



**Detroit
Plan Unit 345**



Summary Plan Description
Your Health and Welfare Benefits

UNITE HERE HEALTH

Summary Plan Description Detroit Plan 345 (Actives) Plan Unit 345

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.

Using this book

Important Phone Numbers	
If you want to	Contact
<ul style="list-style-type: none"> • Find out about your benefits • Ask questions about your eligibility • Update your address • Request forms or ID cards • Get help filing a short-term disability claim • Get help filing a life or AD&D claim 	<p>UNITE HERE HEALTH (800) 419-HERE (4373) www.uhh.org</p>
<p>Get help with your dental benefits</p> <ul style="list-style-type: none"> • Find a network dentist • Get help filing a claim 	<p>Cigna Dental (800) 244-6224 www.mycigna.com</p>
<p>Get help with your vision benefits</p> <ul style="list-style-type: none"> • Find a network eye doctor • Get help filing a claim 	<p>Davis Vision (800) 999-5431 www.davisvision.com</p>
<p>Get help with your life/AD&D benefits</p> <ul style="list-style-type: none"> • Convert to an individual life insurance policy 	<p>Dearborn National (800) 348-4512</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 Chicago regional office at 218 S. Wabash Ave., Suite 800, Chicago, IL 60604. Office hours are from 8:30 a.m. to 4:30 p.m. (Central Time) Monday through Friday. You may also call UNITE HERE HEALTH at (800) 419-HERE (TTY: (855) 386-3889) for assistance. Phones are answered from 9:00 a.m. to 5:00 p.m. local time.

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 Chicago en 218 S. Wabash Ave., Suite 800, Chicago, IL 60604. Los horarios de oficina son de 8:30 a.m. a 4:30 p.m. (Hora Central), de Lunes a Viernes. También puede llamar a UNITE HERE HEALTH al (800) 419-HERE (TTY: (855) 386-3889) para obtener asistencia. Los teléfonos se contestan de 9:00 a.m. a 5:00 p.m. hora local.

What is UNITE HERE HEALTH?

UNITE HERE HEALTH (the Fund) was created to provide benefits for you. UNITE HERE HEALTH serves participants working for employers in the hospitality industry and is governed by a Board of Trustees made up of an equal number of union and employer trustees. Each employer contributes to the Fund based on the terms of specific Collective Bargaining Agreements (CBAs) between the employer and the union.

Your Plan, Detroit Plan 345 (Actives) (Plan Unit 345), is part of UNITE HERE HEALTH. Plan Unit 345 has been adopted by the Trustees to pay for dental, vision, short-term disability, and life and accidental death and dismemberment benefits through the Fund. Other SPDs explain the benefits for other Plan Units, including the retiree benefits under Plan Unit 345 (Retirees).

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.
- 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 UNITE HERE HEALTH at (800) 419-4373.

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 dental benefits, read the section titled "Dental benefits."

Some terms are defined for you in the section titled "Definitions," starting *on page H-2*. The SPD will also explain what some commonly used terms mean. When you have questions about what certain words or terms mean, contact UNITE HERE HEALTH.

Summary of benefits



Summary of benefits

B

No benefits are provided to dependents.

Please call UNITE HERE HEALTH with questions about your benefits: (800) 419-HERE.

Dental Benefits—What You Pay		
	Cigna DPPO Advantage Network Provider	Non-Network Provider
Calendar Year Maximum Benefit	\$2,000 per person <i>does not apply to exams for persons under age 19</i>	
Diagnostic and Preventive Services		
Emergency Palliative Services	\$0	60%
X-rays		
Fillings	\$0	65%
Minor Restorative Services		
Periodontic Services		
Endodontic Services	25%	65%
Oral Surgery		
Prosthodontic Maintenance		
Major Restorative Services		
Prosthodontics	35%	70%

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.

