



Food Service Plan II

Plan Unit 376 - Mid-Atlantic



Summary Plan Description
Your Health and Welfare Benefits

UNITE HERE HEALTH

Summary Plan Description

Food Service Plan II

Plan Unit 376

Mid-Atlantic

Effective January 1, 2020

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

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 call UNITE HERE HEALTH at (833) 637-3519 (TTY: (855) 386-3889 or (855) FUNDTTY) for assistance.

Este folleto contiene un resumen en inglés de los derechos y beneficios de su plan bajo UNITE HERE HEALTH. Si tiene dificultades para entender cualquier parte de este folleto, puede llamar a UNITE HERE HEALTH al (833) 637-3519 (teléfono de texto: (855) 637-3889 o (855) FUNDTTY) para asistencia.

本手冊提供您在 *under UNITE HERE HEALTH* 下的計劃權利和福利的繁體中文總結。如果理解本手冊的內容存在困難，您可以致電 *UNITE HERE HEALTH* at (833) 637-3519 (TTY: (855) 386-3889 或 (855) FUNDTTY) 尋求協助。

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Using this book

Learn:

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

Please take some time to review this book.

If you have dependents, share this information with them, and let them know where you put this book so you and your family can use it for future reference.

What is UNITE HERE HEALTH?

UNITE HERE HEALTH (the Fund) was created to provide benefits for you and your covered dependents. UNITE HERE HEALTH serves participants working for employers in the hospital-ity industry and is governed by a Board of Trustees made up of an equal number of union and employer trustees. Each employer contributes to UNITE HERE HEALTH according to a specific contract, called a Collective Bargaining Agreement (CBA), between the employer and the union.

Your coverage is being offered under the Mid-Atlantic subgroup of the Food Service Plan II (Plan Unit 376), which has been adopted by the Trustees of UNITE HERE HEALTH to provide medical and other health and welfare benefits through the Fund. Other SPDs explain the benefits for other Plan Units, including the benefits offered through the other subgroups of the Food Service Plan II—Colorado, Georgia, National PPO, Northern California and Southern California .

What is this book and why is it important?

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

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

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

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

How do I use my SPD?

This SPD is broken into sections. You can get more information about different topics by carefully reading each section. A summary of the topics is shown at the start of each section. When you have questions, you should always contact the Fund at **(833) 637-3519**. They can help you understand how your benefits work.

Read your SPD for important information about what your benefits are, how your benefits are

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

Some terms are defined for you in the section titled “Definitions” starting *on page J-2*. The SPD will also explain what some commonly used terms mean. When you have questions about what certain words or terms mean, contact the Fund at **(833) 637-3519**.

How do my benefit options affect this SPD?

The benefits described in this SPD describe the terms of all of the benefit options available under the Mid-Atlantic subgroup of Plan Unit 376. However, your employer’s CBA and your own election choices determine which benefit option you and your family are covered under. For example:

- If you decide not to enroll in a dental benefit, the information about the dental benefits will not apply to you.
- If you chose the basic vision benefit, the information about the vision+ benefit will not apply to you.

The benefits you elect apply to both you and any dependents you enroll. You cannot elect coverage for your dependents only. You must elect coverage for yourself in order to elect coverage for your dependents. When you have questions about your benefit options, contact the Fund at **(833) 637-3519**.

Not all of the options described in this SPD will be available to employees of all employers. The Fund determines which benefit options are available under each subgroup of the Plan Unit (Colorado, Georgia, Mid-Atlantic, National PPO, Northern California, and Southern California). Your CBA will determine which benefit options from your subgroup are available to you. You may not be able to elect all of the benefit options offered under your subgroup. Contact your employer or the Fund for more information about what your benefit options are.

How can I get help?

Learn:

- ▶ Where to call for help.

How can I get help?

Call the Fund at (833) 637-3519:

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

You can also visit UNITE HERE HEALTH's website to get forms, an electronic copy of your SPD, and other information: www.uhh.org/fsp.

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How do I get the most from my benefits?

Learn:

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

How do I get the most from my benefits?

Get a primary care provider

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

Your PCP also helps you keep track of when you need preventive healthcare. **You must get a referral from your PCP to see a specialist.**

- ✓ Call Kaiser at (800) 777-7902 or visit www.kp.org/searchdoctors to get help finding a PCP.

Get preventive healthcare

Kaiser pays 100% for most types of preventive healthcare when you use network providers. Getting preventive healthcare helps you stay healthy by looking for signs of serious medical conditions. If preventive healthcare or tests show there is a problem, the sooner you get diagnosed, the sooner you can start treatment. **Be sure to use a network provider.** Kaiser won't pay for preventive healthcare if you use a non-network provider.

- ✓ Call Kaiser at (800) 777-7902 or visit www.kp.org for more information about preventive care.

Re-think emergency room care

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

You have options:

- ✓ Call Kaiser's nurseline at (800) 777-7904.
- ✓ Book a video visit. Register at www.kp.org to schedule a video visit.
- ✓ Visit a Kaiser urgent care center. Visit www.kp.org/facilities or call Kaiser at (800) 777-7902 to find a network urgent care center.

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

Get prior authorization for your care

You or your provider must get prior authorization before you get certain types of care.

- ✓ Your Kaiser PCP usually gets prior authorization for you.

Use network providers

- ✓ In some cases, benefits will be paid only if you use a network provider. For example, *under the Kaiser HMO benefit option and the dental HMO benefit option, only urgent and emergency care will be covered out of network.*

Reduce your costs with a network provider

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

How do I stay in the network?

