabetes education** and training for the care, monitoring, or treatment of diabetes provided by a network provider. Non-network services are not covered.
- Professional services for **nutrition counseling** provided by a network provider. Non-network services are not covered.
- **Repair of sound natural teeth** and their supporting structures, if the covered expenses are the result of an injury. Treatment must be received while you are covered under the Fund. You may have additional dental coverage under your dental benefits—*see page D-18*.
- Services for or in connection with the treatment of **temporomandibular joint dysfunction** (TMJ).
- **Sterilization procedures** for employees and spouses. For female dependent children, FDA-approved sterilization procedures considered preventive healthcare (*see page I-6*) are also covered.
- **Surgical supplies and surgical dressings**, including artificial limbs and eyes, and casts, splints, and trusses.
- Treatment of **tumors, cysts and lesions** not considered a dental procedure.
- **Oral surgery**, including surgical removal of impacted teeth.
- **Medical foods** if you have an inborn error of metabolism (IEM). You must get prior authorization for your medical food costs before the Plan will reimburse you. The Plan 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.
- 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:

## Medical benefits

- ▶ 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.

More details about the benefit are available upon request.

### What's not covered

*See page E-1* 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 D-10*.
- 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.
- 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.
- Surgery to modify jaw relationships including, but not limited to, osteoplasty and genioplasty procedures. However, Le Fort-type operations are covered when primarily to repair birth defects of the mouth, conditions of the mid-face (over or under development of facial features), or damage caused by injury.
- Eye refractions, eyeglasses, or contact lenses. However, these expenses may be covered under the vision benefits (*see page D-26*).
- Private duty nursing care.

# ***Prescription drug benefits***

Learn about your drug benefits:

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

## Prescription drug benefits

The Plan has contracted with Hospitality Rx, LLC (Hospitality Rx) to provide pharmacy benefit management services. Hospitality Rx has contracted with WellDyneRx to provide some administrative services.

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

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

### Important Phone Numbers

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

## What you pay

You must pay the applicable amount shown below for each fill of a prescription drug. You must also pay any expenses that are not considered covered expenses (*see page D-15* for information about what's not covered).

Prescription Drugs	Your Cost for Each Fill or Refill	
	Retail (up to a 34-day supply)	Mail Order (up to a 90-day supply)
Preventive Healthcare Prescription Drugs and Supplies, Including Immunizations <i>see page I-6</i>	\$0	\$0
Generic Drugs	\$10	\$20
Preferred Brand Name Drugs	\$25	\$50
Non-Preferred Brand Name Drugs	\$60	\$120
Specialty and Biosimilar Drugs	25% up to \$50 total copay per fill or refill	

Preferred brand name drugs and supplies are safe, effective, high-quality drugs and supplies. You pay less for these brand name drugs than you do for non-preferred brand name drugs. Prescription drugs and supplies may be added to or removed from the list of preferred drugs from time to time. Contact Hospitality Rx at (844) 813-3860 if you or your healthcare provider has questions about which prescription drugs and supplies are on the list of preferred drugs.

You must use the specialty pharmacy to get specialty and biosimilar prescription drugs. *See page D-15* for more information about the specialty pharmacy.

### Out-of-Pocket limit for covered network expenses

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.

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 surcharges 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.

Amounts you pay out-of-pocket for medical expenses under the section of this SPD titled "Medical benefits" (*See page D-2*) count toward this out-of-pocket limit, too.

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

### Generic prescription drug policy

If you or your provider chooses a covered brand name prescription drug when you could get a generic equivalent instead, you pay the difference in cost between the brand name prescription drug and the generic equivalent. For example, if the brand name prescription drug costs \$80 at retail, and the Fund's cost for the generic equivalent is \$30, you must pay the \$50 difference. You will also have to pay the \$10 (retail) or \$20 (mail) generic prescription drug copay.

The generic prescription drug policy does not apply to certain prescription drugs that need to be closely monitored, or if very small changes in the dose could be harmful. The prescription drugs that are not subject to the generic prescription drug policy change from time to time. You can get up-to-date information by calling Hospitality Rx at (844) 813-3860. This rule will also not apply if the prior authorization program makes an exception to the rule. Your healthcare provider will need to get prior approval for this exception to apply to your prescription drugs.

If you have an exception to the generic prescription drug policy, you will still have to pay the ap-

## Prescription drug benefits

plicable brand name drug copay (\$25 or \$50 for preferred brand name drugs, and \$60 or \$120 for non-preferred brand name drugs).

### 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.
- 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.
- The following single-source vitamins: ferrous sulfate, vitamin D, cyanocobalamin, vitamin K, potassium chloride, bicarbonate, phosphate, calcium acetate, niacin, and Galzin (zinc).

### Free glucometers

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

**(888) 883-7091** for **OneTouch (LifeScan)** products  
or visit [www.OneTouch.orderpoints.com](http://www.OneTouch.orderpoints.com)  
*use order number 739WDRX01*

**(866) 788-9618** for **TrueMetrix (Trividia)** products

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

### Safety and cost containment programs for prescription drugs

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

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

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

*See page H-7* for information about appealing a denial for prior authorization or appealing a denial of prescription drug benefits.

### **Prior authorization**

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

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

### **Step therapy**

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

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

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

### **Case management**

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

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

### 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 90-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 to exceed the time for which you are eligible for benefits. The Fund may apply a surcharge of up to \$50 (or, if less, the cost of the drug) in addition to the applicable copay after the first early refill of a drug each year. You may also have to participate in the 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.



### Mail-order pharmacy

You can save money by using the Hospitality Rx's mail-order pharmacy: WellDyneRx Home Delivery. If you need a prescription drug to treat a chronic, long-term health condition, you can order these prescription drugs through the mail-order pharmacy. You can get up to a 90-day supply of your prescription drug (sometimes called a "maintenance" prescription drug) for the same copay you would pay for a 34-day supply at a retail pharmacy.