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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Summary of benefits

B

Vision Benefits—What You Pay

You are only eligible for vision benefits if your employer is required to make contributions for vision benefits on your behalf

Description of Services <i>Benefits covered once every 12 months</i>	Davis Vision Provider	Non-Network Provider
Eye Exam	\$0	Not covered
Frames	\$0 for collection frames \$20 copay for premium frames \$0 for non-collection frames, up to a \$58 maximum allowance	\$0, up to a \$17 maximum allowance
Lenses	\$0	\$0, up to a \$17 maximum allowance
Elective Contacts <i>(provided instead of glasses)</i>	\$0, up to a \$90 maximum allowance	\$0, up to a \$35 maximum allowance

Life and Accidental Death & Dismemberment (AD&D) Benefit—What the Plan Pays

Life Insurance	\$10,000
AD&D Insurance <i>(full amount)</i>	\$5,000

Short-Term Disability Benefit—What the Plan Pays

Weekly Amount	\$150 per week
Maximum Length of Benefit	26 weeks
When Benefits Start:	
Disabled Because of Accident	1st day
Disabled Because of Sickness (including pregnancy):	1st day
If Hospitalized	8th day
If Not Hospitalized	

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Dental benefits

Learn:

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

Dental benefits

Dental Benefits—What You Pay		
	Cigna DPPO Advantage Network Provider	Non-Network Provider
Calendar Year Maximum Benefit	\$2,000 per person <i>does not apply to exams for persons under age 19</i>	
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Emergency Palliative Services	\$0	60%
X-rays		
Fillings	\$0	65%
Minor Restorative Services		
Periodontic Services		
Endodontic Services	25%	65%
Oral Surgery		
Prosthodontic Maintenance		
Major Restorative Services		
Prosthodontics	35%	70%

Network vs. non-network providers

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

- ✓ Your network is the DPPO Advantage Network. Be careful—dentists in Cigna’s other networks, including the DPPO network, are not in your network unless they are also DPPO Advantage Network providers.

To locate a network provider near you, contact:

Cigna Dental
toll free: **(800) 244-6224**
www.mycigna.com
(you will have to create an account)

What you pay

You must pay your cost-sharing (coinsurance) for your share of covered expenses. You must also pay any expenses that are not considered covered expenses (*see page C-6* for information about excluded expenses), and, if you use a non-network provider, any amounts over the allowable charge.

Maximum benefits

The Plan pays up to \$2,000 per person each year for both network and non-network dental care combined. Once the Plan pays \$2,000 for your dental care during a year, the Plan will not pay any more benefits for your dental care for the rest of that year. However, if you are under age 19, amounts the Plan pays for dental exams will not count toward your \$2,000 maximum.

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 (*see page H-2*) will be based on the less expensive alternate type of treatment. This rule applies if the alternate type of dental treatment is both:

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

What's covered

Covered expenses mean all allowable charges made by a dentist for the types of services and supplies listed below. In order to be considered a covered expense, Cigna must determine that the service or supply was based on a valid dental need and performed according to accepted standards of dental practice.

There are limits on how often certain services and supplies are covered. If the amount of time shown below has not passed since the service or supply was last provided, you may have to pay 100% of the cost. You can always contact Cigna to find out the last time the Plan paid benefits for a certain service or supply. A time limit starts on the date you last got the service or supply. Time limits are measured in consecutive months or years.

If treatment is interrupted and another dentist completes the treatment, Cigna will determine the benefit (if any) to be paid to each dentist.

- **Diagnostic and preventive services** and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease:

Dental benefits

- ▶ Prophylaxes (cleaning) and oral exams—2 every calendar year (applies to both routine cleanings and periodontal maintenance cleanings combined).
- ▶ Bitewing x-rays—2 series every calendar year.
- ▶ Full mouth x-rays (including panoramic film)—1 every 3 calendar years.
- ▶ Space maintainers for non-orthodontic treatment for persons under age 19.
- ▶ Fluoride for persons under age 19—1 treatment every calendar year.
- ▶ Sealants for persons under age 15—1 per tooth every 3 calendar years.
- ▶ Histopathological exams.
- ▶ Emergency palliative treatment for dental pain including minor procedures, when no other definitive dental services are performed. If x-rays are taken in connection with palliative treatment, the x-rays will be considered a separate dental service.
- **Fillings**—limited to once per tooth service every 12 months:
 - ▶ Amalgam filling.
 - ▶ Composite/resin filling.
- **Minor restorative services:**
 - ▶ Brush biopsies.
 - ▶ Periodontic services:
 - Periodontal scaling and root planing (entire mouth).
 - Periodontal prophylaxis.
 - Periodontal maintenance procedures following active therapy—2 every calendar year (applies to both routine cleanings and periodontal maintenance cleanings combined).
 - ▶ Endodontic services:
 - Root canal therapy, as long as any x-ray, test, laboratory work, or follow-up care is part of the root canal therapy and not a separate dental service.
 - ▶ Oral surgery:
 - Osseous surgery.
 - Routine extractions.
 - Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth, including removal of impacted tooth (soft tissue, partially bony, or completely bony).