- ✓ Call Kaiser at **(800) 777-7902** or visit www.kp.org/facilities to get help finding a network provider.

If you need help finding a network provider for any other benefit, go to the part of your SPD that explains your specific healthcare benefits. The information in that part of your SPD will tell you how to stay in network.

If you have questions about your benefits or benefit options, call the Fund at **(833) 637-3519**.

Kaiser HMO medical and prescription drug benefits

Learn about your benefits:

- ▶ How your HMO works.
- ▶ Using this SPD.
- ▶ Getting more information about your HMO benefits.

Kaiser HMO medical and prescription drug benefits

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

Kaiser Permanente:

www.kp.org

| | Member Services | Kaiser Advice Nurse |
|--------------------------|------------------------|----------------------------|
| Inside Washington, D.C. | (301) 468-6000 | (703) 359-7878 |
| Outside Washington, D.C. | (800) 777-7902 | (800) 777-7904 |

Using your Kaiser HMO benefits

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

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

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

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

If you are in either of the Kaiser Select plans, you can also choose from an expanded network of doctors who contract with Kaiser Permanente. Contact Kaiser Permanente for help finding a doctor or with questions about your provider network.

Using this SPD

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

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

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

Getting more information about the Kaiser HMO

You will receive a copy of the Kaiser evidence of coverage for your benefits. This document provides details about your Kaiser HMO benefits, for example, what your cost-sharing is, what is covered, what is excluded, how to use your benefits, and how to file claims and appeals. If you need a copy of this document, you can request it by contacting Kaiser or UNITE HERE HEALTH.

If you are covered under the Select High benefit with the Kaiser dental benefits, more information about your dental benefits through Kaiser is shown in your evidence of coverage. These dental benefits are not the same as the dental benefits through the dental PPO (*see page C-1*), the dental HMO (*see page C-12*), or the dental benefits under the free family dental/vision benefits (*see page C-21*).

Dental PPO benefits

Learn about your benefits if you are enrolled in the dental PPO benefit:

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

This section only applies to you if you choose the dental PPO benefit option. If you choose the dental HMO benefit option or are in the free family dental/vision benefits, please see the applicable sections starting on [page C-12](#) or [page C-21](#) for information about your dental benefits.

Dental PPO benefits

UNITE HERE HEALTH (the Fund) has contracted with Cigna to provide dental benefits to you and your dependents if you choose this benefit option. This part of the Summary Plan Description (SPD) summarizes your dental benefits. You'll be given a detailed document that also lists any other type of dependents you can enroll in dental coverage, in addition to the dependents listed in this SPD. The rules about who your dependent is under the Cigna dental benefits only apply to dental benefits, and do not apply to any other benefits offered under the Plan. Call the Fund at (833) 637-3519 if you need help understanding what dependents are eligible for Cigna Dental coverage, since the Fund makes all eligibility decisions.

If there is any conflict between this SPD and Cigna documents, which contain certain state-specific rules about benefits and cost-sharing, the terms of the Cigna documents govern. If you have any questions about dental benefits, please contact Cigna.

| CIGNA PPO DENTAL BENEFITS—What You Pay | | |
|---|------------------------------------|----------------------|
| Description of Services | Cigna DPPO Advantage Dentists | Non-Network Dentists |
| Dental Services | | |
| Calendar Year Maximum Benefit for Dental (non-ortho) Treatment | \$1,500 per person | |
| Lifetime Maximum Benefit for Orthodontia Treatment | \$2,500 per person | |
| Calendar Year Deductible <i>The deductible does not apply to diagnostic and preventive services.</i> | \$50 per person & \$150 per family | |
| What You Pay for Your Covered Dental Care | | |
| Diagnostic and Preventive Services— <i>Including oral exams, emergency palliative care, x-rays, routine cleaning, fluoride treatment, sealants, and space maintainers</i> | \$0 (no deductible) | 30% (no deductible) |
| Basic Restorative Services— <i>Including fillings, periodontal cleaning, root canals, osseous surgery, routine and surgical extractions, denture adjustment</i> | 20% after deductible | 40% after deductible |
| Major Restorative Services— <i>Including crowns, bridges, dentures</i> | 50% after deductible | 60% after deductible |
| Orthodontic Treatment | 50% | |

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 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)

See page A-9 for more information about how using network providers can save you time and money.

What you pay

You must pay your cost-sharing (deductibles and 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 what's not covered), including any amounts over the allowable charge.

The deductibles do not apply to diagnostic and preventive services, including but not limited to emergency palliative services, and x-ray services.

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

Maximum benefits

Dental care maximum benefit for non-orthodontic care

The Plan pays up to \$1,500 per person each year for both network and non-network dental care combined. Once the Plan pays \$1,500 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.

Orthodontic care maximum benefit

The Plan pays up to a lifetime maximum of \$2,500 per person for both network and non-network orthodontic care combined. Once the \$2,500 maximum is reached, the Plan will not pay any more benefits for your orthodontic care.

Alternate course of treatment

If there is a different type of treatment that would be at least as effective as your dental treatment, but costs less, the allowable charge (*see page J-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.
- 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.