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

**WellDyneRx Home Delivery**

**(844) 813-3860**

[www.mywdrx.com](http://www.mywdrx.com)

### Specialty pharmacy

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

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

**Walgreens Specialty Pharmacy**

**(877) 647-5807**

### What's not covered

*See page D-28* for a list of this Plan's general exclusions and limitations. In addition to that list, the following types of prescription drug treatments, services, and supplies are not covered under the prescription drug benefit:

- Prescription drugs that have not been approved by the FDA. However, the Fund may cover prescription drugs not approved by the FDA in certain situations. You or your healthcare professional may ask for an exception through the Fund's prior authorization program.
- Specialty prescription drugs, other than those used to treat HIV/AIDS, if you do not use the specialty pharmacy.
- Experimental or investigational drugs.
- Fertility drugs.

## Prescription drug benefits

- Prescriptions or refills in amounts over the quantity limits (*see page D-14*).
- Non-sedating antihistamines or histamine receptor blockers.
- Over-the-counter proton pump inhibitors.
- Diagnostics (drugs used to help in the process of diagnosing certain medical conditions) or biologicals (preparations made from living organisms or their products and used as a diagnostic, preventive, or therapeutic agent).
- 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 the drug for purchase. “Me-too” drugs usually have only very small differences in how they work, but are considered “new” drugs with no generic equivalent. Often, the manufacturer charges high prices for these drugs even though there are other drugs available that work just as well for a lower cost. You can find out if a “me too” drug is covered by contacting Hospitality Rx.
- Drugs that require review under a safety or cost containment program (such as a drug that requires prior authorization, or a drug subject to the step therapy program) if that safety or cost containment program is not followed, or does not approve the drug.
- Drugs, medications, or supplies that are not for an FDA-approved indication, that are not covered under the Plan’s or Plan’s designee’s claims processing guidelines or any other internal rule, including but not limited to any national guidelines used by the medical community.
- Glucometers, other than those the Fund gives to you for free. You may be able to get a glucometer through the medical benefits if you do not want one of the free ones, but you will usually have to pay part or all of the cost.
- Rogaine and other drugs to prevent hair loss.
- Drugs or medications used, consumed or administered at the place where dispensed, other than immunizations. (These drugs may be covered under your medical benefits. *See page D-3.*)
- Drugs used for cosmetic reasons.
- Weight control drugs, unless for the treatment of morbid obesity under the direct supervision of a healthcare provider, and authorized in writing by the Fund.
- Human growth hormone, except to treat emaciation due to AIDS.
- Drugs or other covered supplies not purchased from a network pharmacy.
- Medical foods (medical foods may be covered under the medical benefit—*See page D-6*).

# ***Dental benefits***

Learn about your benefits:

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

## Dental benefits

UNITE HERE HEALTH has contracted with MetLife to administer dental benefits for you and your dependents.

Dental benefits		
Description of Services	Network Dentists	Non-Network Dentists
Dental Services		
Calendar Year Maximum Benefit— <i>does not apply to exams for persons under age 19</i>	\$1,000 per person per year	\$800 per person per year
Calendar Year Deductible	\$0	\$50 per person \$50 per family
What You Pay for Your Covered Dental Care		
Diagnostic and Preventive Services	\$0	20%
Minor Restorative Services	20%	30% after deductible
Major Restorative Services	50%	60% after deductible

### Network vs. non-network providers

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

**MetLife**

toll-free: **(800) 942-0854**

[www.metlife.com/mybenefits](http://www.metlife.com/mybenefits)

(you will have to create an account)

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

**See page A-8** for more information about how using network providers can save you time and money.

### What you pay

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

### Deductibles

Your deductible applies only to certain non-network dental care. The deductible does not apply to diagnostic and preventive services.

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

Your \$50 dental deductibles only apply to your dental benefits. Amounts you pay for medical care, prescription drugs, or vision care will not apply to the \$50 dental deductibles.

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

### Maximum benefits

The Plan pays up to \$1,000 per person each year for your network dental care, and up to \$800 per person for your non-network dental care. However, dental exams provided to children under age 19 do not apply to the maximum benefits.

- Amounts the Plan pays for network benefits will apply to the \$800 non-network maximum.
- Amounts the Plan for non-network benefits will apply to the \$1,000 network maximum.

Once the Plan pays its maximum benefit for you during a year, no more benefits will be paid for your dental care for the rest of that year.

### What's covered

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

- **Diagnostic and preventive services and procedures** to evaluate existing conditions and/or to prevent dental abnormalities or disease, including but not limited to exams, cleanings, and consultations with a non-treating dentist.
  - Dental examinations, limited to twice per calendar year.
  - Prophylaxis (cleaning), limited to twice per calendar year (applies to both routine cleanings and periodontal maintenance cleanings combined).
  - Topical application of fluoride for dependent children under age 19, limited to twice per calendar year.

## Dental benefits

- Full mouth x-rays, including panoramic film or panorex, limited to once every 5 calendar years.
- Bitewing x-rays, limited to once each calendar year for employees, spouses, and children age 19 and older, and twice each calendar year for children under age 19.
- Sealants for the first and second molars of dependent children under age 16, limited to 1 treatment per tooth every 60 months.
- Space maintainers for children under age 14, limited to once per lifetime per tooth area.
- Other x-rays.
- **Minor restorative services:**
  - Emergency palliative treatment.
  - Periodontal maintenance, limited to 2 cleanings each calendar year (applies to both routine cleanings and periodontal maintenance cleanings combined).
  - Scaling and root planing, limited to once per quadrant every 24 months.
  - Periodontal surgery, limited to once per quadrant every 36 months.
  - Debridement, limited to once every 36 months.
  - Occlusal adjustments limited to once every 12 months.
  - Root canal therapy, limited to once per tooth per lifetime.
  - Consultations, limited to 2 every 12 months.
  - Fillings, limited to once per tooth every 12 months.
  - Sedative fillings.
  - Resin infiltration, limited to once per tooth every 60 months.
  - Labs and other tests, including pulp vitality and bacteriological studies, and biopsies.
  - Endodontic procedures such as pulp therapy, pulpotomies, pulp capping, and apexification/recalcification.
  - Oral surgery – simple extractions, surgical extractions, and extractions of impacted teeth.
  - Appliances for bruxism.
  - Local chemotherapeutic agents or injection of therapeutic drugs.