- Local anesthetic, analgesic, and routine post-operative care that are not separately reimbursed, but are considered part of the submitted fee for the surgical procedure.
- General anesthesia, but only administered in conjunction with complex oral surgical procedures covered by the Plan, or otherwise deemed necessary by Cigna.
- I.V. sedation, but only if administered in conjunction with complex oral surgical procedures covered by the Plan, or otherwise deemed necessary by Cigna.
- ▶ Prosthodontic maintenance services:
 - Recement bridges.
 - Denture relines and rebases.
 - Denture adjustments, provided any adjustment of or repair to a denture within 6 months of its installation is not a separate dental procedure.
- **Major restorations:**
 - ▶ Inlays—limited to 1 every 5 calendar years.
 - ▶ Crowns—limited to 1 every 5 calendar years:
 - Porcelain fused to high noble metal.
 - Full cast high noble metal.
 - Three-fourths cast, metallic.
 - ▶ Dentures—limited to 1 every 5 calendar years:
 - Complete (full) dentures, upper or lower.
 - Partial dentures.
 - Lower, cast metal base with resin saddles (including any conventional clasps, rests, and teeth).
 - Upper, cast metal base with resin saddles (including any conventional clasps, rests, and teeth).
 - ▶ Fixed appliances—bridges limited to 1 every 5 calendar years:
 - Bridge pontics, cast high noble metal.
 - Bridge pontics, porcelain fused to high noble metal.
 - Bridge pontics, resin with high noble metal.
 - Retainer crowns, resin with high noble metal.

Dental benefits

- Retainer crowns, porcelain fused to high noble metal.
- Retainer crowns, full cast high noble metal.
- Prosthesis over implant (a prosthetic device, supported by an implant or implant abutment)—limited to 1 every 60 months.

What's not covered

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

- Services performed solely for cosmetic reasons.
- Crown restoration services unless the tooth, because of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic, or plastic.
- Replacement of any type of prosthesis supported by an implant or implant abutment unless the existing prosthesis is at least 5 calendar years old, is not serviceable, and cannot be repaired.
- Flap entry and closure when not performed as part of osseous surgery.
- Replacement of a lost or stolen appliance.
- Replacement of a bridge, crown, inlay, or denture within 5 years after the date it was originally installed, unless:
 - The replacement is necessary because of the placement of an original opposing full denture or extraction of normal teeth, or
 - The bridge, crown, or denture, while in the mouth, has been damaged beyond repair as a result of an injury.
- Any replacement of a bridge, crown, or denture which is or can be made usable according to common dental standards.
- Procedures, appliances, or restorations (except full dentures) whose main purpose is to:
 - Change vertical dimension.
 - Diagnose or treat conditions or dysfunction of the temporomandibular joint.
 - Stabilize periodontally involved teeth.
 - Restore occlusion.
- Porcelain or acrylic veneers of crowns or pontics on, or replacing, the upper and lower first, second, and third molars.

- Bite registrations, precision or semi-precision attachments, or splinting.
- Instruction for plaque control, oral hygiene, and diet.
- Dental services that do not meet common dental standards.
- Services that are considered medical services.
- Services and supplies received from a hospital.
- The surgical placement of an implant body or framework of any type, surgical procedures in anticipation of implant placement, any device, index, or surgical template guide used for implant surgery, treatment or repair of an existing implant, prefabricated or custom implant abutments, or removal of an existing implant.
- Treatment in progress before your coverage begins, but only to the extent charges for such treatment are incurred before coverage begins.
- Orthodontic services or supplies.