- **Diagnostic and preventive services** and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease, including exams, cleanings, and consultations with a non-treating dentist.
 - ▶ Prophylaxes (cleaning) and oral exams—2 every 12 months.
 - ▶ Bitewing x-rays—2 series every 12 months.
 - ▶ Full mouth x-rays (which include bitewing x-rays)—1 every 36 months. Panoramic x-rays (including bitewings) are considered a full mouth x-ray.
 - ▶ Topical application of fluoride for persons under age 19—once every 6 months.
 - ▶ Sealants to the first and second permanent molars for persons under age 16—1 application during the person's lifetime. Sealants are covered only on the first or second molar, and only if the tooth is free of decay and has not had a restoration.
- **Emergency palliative care**, including treatment to temporarily relieve pain and discomfort.
- **Diagnostic x-rays** to diagnose a specific condition.
- **Oral surgery**, extractions and other surgical procedures, including pre-operative and post-operative care, and general anesthesia.

- **Endodontic services** and procedures to treat teeth with diseased or damaged nerves (for example, root canals).
 - ▶ Benefits for root canal treatment on primary teeth will be limited to the benefits provided for pulpotomy.
- **Periodontic services** to treat diseases of the gums and supporting structures of the teeth.
 - ▶ Periodontal surgery, including sub-gingival curettage—1 per quadrant every 24 months.
- **Restorative services** to rebuild, repair, or reform the tissues of the teeth, including but not limited to:
 - ▶ Basic restorative services such as amalgam, synthetic porcelain, or resin restorations.
 - ▶ Major restorative services such as crowns, jackets, and gold restorations if the teeth cannot be restored with another filling.
 - ▶ Amalgam or resin restoration—1 per tooth surface every 12 months.
 - ▶ Benefits for multiple restorations on the same tooth will be limited to the benefit provided for one multi-surface restoration.
 - ▶ Benefits for resin restorations are limited to those shown for amalgam restorations if x-rays show decay in the molar or pre-molar on which the resin restoration is placed.
 - ▶ Benefits for cast restorations with cosmetic (elective) components will be limited to the benefits provided for cast metal restorations.
 - ▶ Benefits for teeth which cannot have cast restorations because of decay or missing tooth structure on less than four surfaces are limited to the benefits provided for amalgam or resin restorations.
 - ▶ Benefits for inlays will be limited to the benefits provided for comparable amalgam restorations.
 - ▶ Benefits for four-surface onlays will be limited to the benefits provided for three-surface onlays.
- **Prosthodontic services** and appliances that replace missing natural teeth, including bridges, partial dentures, and complete dentures.
 - ▶ Complete replacement of denture base materials or reline—1 every 24 months.
 - ▶ Benefits for a fixed partial denture placed in a dental arch with three or more missing teeth are limited to the benefits provided for removable dentures. However, this limit does not apply to a pre-existing fixed partial denture that is considered covered.
 - ▶ Benefits for pontics are limited to the benefit for one pontic if the space between teeth created by a missing tooth is greater than the size of the original tooth.

Dental PPO benefits

- ▶ Benefits for personalization of dentures, precision attachments, stress breakers, or specialized techniques are limited to the benefits provided for conventional dentures.
- **Prosthodontic repairs and relines** to prosthetic appliances.
- **Orthodontic services** including x-rays, diagnostic tests, casts and treatment, and fixed or removable appliances, including retention appliances. Only one appliance per person for tooth guidance or to control harmful habits will be covered. Each month of active treatment is a separate service.

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

What's not covered

Unless required by state law, the following types of treatments, services, and supplies are not covered:

- Topically applied fluorides for persons age 19 or older.
- Space maintainers unless used as a passive appliance because primary teeth have been lost.
- Repair or recementing of space maintainers by the same office within six months of initial placement.
- Root canal therapy when x-rays show incompletely filled canals, unresolved periapical pathology, or canals filled with material not approved for endodontic therapy by the American Dental Association.
- Endodontic treatment of a tooth on which endodontic services were previously performed by the same office.
- Endodontic treatment performed in conjunction with removable prosthodontic appliances.
- Pulpal therapy on non-vital deciduous teeth.
- Alveolectomy/alveoloplasty performed in conjunction with extractions.
- Replacement of a cast restoration within 60 months after initial placement of an existing restoration.
- Crown buildup when x-rays show evidence of sufficient vertical height to support a cast restoration.
- Recementing of inlays, onlays, or crowns by the same office within six months of the initial placement.
- Repair of cast restorations.

- Periodontal surgery or therapy in the absence of x-ray evidence of bone loss.
- Grafts or gingivectomies performed in conjunction with osseous surgery.
- Guided tissue regeneration.
- Crown lengthening or gingivoplasty if not performed at least four weeks prior to crown preparation.
- Periodontal maintenance procedures performed within three months after active periodontal therapy.
- Replacement or repair of an existing prosthodontic appliance within 60 months after initial placement or repair.
- Prosthodontic appliances related to implants.
- Reline or rebase of an existing appliance within six months after initial placement.
- Fixed prosthodontics for anyone under age 16.
- Tissue conditioning.
- A pontic when the space between teeth created by a missing tooth is less than 50% of the size of the original tooth.
- Recementing of fixed partial dentures by the same office within 6 months after initial placement.
- Services for injuries or conditions for which you may be able to receive benefits under Workers' Compensation or Employer's Liability laws.
- Services that are available from:
 - Any federal or state government agency, other than programs provided under Title XIX of the Social Security Act, as amended (Medicaid).
 - Any municipality, county, or other political subdivision.
 - Any community agency, foundation, or similar entity.
- Services designed to correct developmental malformations.
- Cosmetic surgery or dentistry for cosmetic reasons.
- Services or appliances, including, but not limited to, prosthodontics (including crowns and bridges), completed before you are covered under the Plan. Although orthodontic treatment that is performed before you are eligible will not be covered, ongoing orthodontia treatment may be covered after you become eligible.
- Prescription drugs or their administration.