- **Major restorative services:**

- ▶ Cast restorations (inlays, onlays, and crowns), prefabricated crowns, and veneers, including core buildup, post and cores, limited to 1 per tooth every 7 calendar years.
- ▶ Dentures, limited to once every 5 calendar years. Adjustments to dentures are covered provided at least 6 months have passed since their installation, and are limited to once every 12 months.
- ▶ Relines and rebases, limited to once every 36 months. Relines and rebases are covered only if at least 6 months have passed since the installation of the dentures.
- ▶ Repairs (other than recementing) to bridges, crowns, inlays, or onlays, limited to once every 12 months.
- ▶ Recementing bridges, crowns, inlays, or onlays, limited to once every 12 months.
- ▶ Tissue conditioning, limited to once every 36 months.
- ▶ Bridge pontics, limited to once every 7 calendar years.
- ▶ Implants, limited to once every 10 calendar years. Repairs of implants are limited to once per implant every 12 months.

### Predetermination of benefits

You or your dentist may contact MetLife before treatment starts for any non-emergency services your dentist expects to cost more than \$250. Your dentist can get treatment predetermination by sending examination and treatment records to MetLife along with an itemized estimate of the cost of the recommended treatment. MetLife will let you and your dentist know how much the Plan will pay for the suggested treatment. Through predetermination, you will know before treatment starts how much of the bill you will be required to pay.

- ✓ Predetermination does not guarantee eligibility for benefits under the Plan.

### Alternate course of treatment

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

- Commonly used in the treatment of the existing condition, as determined by MetLife.
- Recognized by most dentists to be appropriate based on current national dental practices.

### Benefits after coverage ends

If your coverage ends, Plan benefits will only be paid for allowable charges incurred for covered expenses before your coverage ends. However, if your coverage ends after your treatment starts for root canals, crowns, bridges, and dentures, the Plan continues to pay benefits for these, as long as treatment is completed within 60 days of your loss of coverage.

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

### What's not covered

In addition to the Plan's general exclusions and limitations (*See page E-2*), no dental benefits are provided for:

- Services or supplies which are primarily cosmetic.
- Preventive resin restorations.
- Bite registration or analysis.
- Instruction for plaque control and oral hygiene.
- Personal supplies or devices, including but not limited to water picks, toothbrushes, or dental floss.
- Replacement of a bridge, denture, or crown, within 5 years of the date of original placement. Such replacement will be covered only if made necessary by the extraction of natural teeth.
- Replacement at any time, of a bridge, partial, or denture which is or can be made usable according to accepted dental standards.
- Restoration of tooth structure damaged by attrition, abrasion, or erosion.
- Services or supplies (other than a full denture) whose main purpose is to:
  - Alter vertical dimension.
  - Stabilize periodontally involved teeth.
  - Diagnose or treat temporomandibular joint disorder.
  - To correct habits (other than an occlusal guard).
  - To restore or alter occlusion.
- Crowns for periodontal splinting, or if the tooth is restorable by other means.
- Services or supplies that will not restore function.



- Decoration, personalization, or inscription of any tooth, device, appliance, crown, or other dental work.
- Missed appointments.
- Drugs or medications other than therapeutic drugs, sedation, or local chemotherapeutic agents.
- Services which are payable under any other part of the Plan.
- Temporary or provisional restorations or appliances.
- Prescription drugs.
- Services for which the submitted documentation indicates a poor prognosis.
- Any of the following when charged on a separate basis:
  - Claim form completion.
  - Infection control such as gloves, masks, and sterilization of supplies.
  - Local anesthesia, non-intravenous conscious sedation, or analgesia such as nitrous oxide.
- Accidental injury to the teeth or supporting structures, other than injuries caused by chewing or biting food.
- Caries susceptibility tests.
- Adjustment of a denture made within 6 months after installation by the same dentist who installed it.
- Precision attachments other than related to implant prosthetics.
- Repair of an oral birth defect other than a handicapping malocclusion.
- Replacement of a lost or stolen appliance, or duplicate devices or appliances.
- Intra and extraoral photographic images.
- Orthodontia services or appliances.
- Services rendered more frequently than permitted under the Plan, more frequently than commonly accepted according to the dental standards determined by MetLife, or more frequently than specified in the contract with MetLife.



# ***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

### Vision Care Benefits—What the Plan Pays

**Vision Care Services and Supplies—**  
*available every 24 months*

Plan pays 100% up to \$200 per person every 24 months  
*Maximum benefit does not apply to the following services for  
persons under age 19: eye exams or lenses*

## What the Plan pays

The Plan pays up to \$200 per employee for all covered services during a 24-month period, measured from the first day of the month in which the applicable allowable charges are incurred for covered expenses. For example, if covered expenses are first furnished September 20, 2017, the 24-month benefit period would begin again September 1, 2019.

The \$200 benefit maximum does not apply to the following vision care covered expenses for persons under age 19: eye examinations or eyeglass lenses. However, the Plan will cover each of these services only once every 12 months.

## What's covered

- Complete vision examinations, limited to once every 12 months.
- Single vision, bifocal, trifocal, or aphakic eyeglass lenses, limited to once every 12 months.
- Contact lenses.
- Frames.

## What's not covered

*See page E-2* for a list of this Plan's general exclusions and limitations. In addition to that list, the following types of vision care are not covered under the vision benefit:

- Treatment in progress before coverage begins, but only to the extent charges for such treatment are incurred before coverage begins.
- Services and supplies not specifically listed as covered.
- Non-prescription lenses.
- Two pairs of spectacle lenses instead of bifocals.
- Replacement of lost or broken lenses or frames before the beginning of a new 24-month benefit period.

### Get discounted vision care

You can stretch your vision benefit by using the Fund's contracted vision provider. You can get discounted vision care and eye wear if you go to Dr. Trejo's Cass Street location.

900 Cass Street, Suite 102  
Monterey, CA 93940

# ***Medicare supplement benefits***

Learn:

- ▶ What the Plan pays for retirees who are eligible for Medicare.