Predetermination of dental benefits

If your dentist recommends dental work that is estimated to cost \$250 or more, you can ask Cigna to help you determine how much the Plan will pay. This is a voluntary program, but contacting Cigna before you have complex or expensive dental work will help you and your dentist understand what the Plan will pay for your proposed care. By contacting Cigna in advance, you will have a better idea of what your share of the costs will be so you don't get surprise bills.

If you take advantage of this program, Cigna will review your dentist's records and provide you and your dentist with an estimate of what you must pay, and what the Plan will pay.

Predetermination of benefits does not guarantee what benefits the Plan will pay or that any benefits will be paid for dental treatment or services provided. As always, any treatment decisions are between you and your dentist. All Plan rules will apply to any dental claims you file.

Dental benefits after eligibility ends

If your coverage ends, Plan benefits will only be paid for allowable charges incurred for covered expenses before your coverage ends.

However, if your coverage ends after your treatment starts for crowns, jackets, bridges, complete dentures, or partial dentures, the Plan continues to pay benefits for these, as long as treatment is completed within 60 days of the date you lose coverage.

Vision benefits

Learn:

- ▶ How to use your vision benefits.
- ▶ 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

You are only eligible for vision benefits if your employer is required to make contributions for vision benefits on your behalf.

Vision Benefits—What You Pay		
Description of Services	Davis Vision Provider	Non-Network Provider
Eye Exam	\$0	Not covered
Frames	\$0 for collection frames \$20 copay for premium frames \$0 for non-collection frames, up to a \$58 maximum allowance	\$0, up to a \$17 maximum allowance
Lenses	\$0	
Elective Contacts (provided instead of glasses)	\$0, up to a \$90 maximum allowance	\$0, up to a \$35 maximum allowance

You can get one eye exam and one set of eye wear (either glasses or contacts) every 12 months.

Network and non-network vision providers

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

To locate a network provider near you, contact:

Davis Vision
toll free: (800) 999-5431
www.davisvision.com

If you choose a network provider, you can also get discounts on frames and contacts that are not in the Davis Vision collection.

What you pay

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

Upgrade options through network providers

If you use a network provider, you can get certain upgrades or options for a set fee. Upgrades and options include, but are not limited to, progressive lenses, scratch protection, anti-reflective and ultra anti-reflective, and ultraviolet coating, polycarbonate lenses, high index lenses, and polarized and photosensitive lenses. Get your questions about options answered by contacting Davis Vision, or by asking your network provider. Your cost for an upgrade depends on which upgrade(s) you pick.

What the Plan pays

The Plan pays 100% of covered expenses after you make any applicable copay, up to any allowance shown in the table. You must pay any copays, and any amounts that are more than the Plan's allowance.

What's covered

Benefits are available every 12 months, measured from the first day of the month during which the covered expense is incurred. For example, if you get frames and lenses on July 15, the next 12-month benefit period during which you can get new lenses and frames would begin the following July 1.

The following services and supplies are covered if provided by a licensed vision provider:

- Exams, consultations, or treatment by a licensed vision care professional (including dilation when professionally indicated).
- Plastic or glass lenses, including single vision, bifocal lenses, trifocal lenses, or lenticular lenses, including:
 - ▶ Glass grey #3.
 - ▶ Oversize lenses.
 - ▶ Fashion, sun, or gradient tinted plastic.
 - ▶ Polycarbonate lenses if you have monocular vision, or if your prescription is +/- 6.00 diopters or greater.
- Frames.
- Contact lenses in lieu of glasses.
- Medically necessary contacts, with prior authorization from Davis Vision.
- Low vision services including 1 evaluation and up to 4 follow-up visits every 5 calendar years. Low vision aids are also available, subject to any limits set by Davis Vision.

What's not covered

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

- Non-prescription lenses, including non-prescription sun glasses.
- Eye exams conducted by a non-network provider.
- Any type of lenses, frames, services, supplies, or options that are not specifically listed as covered, or that are not covered under the Davis Vision contract.
- Two pairs of glasses instead of bifocals.
- Contacts and eyeglasses during the same 12-month period.
- Medical or surgical treatment of eye disease.
- Vision therapy.
- Replacement of lost or broken lenses or frames before the beginning of a 12-month benefit period.