Dental PPO benefits

- Services of anesthetists or anesthesiologists.
- Services performed on second or third molars if there is no opposing tooth.
- Services performed on a tooth when less than 40% of the root is supported by bone.
- Services performed on a primary tooth when the tooth is about to be lost.
- Charges for completion of forms.
- Sealants for persons age 16 or older.
- Services:
 - That are not necessary and/or customary as determined by the standards of generally accepted dental practice.
 - For which no valid dental need can be demonstrated.
 - That are experimental or investigational (*see page J-3*).
 - Otherwise limited or excluded according to the procedures developed by Cigna.
- Appliances, surgical procedures, and restorations for:
 - Altering vertical dimension.
 - Replacing tooth structure loss resulting from attrition, abrasion, or erosion.
 - Correcting congenital or developmental malformations.
 - Aesthetic or cosmetic purposes.
 - Implantology techniques or edentulous ridge enhancement.
 - Anticipation of future fractures.
- Treatment by an individual operating outside the scope of his or her license.
- Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
- Services performed as a component of another procedure.
- Temporary services or procedures.
- Infection control procedures and fees associated with the rules of the Occupational Safety and Health Administration (OSHA).
- Placement of an additional appliance in the same dental arch less than 60 months following placement of the initial appliance.

- Services covered under the medical benefits (*see page B-1*).
- Services or supplies provided more frequently than allowed by the Plan.

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 Cigna 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 Cigna 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 Cigna will pay.

Predetermination of benefits does not guarantee what benefits Cigna 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. Cigna's benefits and rules will apply to any dental claims you file.

Dental benefits after eligibility ends

If your coverage ends, Cigna will only pay benefits 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, Cigna continues to pay benefits for these, as long as treatment is completed within 3 months the date you lose coverage.

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Dental HMO benefits

Learn about your benefits if you are enrolled in the dental HMO benefit:

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

This section only applies to you if you choose the dental HMO benefit option. If you choose the dental PPO benefit option or are enrolled in the free family dental/vision benefit option, please see the applicable section starting on [page C-1](#) or [page C-21](#) for information about your dental benefits.

Dental HMO benefits

UNITE HERE HEALTH (the Fund) has contracted with Cigna to provide dental benefits to you and your dependents if you choose this benefit option. This part of the Summary Plan Description (SPD) summarizes your dental benefits. You'll be given a detailed document that also lists any other type of dependents you can enroll in dental coverage, in addition to the dependents listed in this SPD. The rules about who your dependent is under the Cigna dental benefits only apply to dental benefits, and do not apply to any other benefits offered under the Plan. Call the Fund at **(833) 637-3519** if you need help understanding what dependents are eligible for Cigna Dental coverage, since the Fund makes all eligibility decisions.

If there is any conflict between this SPD and Cigna documents, which contain certain state-specific rules about benefits and cost-sharing, the terms of the Cigna documents govern. If you have any questions about dental benefits, please contact Cigna.

Cigna Dental Care Access Network
(800) 244-6224 toll free
www.mycigna.com
(you have to register for an account)

Dental Benefits—Dental Health Maintenance Organization

Benefits are only payable if you use a network provider. Your copay depends on the type of dental care you get. This table shows the copays for some of the more common dental procedures. However, the contract with Cigna governs your dental benefits, and the contract will govern if there is a conflict.

| | |
|--|---|
| Periodic Oral Exam | \$0 copay |
| Most X-rays | |
| Regular Periodic Cleaning (adult or child prophylaxis) — up to 2 total per person each year | |
| Topical Application of Fluoride — up to 2 total per person each year | |
| Sealants | \$17 copay/tooth |
| Periodontal Scaling and Root Planing— up to 4 quadrants total per person every 12 months | \$60 - \$110 copay per quadrant |
| Periodontal Maintenance— up to 4 total per person each year | \$77 copay |
| Amalgam Fillings | \$6 - \$18 copay, depending on number of surfaces |
| Onlays (metallic) | \$370 - \$440 copay, depending on type of onlay |

| Dental Benefits—Dental Health Maintenance Organization | |
|--|--|
| Crowns — <i>1 replacement per person every 5 years</i> | \$370 - \$470 copay, depending on type of crown |
| Gingivectomy or Gingivoplasty (other than for restorative procedure) | \$105 - \$240 copay, depending on teeth per quadrant |
| Pulp Cap | \$14 copay |
| Root Canal | \$275 - \$440 copay, depending on type of root canal |
| Full Denture (Upper or Lower) — <i>1 set per person every 5 years</i> | \$535 copay each |
| Denture Reline or Rebase — <i>1 reline or rebase per person every 36 months</i> | \$120 - \$210 copay, depending on type of repair |
| Removal of Impacted Tooth | \$71 - \$200 copay, depending on type of removal |
| Orthodontia for Child under 19 (24 months of treatment) | \$2,280 copay total (\$95 copay per month) |
| Orthodontia for Adult (24 months of treatment) | \$3,000 copay total (\$125 copay per month) |
| There is no limit on the benefits paid for your dental care each year | |

Using your benefits

- ✓ **Your dental benefits don't take effect until you select a dentist.** Call Cigna at **(800) 244-6224** (1-800-CIGNA24) to select a dentist.
- ✓ You must see a primary dentist in the Cigna Dental Care Access Network. If you don't, your dental bills will not be paid.