## Medicare supplement benefits

Medicare supplement benefits apply to you (the retiree) if you meet all of the following rules:

- You were employed for at least 20 consecutive years with a contributing employer prior to retirement.
- You are no longer employed by a contributing employer.
- You are receiving a retirement benefit from the Monterey Culinary Pension Fund.
- You are eligible for Medicare.

If you are eligible for the Medicare supplement benefit, you may enroll your spouse once he or she becomes age 65 or older and eligible for Medicare. There is no cost to you to enroll either yourself or your spouse in the Medicare supplement benefit.

In general, the Plan's Medicare supplement benefits pay 100% of the Medicare Part A and Part B deductibles and the 20% coinsurance Medicare does not pay. Medicare supplement benefits are determined based on what Medicare would pay—even if you or your spouse have not actually enrolled in Medicare (*see page F-4* for more information about coordination with Medicare).

However, no reimbursement will be made for or in connection with any Medicare Part C or Medicare Part D plans.

*See page H-2* for information about filing a claim under the Medicare supplement benefit.

### Supplemental benefits for Medicare Part A

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

- 100% of the Medicare Part A inpatient deductible during a “spell of illness” as defined by Medicare, including:
  - ▶ 100% of the daily Medicare coinsurance beginning with the 60th day of confinement through the 90th day of confinement.
  - ▶ 100% of the daily coinsurance for Skilled Nursing Facility confinement from the 21st day through the 100th day.

### Supplemental benefits for Medicare Part B

For Medicare Part B covered services, the Plan pays:

- 100% of the Medicare Part B Deductible.
- 100% of the Medicare Part B coinsurance.
- 80% of private duty nursing services not covered by Medicare.

### What's not covered

In addition to the Plan's general exclusions and limitations (*see page D-28*), no Medicare supplement benefits will be provided for:

- Amounts considered by Medicare to be in excess of Medicare's allowable expense or maximum benefits.
- Treatment, services, or supplies not considered by Medicare to be covered expenses.
- Outpatient treatment or services for mental health conditions.
- Prescription drugs other than those consumed at the place they are administered.
- Any cost sharing you pay under a Medicare Part C or Part D plan.

### Prescription drug discounts

If you use a network retail pharmacy (*see page D-10*) or the mail order pharmacy (*see page D-15*), you can get discounts on your prescription drugs. Make sure you use your ID card to alert the pharmacy to charge you UNITE HERE HEALTH's discounted rate, plus any contracted fees. You pay 100% of the cost, but this will usually be less than the pharmacy's undiscounted price.

This discount drug card is available to anyone eligible for the Medicare supplement benefit, including both retirees and spouses.





# ***Life and AD&D benefits***

## Learn:

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

## Life and AD&D benefits

Life insurance is provided to eligible employees and eligible dependents, certain former employees who were hired before January 1, 2011, and certain retirees.

<i>Life and Accidental Death &amp; Dismemberment (AD&amp;D) Benefit</i>	
<i>What the Plan Pays</i>	
<b>Active Employees</b>	
Life Insurance—Active Employees	\$1,000—Basic \$2,500—Supplemental
AD&D Insurance ( <i>full amount</i> )—Active Employees	\$1,000—Basic \$2,500—Supplemental
<b>Dependents of Active Employees</b>	
Life Insurance—Dependents:	
Spouse	\$1,000
Child from 14 days to age 26	\$1,000
Child from live birth to age 14 days	\$500
<b>Former Employees—Who Were Hired before January 1, 2011</b> ( <i>this benefit continues even for persons no longer covered under Plan Unit 175</i> )	
Life Insurance—Former Employees	\$2,500
<b>Retirees</b>	
Life Insurance—Retirees	\$2,500

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

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

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

### Life insurance benefit

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

#### Continuation if you become totally disabled

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

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

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

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

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

#### Converting to individual life insurance coverage

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

## Life and AD&D benefits

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

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

### Accidental death & dismemberment insurance benefit

If you die or suffer a covered loss within 365 days of an accident that happens while you are eligible for coverage, AD&D benefits will be paid as shown below. However, the total amount payable for all losses resulting from one accident is \$3,500.

Your AD&D Benefit for a loss (death or dismemberment) within 365 days of an accident		
Event	Benefit	Who Receives
Death	\$3,500	Your beneficiary
Loss of both hands or feet	\$3,500	You
Loss of sight in both eyes	\$3,500	You
Loss of one hand and one foot	\$3,500	You
Loss of one hand and sight in one eye	\$3,500	You
Loss of one hand or one foot	\$1,750	You
Loss of the sight in one eye	\$1,750	You
Loss of index finger and thumb on same hand	\$875	You

### AD&D exclusions

AD&D benefits do not cover losses caused by:

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

- War or an act of war while serving in the military, if you die while in the military or within 6 months after your service in the military.

See your certificate for complete details.

### **Additional accidental death & dismemberment insurance benefits**

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

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

### **Naming a beneficiary**

Your beneficiary is the person or persons you want Dearborn National to pay if you die. Beneficiary designation forms are available on [www.uhh.org](http://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.

## Life and AD&D benefits

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

### Additional services

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

- **Beneficiary Resource Services**—Beneficiary Resource Services is available to beneficiaries of an insured person who dies, and to participants who qualify for the terminal illness benefit. The program combines grief and financial counseling, funeral planning, and legal support provided by Bensinger, DuPont & Associates, a nationwide organization utilizing qualified and accessible grief counselors and legal and financial consultants. Services are provided via telephone, face-to-face contact, and referrals to local support resources. Free online will preparation is also included. Call **(800) 769-9187** for more information or go to [www.beneficiaryresource.com](http://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.