Short-Term disability benefits

Learn:

- ▶ What your short-term disability benefit is.
- ▶ How your short-term disability benefits are determined.
- ▶ What isn't covered under your short-term disability benefit.

Short-Term disability benefits

Short-term disability benefits are designed to provide benefits as the result of a disability caused by a non-occupational injury or sickness. To be entitled to benefits, you must be eligible when disability begins. No benefits are available for any period of continuous disability beginning:

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

You are considered disabled if you are prevented by injury or sickness from engaging in the normal activities of your job. You must submit a completed application for benefits and a doctor's statement establishing total disability before benefits can begin. Contact your UNITE HERE HEALTH for the required forms.

What the Plan Pays

The Plan pays a weekly benefit of \$150 for as long as you are disabled and under the regular care of a physician – up to 26 weeks during any one period of disability. The Plan provides a daily benefit of 1/7 of your weekly rate for periods of disability less than 7 days.

Benefits begin on:

- The 1st day of disability caused by injury
- The 1st day of disability caused by sickness
- The 8th day of disability caused by sickness while you are hospitalized

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

Multiple Periods of Disability

Periods of disability due to the same cause will be treated as one period of disability unless you have returned to work for at least 2 weeks.

Periods of disability due to unrelated causes will be treated as one period of disability unless you have returned to work for at least 1 day.

What's Not Covered

No short-term disability benefits are provided under any of the conditions or circumstances listed in the general exclusions and limitations section (*see page D-2*).

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

Event	Benefit	Who Gets
Life Insurance	\$10,000	Your beneficiary
AD&D Insurance (<i>full amount</i>)	\$5,000	You (or your beneficiary if you die)

Life insurance and AD&D insurance benefits are provided under a group insurance policy issued to UNITE HERE HEALTH by Dearborn National. The terms and conditions of your 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 above, and will be paid to your beneficiary(ies) if you die while you are eligible for coverage or within the 31-day period immediately following the date coverage ends.

Continuation if you become totally disabled

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

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

For purposes of continuing your life insurance benefit, you are totally disabled if an injury or a sickness is expected to prevent you from engaging in any occupation for which you are reasonably

qualified by education, training, or experience for at least 12 months.

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

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

Converting to individual life insurance coverage

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

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

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

Terminal Illness Benefit

If you have a terminal illness, your life insurance pays a cash lump sum equal to 75% of the death benefit in force on the day proof of terminal illness is accepted. The remaining 25% of your death benefit will be paid to your named beneficiaries after your death. "Terminal illness" means an illness so severe that you have a life expectancy of 24 months or less.

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 \$5,000.

Life and AD&D benefits

Your AD&D Benefit for a loss (death or dismemberment) within 365 days of an accident		
Event	Benefit	Who Receives
Death	\$5,000	Your beneficiary
Loss of both hands or feet	\$5,000	You
Loss of sight in both eyes		
Loss of one hand and one foot		
Loss of one hand and sight in one eye		
Loss of one hand or one foot	\$2,500	
Loss of the sight in one eye		
Loss of index finger and thumb on same hand	\$1,250	

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.

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Additional accidental death & dismemberment insurance benefits

The additional insurance benefits described below have been added to your AD&D benefits. The

full terms and conditions of these additional insurance benefits are contained in a certificate made available by Dearborn National. If there is a conflict between these highlights and the certificate, the certificate governs.

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

Naming a beneficiary

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

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

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

Additional services

In addition to the benefits described above, Dearborn National has also made the following services available. These services are not part of the insured benefits provided to UNITE HERE

Life and AD&D benefits

HEALTH by Dearborn National but are made available through outside organizations that have contracted with Dearborn National. They have no relationship to UNITE HERE HEALTH or the benefits it provides.

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

- ▶ What your Plan doesn't cover.

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, hearing aids, 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 physician.
- 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 are not required to pay.
 - ▶ Which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish, or municipal hospital when there is no legal requirement to pay for such treatment, services, or supplies.
- Any charge which is more than the Plan's allowable charge (*see page H-2*).
- Treatment, services, or supplies not recommended or approved by your healthcare provider, or not medically necessary in treating the injury or sickness as defined by UNITE HERE HEALTH (*see page H-3*).
- Experimental treatment (*see page H-3*), 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.