Your dental benefits are provided through a dental health maintenance organization (DHMO). Under a DHMO, you must follow certain rules in order to get dental benefits. If you don't follow these rules, you may have to pay the entire cost of the dental care yourself. **If you have any questions about how to use your dental benefits, please contact Cigna at (800) 244-6224.**

- You must pick a primary dentist (*see page C-14*) who is in the Cigna Dental Care Access Network. Your primary dentist provides your dental care and refers you to specialists, if necessary. You don't need a referral to see a network orthodontist.
- Except in emergencies, you must use a network dentist. If you don't use a network dentist, you will have to pay the full cost of your dental care.

Dental HMO benefits

If you have an emergency, such as excessive bleeding, acute infection or severe pain, try to reach your primary dentist. Your primary dentist should handle any emergency within 24 hours. If you are outside the Cigna service area, or you cannot reach your primary dentist, you can go to any dentist to get treatment. You can then file a claim with Cigna. Cigna will pay you back for up to \$50 for your treatment for immediate relief of the emergency. You will still be responsible for: any copays for your care; charges in excess of the \$50 maximum reimbursement, or any charges that Cigna does not cover. Once you have immediate relief for the emergency, you should see your primary dentist for any follow-up treatment.

- You can always get a second opinion regarding proposed dental care. Just contact Cigna to get a referral to another dentist.
- If you live and work outside the Cigna Dental Care Access Network service area, you will not have any dental benefits. This rule applies to any dependents (such as adult children attending college or who no longer live with you). This rule applies until you, or your dependent, live or work in the service area again.
- Certain state laws will govern how Cigna pays your benefits. Your dental benefits and who is considered your dependent for dental benefits may be slightly different than described in this SPD.
- Cigna will not usually coordinate dental benefits if you have coverage under another dental plan, or if you and your spouse are both covered under Cigna as employees.

Your primary dentist

You must pick a primary dentist, and use your primary dentist, for your dental care. If you need specialist care, your primary dentist will refer you for specialist care. You must have this referral in order to get benefits for specialist care.

You can pick any dentist in the Cigna DHMO network who is taking new patients. You do not have to pick the same primary dentist as your dependents. You and your spouse can use one primary dentist while your children use another dentist.

Children under age 13 can use a pediatric dentist as the primary dentist. After a child turns 13, he or she can only see a pediatric dentist with a referral from a primary dentist who is not a pediatric dentist.

You can change your primary dentist any time you want, and as often as you want. However, you must wait to see your new primary dentist until Cigna has processed your request to change primary dentists. Cigna can tell you whether your change in primary dentists has been made.

You can log on to www.mycigna.com, or contact Cigna at **(800) 244-6224** to choose a primary dentist or to change a primary dentist.

What you pay

You will pay any required copay for your dental care. The booklet titled “Patient Charge Schedule” lists your copays. If you need a copy of this booklet, contact UNITE HERE HEALTH or Cigna. Many types of routine dental care, such as standard exams and x-rays, have no copays. You will have to pay a copay for other types of covered expenses for your dental care.

You will also have to pay for any dental care that is not considered a covered expense, including any dental care you get more frequently than allowed.

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 you got 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.

The types of services and supplies that are covered are listed below. Cigna’s patient charge schedule and certificates of coverage contain more specific information about what is covered.

- **Diagnostic and preventive services** and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease, including exams and cleanings.
 - ▶ Oral exams, limited to 4 every 12 months.
 - ▶ Prophylaxis (regular cleaning), limited to 2 every year. Additional, medically necessary visits may be permitted under certain circumstances. A copay will usually apply to any additional visits.
 - ▶ Panoramic x-rays, limited to 1 set every 3 years.
 - ▶ Intraoral x-rays (complete series), limited to 1 set every 3 years.
 - ▶ Cone beam CT capture, limited to 1 every year, and only covered in connection with temporomandibular joint (TMJ) evaluation.
 - ▶ Topical application of fluoride, limited to 2 times every year.
 - ▶ Sealants.
 - ▶ Space maintainers.

Dental HMO benefits

- **Emergency palliative care**, including treatment to temporarily relieve pain and discomfort.
- **Diagnostic x-rays** to diagnose a specific condition.
- **Restorative services**, including amalgam and resin-based fillings and polishing.
- **Crowns and bridges**, including inlays, onlays, crowns, core buildups, pin retention, pontics, and recementation. Replacement of crowns and bridges are limited to 1 every 5 years.
- **Endodontic services** and procedures to treat teeth with diseased or damaged nerves, including pulp caps, pulpotomies, root canals, apicoectomy or periapical surgery and retrograde filling.
- **Periodontic services** to treat diseases of the gums and supporting structures of the teeth, including gingivectomy or gingivoplasty, clinical crown lengthening, osseous surgery, bone replacement graft, and soft tissue graft.
 - ▶ Periodontal scaling and root planing is limited to 4 quadrants every 12 months.
 - ▶ Periodontal maintenance is limited to 4 per year, and only after active periodontal therapy.
 - ▶ Full mouth debridement is limited to 1 time per lifetime.
 - ▶ Periodontal regenerative procedures are limited to once per site (or tooth).
 - ▶ Localized delivery of antimicrobial agents is limited to 8 teeth (or sites) every 12 months.
- **Prosthetics** (removable tooth replacements) and repairs (relining and rebasing).
 - ▶ Adjustments to prosthetics will be covered up to 4 times during the first 6 months after insertion.
 - ▶ Replacement prosthetics are limited to 1 every 5 years.
 - ▶ Denture relining is limited to 1 every 36 months.
 - ▶ Replacement of crowns, bridges, and implant-supported dentures is limited to 1 every 5 years.
- **Oral surgery**, extractions and other surgical procedures, including pre-operative and post-operative care, and general anesthesia. No coverage is provided if you are under age 15.
 - ▶ Occlusal orthotic devices or guards are limited to 1 set every 24 months, and are only covered in connection with TMJ treatment.
 - ▶ General anesthesia is covered when done by an oral surgeon for a medically necessary covered expense, and limited to 1 hour per appointment.