# ***General exclusions and limitations***

Learn:

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

## General exclusions and limitations

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

- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a healthcare provider.
- Any injury, sickness, or dental or vision treatment which arises out of or in the course of any occupation or employment, or for which you have gotten or are entitled to get benefits under a workers' compensation or occupational disease law, whether or not you have applied or been approved for such benefits.
- Any treatment, services, or supplies:
  - For which no charge is made.
  - For which you, your spouse or your child is not required to pay.
  - Which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish, or municipal hospital when there is no legal requirement to pay for such treatment, services, or supplies.
- Any charge which is more than the Plan's allowable charge (*see page I-2*).
- Treatment, services, or supplies not recommended or approved by your healthcare provider, or not medically necessary in treating the injury or sickness as defined by UNITE HERE HEALTH (*see page I-5*).
- Experimental treatment (*see page I-4*), or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH.
- Any expense or charge for failure to appear for an appointment as scheduled, or charge for completion of claim forms, or finance charges.
- Any treatment, services, or supplies provided by an individual who is related by blood or marriage to you, your spouse, or your child, or who normally lives in your home.
- Any treatment, services, or supplies purchased or provided outside of the United States (or its Territories), unless for a medical emergency. The decision of the Trustees in determining whether an emergency existed will be final.
- Any charges incurred for treatment, services, or supplies as a result of a declared or undeclared war or any act thereof; or any loss, expense or charge incurred while a person is on active duty or in training in the Armed Forces, National Guard, or Reserves of any state or any country.
- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault.



## General exclusions and limitations

- 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.
- Preventive medicine, unless specifically included as covered services.
- Any charges incurred for education or training, unless specifically included as covered services.
- Ambulatory surgical facility fees for procedures normally performed in a doctor's office.
- Cosmetic, plastic, or reconstructive surgery, unless that surgery is either: (1) to treat an injury, or (2) breast reconstruction following a mastectomy.
- To the extent of any penalty assessed for any treatment or services requiring prior authorization, when this mandatory program is not used as required.
- Any elective procedure (other than sterilization or abortion, or as otherwise specifically stated as covered) that is not for the correction or cure of a bodily injury or sickness.
- Procedures to reverse a voluntary sterilization.
- Treatment for or in connection with infertility.
- Sex transformation for any reason.
- 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.
- Any expense or charge by a rest home, old age home, or a nursing home.
- Any charges incurred while you are confined in a hospital, nursing home, or other facility or institution (or a part of such facility) which are primarily for education, training, or custodial care.
- 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).

## General exclusions and limitations

- Any smoking cessation treatment, drug, or device to help you stop smoking or using tobacco, other than preventive healthcare services or as otherwise stated as covered.
- 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, as long as treatment is provided within 12 months of the injury or illness. However, eye exams may be covered under the vision benefits (*see page D-26*).
- Hearing aids.
- Rolting, acupuncture, or biofeedback training.
- Naturopathy or naprapathy.
- Athletic training.
- 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.
- 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.
- Charges or claims incurred as a result, in whole or in part, of fraud, false information, or misrepresentation.

# ***Coordination of benefits***

## Learn:

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

## Coordination of benefits

These coordination of benefits provisions only apply to medical benefits and the vision benefits. If you have questions about how your benefits are coordinated, contact the Fund.

No coordination of benefits applies to prescription drug benefits or life and AD&D benefits.

MetLife will follow its own rules to coordinate dental benefits; if there is a conflict between the information described in this section, and the agreement with MetLife, the agreement with MetLife will govern. Contact MetLife with questions about coordination of your dental benefits.

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

This Plan coordinates benefits with the following types of plans:

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

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

### Which plan pays first

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

### Order of payment

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

- Plans that do not contain COB provisions always pay before those that do.
- Plans that have COB and cover a person as an employee always pay before plans that cover the person as a dependent.
- Plans that have COB and that covers a person (or dependent of such person) who is laid off,

retired, or enrolled in continuation coverage offered in accordance with federal or state law will be secondary to active coverage, including self-paid coverage. Continuation coverage 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.

### 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](http://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.





# ***Subrogation***

## Learn:

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

### The Plan's right to recover payments

#### When injury is caused by someone else

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

Typical examples include injuries sustained:

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

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

#### Statement of facts and repayment agreement

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

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

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

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

#### Settling your claim

Before you settle your claim with a third party, you or your attorney should contact UNITE

HERE HEALTH to obtain the total amount of medical bills paid. Upon settlement, UNITE HERE HEALTH is entitled to reimbursement for the amount of the benefits it has paid or the full amount of the settlement or other recovery you or a dependent receive, whatever is less.

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

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

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

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

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



# ***Eligibility for coverage***

## Learn:

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

## 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

The Plan provides three levels of health care benefits depending on your employment classification and the level of employer contribution required by your Collective Bargaining Agreement.

- **Class I Employees:** employees covered under the terms of a CBA.
- **Class II Employees:** officers, agents, representatives, or employees of UNITE HERE or UNITE HERE HEALTH.
- **Class III Employees:** full-time employees of an employer party to a CBA, and proprietors or self-employed partners who are parties to a CBA.
- **Class IV Employees:** full-time employees of an employer party to a CBA, other than the employees covered by the terms of the CBA.

### 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 or a participation agreement to contribute to UNITE HERE HEALTH on your behalf.
- The contributions required by the CBA are received by UNITE HERE HEALTH.
- You meet the Plan's eligibility rules.

### 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.

You can add dependents after your coverage starts. See “Dependent coverage” starting [on page G-6](#) 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.
- Your **children** who are under age 26, including any of the following:
  - ▶ Biological children.
  - ▶ Step-children.
  - ▶ Adopted children or children placed with you for adoption, if you are legally responsible for supporting the children until the adoption is finalized.
  - ▶ Children for whom you are the legal guardian or for whom you have sole custody under a state domestic relations law.
  - ▶ Children entitled to coverage under a Qualified Medical Child Support Order.
    - ✓ Federal law requires UNITE HERE HEALTH to honor Qualified Medical Child Support Orders. UNITE HERE HEALTH has established procedures for determining whether a divorce decree or a support order meets federal requirements and for enrollment of any child named in the Qualified Medical Child Support Order. To obtain a copy of these procedures at no cost, or for more information, contact the Fund.

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

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

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

### Enrollment requirements

#### Employees

You or your employer must provide the Fund with any required information before benefits will be paid on your behalf. 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).
- Documentation of dependent status issued and certified by the United States Immigration and Naturalization Service (INS).
- Documentation of dependent status issued and certified by a foreign embassy.