General exclusions and limitations

- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault.
- Services, treatment, or supplies provided by a non-network provider when Plan benefits are only payable if the service, treatment, or supply is provided by a network provider.
- A service or item that is not covered under the Plan's claims processing guidelines or any other internal rule, guideline, protocol or similar criterion that the Plan relies upon.
- Any expense greater than any maximum benefit, or any expense incurred before eligibility for coverage begins or after eligibility terminates, unless specifically provided for under this Plan.
- Charges or claims incurred as a result, in whole or in part, of fraud, false information, or misrepresentation.
- Any services, treatment, or supplies provided to a dependent spouse or a dependent child.
- Cosmetic, plastic, or reconstructive surgery, unless that surgery is either: (1) to treat an accidental injury and such surgery occurs within 24 months of the accident, or (2) breast reconstruction following a mastectomy.
- Any elective procedure (other than sterilization or abortion) that is not for the correction or cure of a bodily injury or sickness.
- 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.
- Sex transformation for any reason.
- Supplies or equipment for personal hygiene, comfort or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, tanning beds, or water beds.
- Hearing aids or hearing exams.

Coordination of dental benefits

Learn:

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

Coordination of dental benefits

This section is a summary of Cigna's Coordination of Benefits provisions. However, Cigna 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 Cigna, the agreement with Cigna will govern.

If you have questions about how Cigna coordinates benefits, contact Cigna.

No coordination of benefits applies to vision benefits, short-term disability benefits, or life and AD&D benefits.

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

This Plan coordinates benefits with the following types of plans:

- Group, blanket, or franchise insurance coverage.
- Group Blue Cross or Blue Shield coverage.
- Any other group coverage, including labor-management trusteed plans, employee organization benefit plans, or employer organization benefit plans.
- Any coverage under governmental programs or provided by any statute, except Medicaid.
- Any automobile insurance policies (including "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.
- The plan that covers the person under a right of continuation provided by federal or

Coordination of dental benefits

state law (like COBRA) will be the secondary plan and the plan that covers the person as an active employee will be the primary plan. However, this rule will not apply if the other plan does not have a similar rule and the plans cannot agree on the order of benefit determination.

- 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.

Benefit reserve

When this Plan is the secondary plan, the difference between the amount this Plan would have paid if it had been the primary plan and the benefit payment this Plan actually paid as the secondary plan will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay

Coordination of dental benefits

any allowable expense not otherwise paid during the calendar year while you are eligible, up to 100% of the total of all allowable expenses. At the end of the calendar year, your benefit reserve returns to zero and a new benefit reserve will be calculated for each new calendar year.

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 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 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 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 your behalf 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:

- ▶ How you enroll.
- ▶ 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.

When you become eligible for coverage

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

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

✓ *No coverage is provided for dependents.*

Enrollment requirements

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

When your coverage begins (initial eligibility)

Your coverage begins at 12:01 a.m. on the first day of the coverage period corresponding to the work period for which your employer is first required to make contributions on your behalf.

For purposes of establishing initial eligibility:

Work period means the two-calendar-month period for which all of the following rules are met:

- Your employer is required to make contributions to UNITE HERE HEALTH on your behalf.

Eligibility for coverage

- You are credited with at least 1 hour of work during each of the two months.
- You are credited with at least 30 total days of work.

Lag period means the 2-calendar-month period between the end of a work period and the beginning of the corresponding coverage period.

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

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

Suppose you meet the eligibility rules during the months of July and August. Your coverage begins November 1, and continues through the entire month of November.

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 are credited with at least 15 days of work, and for which your employer is required to 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	Employer Contribution Due	Coverage Period
September	October–November	December
October	November–December	January
November	December–January	February

Eligibility for coverage

You have already become eligible. Suppose your employer is required to contribute on your behalf for September because you are credited with at least 15 days of work for that month. Your coverage continues during December. Contributions for October continues your coverage for January, as long as you are credited with at least 15 days of work, and so on.

Self-payments to continue your eligibility

Self-payments for continuing eligibility

- ✓ All self-payments must be postmarked no later than the 15th day of the month immediately preceding the coverage period for which continued coverage is intended.