- ▶ I.V. sedation is covered when done by an oral surgeon or periodontist for a medically necessary covered expense, and limited to 1 hour per appointment.
- **Orthodontic treatment**, limited to 24 months of treatment. Each month of active treatment is a separate service and has a separate copay.

What's not covered

Unless required by state law, the following types of treatments, services, and supplies are not covered.

- Services or supplies provided by a non-network dentist without Cigna's prior approval, except in the case of emergency care received in accordance with Cigna's rules governing emergency care.
- Services or supplies provided by a specialist when such specialist care has not been referred by your primary dentist and approved by Cigna.
- Services or supplies provided by a network dentist who has not been approved by Cigna as your primary dentist, except in the case of emergency care received in accordance with Cigna's rules governing emergency care.
- Services not specifically listed as covered under Cigna's patient charge schedule or the terms of Cigna's contract.
- Services or supplies provided more frequently than allowed under Cigna's patient charge schedule or the terms of Cigna's contract.
- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit.
- For charges that would not have been made in any facility, other than a hospital or a correctional institution, owned or operated by the United States government or by a state or municipal government if you had no insurance.
- To the extent that payment is unlawful where you are living when the expenses are incurred or the services are received.
- For charges that you (or your dependents) are not legally required to pay.
- For charges that would not have been made if you had no insurance.
- For or in connection with self-inflicted injury.
- Services related to any injury or illness paid under worker's compensation, occupational disease or similar law.
- Services provided or paid by or through a Federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.

Dental HMO benefits

- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- Cosmetic dentistry or cosmetic dental surgery (as defined by Cigna), unless specifically listed as covered under Cigna's patient charge schedule.
- General anesthesia, sedation and nitrous oxide, unless medically necessary and in connection with covered services performed by an oral surgeon or periodontist. Cigna does not cover general anesthesia or I.V. sedation for anxiety control or patient management.
- Prescription drugs.
- Procedures, appliances, or restorations, if the main purpose is to change a vertical dimension (degree of separation of the jaw when teeth are in contact), or restore teeth that have been damaged by attrition, abrasion, erosion, and/or abfraction.
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect.
- Surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s) or any services related to the surgical placement of a dental implant, unless specifically listed on the patient charge schedule.
- Services considered to be unnecessary or experimental in nature, or that do not meet commonly accepted dental standards.
- Procedures or appliances for minor tooth guidance or to control harmful habits.
- Hospitalization, including any associated incremental charges for dental services performed in a hospital, except that benefits are payable for network general dentist charges for covered services performed at a hospital (other associated charges are not covered).
- Services to the extent that you are covered under any group medical plan, unless required under state law.
- The completion of crowns, bridges, dentures, or root canal treatment already in progress when you become eligible for dental benefits.
- The completion of implant-supported prosthesis, including crowns, bridges, and dentures, already in progress when you become eligible for dental benefits, unless specifically listed as covered under the patient charge schedule.
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed as covered under the patient charge schedule.
- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periadicular surgery.

- Intentional root canal treatment in the absence of injury or disease solely to facilitate a restorative procedure.
- Services performed by a prosthodontist.
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- Any localized delivery of antimicrobial agent procedures when more than 8 of these procedures are reported on the same date of service.
- Infection control and/or sterilization.
- The recementation of any inlay, onlay, crown, post and core, or fixed bridge within 180 days of initial placement.
- Services to correct congenital malformations, including the replacement of congenitally missing teeth.
- Crowns, bridges, and/or implant-supported prosthesis used solely for splinting.
- Resin-bonded retainers and associated pontics.
- Services or supplies for anyone not considered a dependent under the terms of the Cigna contract.
- Treatment already in progress when you become covered under the dental benefits.
- Any other service or supply not covered under the terms of Cigna's contract.

Dental benefits under the free family dental/vision benefits

Learn about your dental benefits if you are enrolled in the free family dental/vision benefit:

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

This section only applies to you if you choose the dental PPO benefit option. If you enroll in the dental PPO or the dental HMO benefit option, please see the applicable sections starting on [page C-1](#) or [page C-12](#) for information about your dental benefits.

Dental benefits under the free family dental/vision benefits

This benefit only applies if your CBA requires your employer to contribute for the free family dental and vision benefits.

UNITE HERE HEALTH (the Fund) has contracted with Cigna to provide dental benefits to you and your dependents if you choose this benefit option. This part of the Summary Plan Description (SPD) summarizes your dental benefits. You'll be given a detailed document that also lists any other type of dependents you can enroll in dental coverage, in addition to the dependents listed in this SPD. The rules about who your dependent is under the Cigna dental benefits only apply to dental benefits, and do not apply to any other benefits offered under the Plan. Call the Fund at (833) 637-3519 if you need help understanding what dependents are eligible for Cigna Dental coverage, since the Fund makes all eligibility decisions.

If there is any conflict between this SPD and Cigna documents, which contain certain state-specific rules about benefits and cost-sharing, the terms of the Cigna documents govern. If you have any questions about dental benefits, please contact Cigna.