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

No benefits of any kind will be 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 coverage period corresponding to the work period for



which you establish initial eligibility. The terms of your employer's CBA determines when your employer must make contributions for your work, and when you establish initial eligibility.

For purposes of establishing initial eligibility:

**Work period** means the 3-calendar-month period for which you must meet the eligibility requirements each month of the work period:

- **Class I employees:** Your work period is any 3-calendar-month period for which your employer must make monthly contributions to UNITE HERE HEALTH on your behalf equal to 130 hours of work each month. Overtime hours do not count toward the 130 hour requirement.
- **Classes II, III, and IV employees:** Your work period is any 3-calendar-month period for which your employer must make a contribution to UNITE HERE HEALTH on your behalf.

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

**Coverage period** means the 2-calendar-month period for which you get coverage because you met the eligibility rules in the corresponding work period.

### Example: Establishing Initial Eligibility

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

Suppose you work the required hours, or get contributions, during each of September, October and November. Your coverage begins January 1, and continues through January and February.

## Continuing eligibility

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

For purposes of continuing eligibility:

**Work period** means a calendar during which you meet the eligibility requirements described in your CBA:

- **Class I employees:** Your work period is any month for which your employer must make a contribution to UNITE HERE HEALTH on your behalf equal to:
  - 130 hours per month for the months of May through October **OR**
  - 100 hours per month for the months of November through April.

Overtime hours do not count toward the 100 or 130 hour requirement.

## Eligibility for coverage

- **Classes II, III, and IV employees:** Your work period is any month for which your employer must make a contribution to UNITE HERE HEALTH on your behalf.

**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 you get coverage because you met the eligibility rules in the corresponding work period.

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. Suppose your employer is required to contribute on your behalf for December. If you meet the continuing eligibility rule described above, your coverage continues during March. Contributions in the amounts described above for January continues your coverage for April, and so on.

## 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.

## Vacation hours to continue coverage

You can use your vacation hours to become eligible.

- If you do not work enough hours to continue your eligibility, your vacation hours are automatically used to help you maintain eligibility, or reduce the self-payments you make to continue your eligibility.
- You must use vacation hours within 12 months of earning them.
- Vacation hours are lost after your death.

Contact UNITE HERE HEALTH when you have questions about your eligibility

## Self-payments

### Self-payments to establish or continue eligibility

*These self-payment rules only apply to Class I employees.*

This section describes the rules governing how you can make self-payments to start or continue your coverage if you don't meet work the minimum number of hours to earn eligibility. If you don't follow the rules, your coverage will end on the last day of the coverage period for which your last self-payment was accepted by UNITE HERE HEALTH.

- ✓ Contact the Fund at (855) 483-4373 for more information about the current self-pay rate.

### Self-Payments for initial eligibility

You may make self-payments to establish initial eligibility if, during the work period during which you are establishing initial eligibility you meet the following rules. Self-payments must be mailed to the Fund and post marked no later than the 15th day of the month immediately before the coverage period for which it is buying coverage.

If you are:	And you work at least:	Your may make a self-payment of:
A banquet worker	48 hours per month	130 hours <i>minus</i> the number of hours you actually worked
<u>Not</u> a banquet worker	90 hours per month	

Self-payments must be mailed to UNITE HERE HEALTH and post marked no later than the 15th day of the second month following the month in which you are short hours.

For example, you are **not** a banquet worker, and you worked 90 hours in September, 110 in October, and 130 hours in November. In order to gain initial eligibility for the January–February coverage period, you must make a self-payment for 40 hours for September, and 20 hours for October.

## Eligibility for coverage

### Self-Payments for continuing eligibility

You may make self-payments to continue your eligibility. The length of time for which you can make self-payments depends on how many hours you work each month:

If you are:	And you work:	You may make self-payments:
<b>A banquet worker</b>	48 hours or more per month	as long as you work at least 48 hours each month
	Less than 48 hours per month	for up to 3 months*
<b><u>Not</u> a banquet worker</b>	70 hours or more per month	as long as you work at least 70 hours each month
	Less than 70 hours per month	for up to 3 months*

\* If you work less than 48 or 70 hours per month, you may be able to make self-payments for 3 more months if your reduction in hours was involuntary, as determined by UNITE HERE HEALTH.

The amount of the required monthly self-payment to continue eligibility is:

- For May through October: 130 hours minus the number of hours you actually worked.
- For November through April: 100 hours minus the number of hours you actually worked.

Self-payments must be mailed to UNITE HERE HEALTH and post marked no later than the 15th day of the month immediately before the coverage period for which the self-payment is intended.

### Self-Payment rules if your employment ends

You may make self-payments for the month in which your employment ends as follows:

- If you have not worked any hours during the month in which your employment ends, you may make a self-payment for that month.
- If you have worked the minimum number of hours during the month your employment ends (70 hours for non-banquet employees or 48 hours for banquet employees), you may make a self-payment for the month in which employment ends and for the month next following.

### 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.

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# ***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 G-5*. 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 G-20*.

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 the Fund at **(855) 483-4373**.

### 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 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 last day of the month in which your dependent no longer meets the Plan's definition of a dependent (*see page G-3*).

### 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.

### Certificate of creditable coverage

You may request a certificate of creditable coverage within the 24 months immediately following the date your or your dependents' coverage ends. The certificate shows the persons covered by the Fund and the length of coverage applicable to each. However, the Fund will not automatically send you a certificate of creditable coverage.

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

**G-14**

# ***Reestablishing eligibility***

## Learn:

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

### Portability

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

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

### Family and Medical Leave Act (FMLA)

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

### 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 are in Class I:**

If you (the employee) lose coverage for five consecutive months, you will have a one-time opportunity to re-establish coverage for the sixth month by making a self-payment for hours you worked in the third month of this 5-month period equal to the difference between the hours worked and the required self-payment to continue eligibility (*see page G-7* for the applicable self-payment amount). To be entitled to make this one-time self-payment, you must have a minimum of 70 hours (or 48 hours if you are a banquet employee).