You can make self-payments only if you lose eligibility as the result of:

- Temporary lay-off.
- Approved leaves of absence.
- Reduction in hours.
- Approved vacation time off.

The work period for which you are making a self-payment must immediately follow a work period for which you were credited with at least the minimum work requirement to maintain eligibility.

Self-payments can only be made for up to 12 consecutive months. Self-payments cannot be made after your employment terminates.

If you stop making self-payments for coverage, unless you meet the eligibility rules your eligibility will end. You will not be able to start making self-payments until you become eligible again.

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.

Eligibility for coverage

- 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.

Termination of coverage

Learn:

- ▶ When your coverage ends.

Termination of coverage

Your coverage continues as long as you maintain your eligibility as described *on page F-3*. However, your coverage ends if one of the events described below happens. If your coverage terminates, you may be eligible to make self-payments to continue your coverage (called COBRA continuation coverage). *See page F-16*.

If you are absent from covered employment because of uniformed service, you may elect to continue healthcare coverage under the Plan for up to 24 months from the date on which your absence due to uniformed service begins. For more information, including the effect of this election on your COBRA rights, contact UNITE HERE HEALTH at **(800) 419-HERE**.

When your coverage ends

Your 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.
- The day you enter any branch of the Armed Forces.
- With respect to dental benefits only, the earlier of:
 - ▶ The date the contract with Cigna terminates.
 - ▶ The last day of the month for which the Fund makes its last payment to Cigna.

The effect of severely delinquent employer contributions

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

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

Special termination rules

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

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

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

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

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

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

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

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

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

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

Reestablishing eligibility

Learn:

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

Portability

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

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

Family and Medical Leave Act (FMLA)

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

If you are making monthly employee contributions for your coverage when leave begins, you can continue your coverage during your leave by making any required payments to your employer. If you stop making payments, your coverage will start again on the first day of the month for which your employer must make a contribution on your behalf after you return to work.

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 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

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 F-3*). If your loss of eligibility lasts for 12 months or more you must again satisfy the Plan's initial eligibility rules.

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 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 are a qualified beneficiary if you lose coverage due to a qualifying event and you were covered by the Plan on the day before the earliest qualifying event occurs.

What is a qualifying event?

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

- 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.
- 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 vision benefits and dental benefits. **Life and AD&D and short-term disability benefits cannot be continued under COBRA.** However, you may be able to convert your life insurance to an individual policy. Contact UNITE HERE HEALTH 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.
- You may be able to continue coverage for up to an additional 11 months, for a total of 29 months. The Social Security Administration must determine that you 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.

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 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 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, and date of birth to UNITE HERE HEALTH in writing. Be sure you sign and date your submission.

If you do not provide the required notice and documentation, you will lose the right to elect COBRA continuation coverage.

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

COBRA continuation coverage

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 are entitled to COBRA continuation coverage.

- If you are not entitled to COBRA continuation coverage, you 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 are entitled to COBRA continuation coverage, you 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 you at your last known address on file.

If you 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.

If your election form is received within the 60-day election period, you 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 do not pay any required premium when due.
- The date the Plan terminates.
- The date Medicare coverage becomes effective if it begins after your election of COBRA (Medicare coverage means you are entitled to coverage under Medicare; you have applied or enrolled for that coverage, if application is necessary; and your Medicare coverage is effective).
- The date the Plan's eligibility requirements are once again satisfied.
- The end of the month occurring 30 days after the date disability under the Social Security Act ends, if that date occurs after the first 18 months of continuation coverage have expired.
- The date coverage begins under any other group health plan.

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

To get more information

If you have any questions about COBRA continuation coverage, your rights, or the Plan's notification procedures, please call UNITE HERE HEALTH at **(800) 419-HERE**.

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

Claim filing and appeal provisions

Learn:

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

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.

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 UNITE HERE HEALTH at **(800) 419-HERE**.

Dental claims

Cigna DPPO Advantage dentists will generally file dental claims for you. However, if you need to file a claim, for example because you used a non-network provider, you should send the claim to Cigna.

Cigna Dental
P.O. Box 188037
Chattanooga, TN 37422-8037

Vision claims

Network vision providers will generally file vision claims for you. However, if you need to file a claim, for example because you used a non-network vision provider, the claim should be sent to Davis Vision.