Cigna Dental Care Access Network

toll free: (800) 244-6224

www.mycigna.com

(you have to register for an account)

Dental Benefits—Dental Health Maintenance Organization

Benefits are only payable if you use a network provider. Your copay depends on the type of dental care you get. This table shows the copays for some of the more common dental procedures. However, the contract with Cigna governs your dental benefits, and the contract will govern if there is a conflict.

| | |
|---|-----------------|
| Periodic Oral Exam | \$0 copay |
| Most X-rays | |
| Regular Periodic Cleaning (adult or child prophylaxis) — <i>up to 2 total per person each year</i> | |
| Topical Application of Fluoride — <i>up to 2 total per person each year</i> | |
| Sealants | \$3 copay/tooth |
| Periodontal Scaling and Root Planing— <i>up to 4 quadrants total per person every 12 months</i> | \$25 copay |
| Periodontal Maintenance— <i>up to 4 total per person each year</i> | \$20 copay |

Dental benefits under the free family dental/vision benefits

| Dental Benefits—Dental Health Maintenance Organization | |
|--|--|
| Amalgam Fillings | \$0 copay |
| Onlays (metallic) | \$100 copay |
| Crowns — <i>1 replacement per person every 5 years</i> | \$100–\$210 copay, depending on type of crown |
| Gingivectomy or Gingivoplasty (other than for restorative procedure) | \$45–\$70 copay, depending on number of teeth per quadrant |
| Pulp Cap | \$0 copay |
| Root Canal | \$50–\$135 copay, depending on type of root canal |
| Full Denture (Upper or Lower) — <i>1 set per person every 5 years</i> | \$120–\$125 copay, depending on type of denture |
| Denture Reline or Rebase — <i>1 reline or rebase per person every 36 months</i> | \$25–\$45 copay, depending on type of repair |
| Removal of Impacted Tooth | \$25–\$90 copay, depending on type of removal |
| Orthodontia for Child under 19 (24 months of treatment) | \$1,104 copay total (\$46 copay per month) |
| Orthodontia for Adult (24 months of treatment) | \$1,608 copay total (\$67 copay per month) |
| There is no limit on the benefits paid for your dental care each year | |

Using your benefits

- ✓ **Your dental benefits don't take effect until you select a dentist.** Call Cigna at **(800) 244-6224** (1-800-CIGNA24) to select a dentist.
- ✓ You must see a primary dentist in the Cigna Dental Care Access Network. If you don't, your dental bills will not be paid.

Your dental benefits are provided through a dental health maintenance organization (DHMO). Under a DHMO, you must follow certain rules in order to get dental benefits. If you don't follow these rules, you may have to pay the entire cost of the dental care yourself. **If you have any questions about how to use your dental benefits, please contact Cigna at (800) 244-6224.**

- You must pick a primary dentist (*see page C-24*) who is in the Cigna Dental Care Access Network. Your primary dentist provides your dental care and refers you to specialists, if necessary. You don't need a referral to see a network orthodontist.

Dental benefits under the free family dental/vision benefits

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

If you have an emergency, such as excessive bleeding, acute infection or severe pain, try to reach your primary dentist. Your primary dentist should handle any emergency within 24 hours. If you are outside the Cigna service area, or you cannot reach your primary dentist, you can go to any dentist to get treatment. You can then file a claim with Cigna. Cigna will pay you back for up to \$50 for your treatment for immediate relief of the emergency. You will still be responsible for: any copays for your care; charges in excess of the \$50 maximum reimbursement, or any charges that Cigna does not cover. Once you have immediate relief for the emergency, you should see your primary dentist for any follow-up treatment.

- You can always get a second opinion regarding proposed dental care. Just contact Cigna to get a referral to another dentist.
- If you live and work outside the Cigna Dental Care Access Network service area, you will not have any dental benefits. This rule applies to any dependents (such as adult children attending college or who no longer live with you). This rule applies until you, or your dependent, live or work in the service area again.
- Certain state laws will govern how Cigna pays your benefits. Your dental benefits and who is considered your dependent for dental benefits may be slightly different than described in this SPD.
- Cigna will not usually coordinate dental benefits if you have coverage under another dental plan, or if you and your spouse are both covered under Cigna as employees.

Your primary dentist

You must pick a primary dentist, and use your primary dentist, for your dental care. If you need specialist care, your primary dentist will refer you for specialist care. You must have this referral in order to get benefits for specialist care.

You can pick any dentist in the Cigna DHMO network who is taking new patients. You do not have to pick the same primary dentist as your dependents. You and your spouse can use one primary dentist while your children use another dentist.

Children under age 13 can use a pediatric dentist as the primary dentist. After a child turns 13, he or she can only see a pediatric dentist with a referral from a primary dentist who is not a pediatric dentist.

You can change your primary dentist any time you want, and as often as you want. However, you must wait to see your new primary dentist until Cigna has processed your request to change primary dentists. Cigna can tell you whether your change in primary dentists has been made.

You can log on to www.mycigna.com, or contact Cigna at **(800) 244-6224** to choose a primary dentist or to change a primary dentist.

Dental benefits under the free family dental/vision benefits

What you pay

You will pay any required copay for your dental care. The booklet titled “Patient Charge Schedule” lists your copays. If you need a copy of this booklet, contact UNITE HERE HEALTH or Cigna. Many types of routine dental care, such as standard exams and x-rays, have no copays. You will have to pay a copay for other types of covered expenses for your dental care.

You will also have to pay for any dental care that is not considered a covered expense, including any dental care you get more frequently than allowed.

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 you got 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.

The types of services and supplies that are covered are listed below. Cigna’s patient charge schedule and certificates of coverage contain more specific information about what is covered.