If you do not make this self-payment when allowed to do so, and your loss of eligibility is less than 12 months, you can reestablish your eligibility by satisfying the Plan's continuing eligibility rules (*page G-5*).

If you lose eligibility for 12 months or more you must again satisfy the Plan's initial eligibility rules.

#### **If you are in Classes II, III, or IV:**

If you lose eligibility, and your loss of eligibility is less than 12 months, you can reestablish your eligibility by satisfying the Plan's continuing eligibility rules (*page G-5*).

If you lose eligibility for 12 months or more you must again satisfy the Plan's initial eligibility rules.

### Reestablishing eligibility for dependents

Your dependents will become eligible again when your coverage is re-established.



# ***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 G-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 and AD&D 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 G-20*), as long as those qualifying events would have resulted in a loss of coverage despite the occurrence of any previous qualifying event.

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

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

## *COBRA continuation coverage*

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

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

### **Notifying UNITE HERE HEALTH when qualifying events occur**

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

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

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

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

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

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

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

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

## COBRA continuation coverage

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

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

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

### Election and payment deadlines

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

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

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

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

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

## COBRA continuation coverage

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

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

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

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

## Termination of COBRA continuation coverage

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

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

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

## *COBRA continuation coverage*

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

### **To get more information**

If you have any questions about COBRA continuation coverage, your rights, or the Plan's notification procedures, please call the Fund at **(855) 483-4373**.

For more information about health insurance options available through a Health Insurance Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

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# ***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

### Filing a benefit claim

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

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

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

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

Claims for life or AD&D benefit claims must include a certified copy of the death certificate. All claims for benefits must be made as shown below. If you need help filing a claim, contact the Fund at **(855) 483-4373**.

#### Healthcare claims

Network providers usually will file the claim for you. However, if you need to file a claim, for example because you used a non-network provider, all claims for hospital, medical, or surgical treatment must be mailed to Blue Cross and Blue Shield of Illinois.

#### **Blue Cross and Blue Shield of Illinois**

P. O. Box 805107  
Chicago, IL 60680-4112

#### Prescription drug claims

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

#### **WellDyneRx Claim Reimbursement**

PO Box 90369  
Lakeland, FL 33804



## Claim filing and appeal provisions

### Dental claims

Network dentists usually will file the claim for you. However, if you need to file a claim, for example because you used a non-network dentist, all claims must be mailed to MetLife:

**MetLife**  
P. O. Box 981282  
El Paso, TX 79998-1282

### All other claims

All life or AD&D claims, vision claims, Medicare supplement claims, or any claims denied because you are not eligible, should be mailed to UNITE HERE HEALTH.

**UNITE HERE HEALTH**  
P.O. Box 6020  
Aurora, IL 60598-0020  
**(855) 483-4373**

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

### Deadlines for filing a benefit claim

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

Deadline for filing a claim	
Type of claim	Deadline to file
Life insurance	Within a reasonable amount of time
AD&D insurance	<ul style="list-style-type: none"><li>• Written <i>notice</i> must be received within 31 days of loss (or as soon as possible).</li><li>• Written <i>proof</i> of loss must be received within 90 days of loss (or as soon as possible). Other deadlines may apply to your additional AD&amp;D insurance benefits—your insurance certificate provides more information.</li></ul>
All other claims (including healthcare, prescription drug, dental, vision, and Medicare supplement claims)	18 months following the date the claim was incurred

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

## Claim filing and appeal provisions

### **Individuals who may file a benefit claim**

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

#### **Who is an authorized representative?**

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

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

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

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

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

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

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

### **Determination of claims**

#### **Post-service healthcare claims not involving concurrent care decisions**

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

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

## Claim filing and appeal provisions

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

### Concurrent care decisions

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

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

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

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

### Life and AD&D benefit claims

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

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

## Rules for prior authorization of benefits

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

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

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

## *Claim filing and appeal provisions*

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

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

### **Special rules for decisions involving urgent concurrent care**

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

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

### **If a request for prior authorization is denied**

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

### **Appealing a benefit prior authorization denial**

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

## **If a benefit claim is denied**

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

### **Life and AD&D claims**

You can file an appeal within 60 days of Dearborn National's decision. Dearborn National will generally respond to your appeal within 60 days (but may request a 60-day extension). If you need

## Claim filing and appeal provisions

help filing a claim or appeal, or have questions about how Dearborn National's claim and appeal process works, contact Dearborn National.

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

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

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

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

### **Two levels of appeal for prior authorization denials made by Nevada Health Solutions**

#### **First level of appeal**

All appeals for benefit claims that are denied by Nevada Health Solutions (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:

**Nevada Health Solutions**  
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

## *Claim filing and appeal provisions*

### **Two levels of appeals for prescription drug claim denials made by Hospitality Rx**

#### **First level of appeal**

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

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

#### **Second level of appeal**

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

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

### **One level of appeal for most other claims**

If you disagree with all or any part of a dental claim denial, vision claim denial, short-term disability benefits, life or AD&D denial, or healthcare claim denial, and you wish to appeal the decision, you must follow the steps in this section. (See the preceding sections to learn how to appeal a prior authorization denial by Nevada Health Solutions or appeal a prescription drug denial.)

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

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

### 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 D-6* for details).

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

## Claim filing and appeal provisions

- 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
<b>Subject to one level of appeal</b>	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
<b>Subject to two levels of appeal</b>	As soon as possible but not later than 72 hours for both levels of appeal combined	Within a reasonable time period, but not later than 15 days for each level of appeal	Within a reasonable time period, but not later than 30 days for each level of appeal

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

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

### Independent external review procedures

Within four months after the date you receive a final notice from the Appeals Subcommittee that your appeal has been denied, you may request an external review by an independent external



## Claim filing and appeal provisions

review organization. If you wish to have the external review organization review your claim, you should submit your request to the Plan.

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

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

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

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

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

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

### **Internal appeal exception**

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

## *Claim filing and appeal provisions*

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.