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

Claim filing and appeal provisions

All other claims

Claims for all other services or supplies including for short-term disability, life or AD&D benefits, or services and supplies denied because you are not eligible, send claim information to:

UNITE HERE HEALTH
P.O. Box 6020
Aurora, IL 60598-0020
(866) 686-0003

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
Dental claims	1 year following the date the claim was incurred
Vision claims	365 days following the date the claim was incurred
Life insurance	Within a reasonable amount of time
AD&D insurance	<ul style="list-style-type: none">• Written <i>notice</i> must be received within 31 days of loss (or as soon as possible).• Written <i>proof</i> of loss must be received within 90 days of loss (or as soon as possible). Other deadlines may apply to your additional AD&D insurance benefits—your insurance certificate provides more information.
All other claims (including short-term disability 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

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.

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

Claim filing and appeal provisions

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.

Short-term disability claims

In general, you will be notified of the decision on your claim for short-term disability benefits no later than 45 days after receiving your claim.

This 45-day period may be extended for up to an additional 30 days if special circumstances require additional time. The Fund will notify you in writing if it requires more processing time before the end of the first 45-day period.

If the extension described above is necessary because you failed to submit information necessary to decide your claim, you shall be afforded 45 days from the receipt of such notice within which to provide the necessary information. The necessary information that you must submit to UNITE HERE HEALTH will be specified in the notice of extension. The period for processing will be suspended from the date the notification of extension is sent until the date on which UNITE HERE HEALTH receives your response. Failure to provide required information within 45 days will result in the denial of the benefit otherwise payable.

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.

Life and AD&D claims

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

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

Claim filing and appeal provisions

Appealing all other 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.

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.

If you disagree with all or any part of a dental claim denial, vision claim denial, short-term disability benefits, or other claim denial, and you wish to appeal the decision, you must follow the steps in this section.

You must submit an appeal within 12 months of the date you 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 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.

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

Claim filing and appeal provisions

Review of appeals

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

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

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

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

Notice of the decision on your appeal

You will be notified of the decision on your appeal within 60 days after the receipt of your 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 the reasons for the denial, your right to request access to documents, records, and other information relevant to your claim, your right to bring civil action, and your right to more information about any internal rules used to decide your claim.

Claim filing and appeal provisions

Non-assignment of claims

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

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

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

Commencement of legal action

Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted.

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

Definitions

Allowable charges

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

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

- **Allowable charges** for services furnished by network providers are based on the rates specified in the contract between UNITE HERE HEALTH and the provider network. Providers in the network usually offer discounted rates. This means lower out-of-pocket costs for you.
- 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.”)

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 copays.

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.

Covered expense

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

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.

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.

Dentist

A dentist must be licensed to practice dentistry or perform oral surgery in the state in which he or she is practicing, and acting within the scope of the license. A physician may be considered a dentist if he or she performs a covered dental service and operates within the scope of his or her license.

Medically necessary

Medically necessary services, supplies, and treatment are:

- Consistent with and effective for the injury or sickness being treated;
- Considered good medical practice according to standards recognized by the organized medical community in the United States; and
- Not experimental or investigational (*see page H-3*), 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.

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**

Definitions

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.

Plan Document

The rules and regulations governing the Plan of benefits provided to eligible employees participating in Plan Unit 345 (Detroit).

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. The Plan is supported by these employer contributions.

What benefits are provided through insurance companies?

This Plan provides the dental benefits, the vision care benefits, and the short-term disability 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. Cigna Health and Life Insurance Company (Cigna) administers the dental benefits. Davis Vision administers the vision benefit.

Interpretation of Plan provisions

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

Other important information

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

Employer and employee organizations

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

Plan administrator and agent for service of legal process

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

UNITE HERE HEALTH
Chief Executive Officer
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 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.

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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 if there is a loss of coverage under the Plan as a result of a qualifying event. You 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

Cigna Health and Life Insurance Company (Cigna)

900 Cottage Grove Road
Bloomfield, CT 06002
(800) 244-6224

Davis Vision

175 East Houston Street
San Antonio, TX 78205
(800) 999-5431

Dearborn National

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

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UNITE HERE Local 11
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Charlotte, NC 28217

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