# ***Definitions***

Learn:

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

### Allowable charges

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

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

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

### Copay or copayment

A fixed amount (for example, \$20) you pay for a covered health care service. You usually have to pay your **copay** to the provider at the time you get health care. The amount can vary by the type of covered health care service. Usually, once you have paid your **copay**, this Plan pays the rest of the covered expenses. For example, each time you see specialist in their office, a \$25 **copay** applies.

Your **copays** for your medical care and prescription drugs count toward your out-of-pocket limit.

You can get more information about your medical and prescription drug 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, 10% or 20%) of the allowable charge for the service. You pay your **coinsurance** plus any deductibles or copays. For example, if your ambulance trip costs \$1,000, your 20% **coinsurance** equals \$200. The Fund pays the rest of the allowable charge.

Your **coinsurance** for your medical care and prescription drugs count toward your out-of-pocket limit.

### Cosmetic or reconstructive surgery

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

Mastectomies, and reconstruction following a mastectomy, will not be considered **cosmetic or reconstructive surgery** (*see page D-5*).

### Covered expense

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

### Deductible

The amount you owe for covered expenses before the Fund begins paying benefits. For example, the Plan will not start paying benefits on your behalf until you meet your \$400 individual **deductible** or \$1,200 family **deductible** for care.

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

### Durable medical equipment (DME)

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

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

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

### 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.

Neither a doctor nor a **healthcare provider** is:

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

### Injuries and sicknesses

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

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

The Plan only pays benefits for preventive healthcare for a pregnant dependent child. *Maternity charges for a pregnant dependent child that are not preventive healthcare (see page I-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 G-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 I-4*), nor unproven as determined by appropriate governmental agencies, the organized medical community in the United States, or standards or procedures adopted from time-to-time by the Trustees.

However, with respect to mastectomies and associated reconstructive treatment, allowable charges for such treatment are considered **medically necessary** for covered expenses incurred based on the treatment recommended by the patient’s 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, the Plan limits what you have to pay for your cost-sharing (copays, coinsurance, and deductibles) for medical care and for prescription drugs. This is called an out-of-pocket limit. Once your out-of-pocket costs for network covered expenses meets the **out-of-pocket limit**, the Plan will usually pay 100% for your (or your family's) network covered expenses during the rest of that year.

Amounts you pay out-of-pocket for services and supplies that are not covered, such as amounts over the allowable charges, or 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**, except for emergency treatment, 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.

Amounts you pay for your \$150 penalty for not following the prior authorization program and amounts you pay in addition to your prescription drug copay when you choose a brand name drug when a generic equivalent is available or for early refill surcharges, do not count toward your **out-of-pocket limit**.

You can get more information about your **out-of-pocket limits** [on page D-3](#).

### Plan Document

The rules and regulations governing the Plan of benefits provided to eligible employees and dependents participating in Plan Unit 175 (Monterey Culinary Health Plan).

### Preventive healthcare

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

- Services rated “A” or “B” by the United States Preventive Services Task Force (USPSTF).
- 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.



***Other important information***



## Other important information

### Who pays for your benefits?

Employers participating in the Plan are required to make contributions for their employees. These contributions are controlled by the terms of the Collective Bargaining Agreements negotiated by your local union. Depending on your classification (*see page G-2*) and your Collective Bargaining Agreement, you may also be required to contribute towards the cost of dependent coverage. The Plan is supported by employer contributions and any required contributions you make.

### What benefits are provided through insurance companies?

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

The Fund provides the life insurance and AD&D benefits on a fully insured basis. These benefits are funded and guaranteed under group policies underwritten by Dearborn National.

The Fund also contracts with other organizations to help administer certain benefits. Prescription drug benefits are administered by Hospitality Rx, LLC, a wholly owned subsidiary of UNITE HERE HEALTH. Dental benefits are administered through MetLife. The prior authorization program is managed by Nevada Health Solutions.

### Interpretation of Plan provisions

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

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

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

- Make the final decisions about applications for or entitlement to Plan benefits, including:
  - The exclusive discretion to increase, decrease, or otherwise change Plan provisions for the efficient administration of the Plan or to further the purposes of UNITE HERE HEALTH,
  - The right to obtain or provide information needed to coordinate benefit payments with other plans,
  - The right to obtain second medical or dental opinions or to have an autopsy performed when not forbidden by law;

## Other important information

- Interpret all Plan provisions and associated administrative rules and procedures;
- Authorize all payments under the Plan or recover any amounts in excess of the total amounts required by the Plan.

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

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

### Amendment or termination of the Plan

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

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

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.

## *Other important information*

### **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.

### **Limited retroactive terminations of coverage allowed**

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

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

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



# ***Your rights under ERISA***



## *Your rights under ERISA*

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

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

### **Receive information about your Plan and benefits**

ERISA provides that all Plan participants shall be entitled to:

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

### **Continue group health Plan coverage**

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

### **Prudent actions by Plan fiduciaries**

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

### **Enforce your rights**

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

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

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

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

### **Assistance with your questions**

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

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

# Important phone numbers and addresses

## **Blue Cross and Blue Shield of Illinois**

300 East Randolph Street  
Chicago, IL 60601-5099  
**(800) 810-2583**  
[www.bcbsil.com](http://www.bcbsil.com)

## **Dearborn National**

1020 31st Street  
Downers Grove, IL 60515-5591  
**(800) 348-4512**  
[www.dearbornnational.com](http://www.dearbornnational.com)

## **Hospitality Rx**

P.O. Box 6020  
Aurora, IL 60598-0020  
**(844) 813-3860**  
[www.hospitalityrx.org](http://www.hospitalityrx.org)

## **MetLife**

P.O. Box 3532  
Laguna Hills, CA 92654-3532  
**(800) 880-1800**  
[www.metlife.com](http://www.metlife.com)

## **Nevada Health Solutions**

P.O. Box 61440  
Las Vegas, NV 89160  
**(855) 487-0353**  
[www.nevadahealthsolutions.org](http://www.nevadahealthsolutions.org)

## **UNITE HERE HEALTH**

711 North Commons Drive  
Aurora, IL 60504  
**(630) 236-5100**  
[www.uhh.org](http://www.uhh.org)

***UNITE HERE HEALTH***  
***Board of Trustees***



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