- **Diagnostic and preventive services** and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease, including exams and cleanings.
 - ▶ Oral exams, limited to 4 every 12 months.
 - ▶ Prophylaxis (regular cleaning), limited to 2 every year. Additional, medically necessary visits may be permitted under certain circumstances. A copay will usually apply to any additional visits.
 - ▶ Panoramic x-rays, limited to 1 set every 3 years.
 - ▶ Intraoral x-rays (complete series), limited to 1 set every 3 years.
 - ▶ Cone beam CT capture, limited to 1 every year, and only covered in connection with temporomandibular joint (TMJ) evaluation.
 - ▶ Topical application of fluoride, limited to 2 times every year.
 - ▶ Sealants.
 - ▶ Space maintainers.

Dental benefits under the free family dental/vision benefits

- **Emergency palliative care**, including treatment to temporarily relieve pain and discomfort.
- **Diagnostic x-rays** to diagnose a specific condition.
- **Restorative services**, including amalgam and resin-based fillings and polishing.
- **Crowns and bridges**, including inlays, onlays, crowns, core buildups, pin retention, pontics, and recementation. Replacement of crowns and bridges are limited to 1 every 5 years.
- **Endodontic services** and procedures to treat teeth with diseased or damaged nerves, including pulp caps, pulpotomies, root canals, apicoectomy or periapical surgery and retrograde filling.
- **Periodontic services** to treat diseases of the gums and supporting structures of the teeth, including gingivectomy or gingivoplasty, clinical crown lengthening, osseous surgery, bone replacement graft, and soft tissue graft.
 - ▶ Periodontal scaling and root planing is limited to 4 quadrants every 12 months.
 - ▶ Periodontal maintenance is limited to 4 per year, and only after active periodontal therapy.
 - ▶ Full mouth debridement is limited to 1 time per lifetime.
 - ▶ Periodontal regenerative procedures are limited to once per site (or tooth).
 - ▶ Localized delivery of antimicrobial agents is limited to 8 teeth (or sites) every 12 months.
- **Prosthetics** (removable tooth replacements) and repairs (relining and rebasing).
 - ▶ Adjustments to prosthetics will be covered up to 4 times during the first 6 months after insertion.
 - ▶ Replacement prosthetics are limited to 1 every 5 years.
 - ▶ Denture relining is limited to 1 every 36 months.
 - ▶ Replacement of crowns, bridges, and implant-supported dentures is limited to 1 every 5 years.
- **Oral surgery**, extractions and other surgical procedures, including pre-operative and post-operative care, and general anesthesia. No coverage is provided if you are under age 15.
 - ▶ Occlusal orthotic devices or guards are limited to 1 set every 24 months, and are only covered in connection with TMJ treatment.
 - ▶ General anesthesia is covered when done by an oral surgeon for a medically necessary covered expense, and limited to 1 hour per appointment.

Dental benefits under the free family dental/vision benefits

- ▶ I.V. sedation is covered when done by an oral surgeon or periodontist for a medically necessary covered expense, and limited to 1 hour per appointment.
- **Orthodontic treatment**, limited to 24 months of treatment. Each month of active treatment is a separate service and has a separate copay.

What's not covered

Unless required by state law, the following types of treatments, services, and supplies are not covered.

- Services or supplies provided by a non-network dentist without Cigna's prior approval, except in the case of emergency care received in accordance with Cigna's rules governing emergency care.
- Services or supplies provided by a specialist when such specialist care has not been referred by your primary dentist and approved by Cigna.
- Services or supplies provided by a network dentist who has not been approved by Cigna as your primary dentist, except in the case of emergency care received in accordance with Cigna's rules governing emergency care.
- Services not specifically listed as covered under Cigna's patient charge schedule or the terms of Cigna's contract.
- Services or supplies provided more frequently than allowed under Cigna's patient charge schedule or the terms of Cigna's contract.
- For or in connection with an injury arising out of, or in the course of, any employment for wage or profit.
- For charges that would not have been made in any facility, other than a hospital or a correctional institution, owned or operated by the United States government or by a state or municipal government if you had no insurance.
- To the extent that payment is unlawful where you are living when the expenses are incurred or the services are received.
- For charges that you (or your dependents) are not legally required to pay.
- For charges that would not have been made if you had no insurance.
- For or in connection with self-inflicted injury.
- Services related to any injury or illness paid under worker's compensation, occupational disease or similar law.

Dental benefits under the free family dental/vision benefits

- Services provided or paid by or through a Federal or state governmental agency or authority, political subdivision or a public program, other than Medicaid.
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- Cosmetic dentistry or cosmetic dental surgery (as defined by Cigna), unless specifically listed as covered under Cigna's patient charge schedule.
- General anesthesia, sedation and nitrous oxide, unless medically necessary and in connection with covered services performed by an oral surgeon or periodontist. Cigna does not cover general anesthesia or I.V. sedation for anxiety control or patient management.
- Prescription drugs.
- Procedures, appliances, or restorations, if the main purpose is to change a vertical dimension (degree of separation of the jaw when teeth are in contact), or restore teeth that have been damaged by attrition, abrasion, erosion, and/or abfraction.
- Replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect.
- Surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s) or any services related to the surgical placement of a dental implant, unless specifically listed on the patient charge schedule.
- Services considered to be unnecessary or experimental in nature, or that do not meet commonly accepted dental standards.
- Procedures or appliances for minor tooth guidance or to control harmful habits.
- Hospitalization, including any associated incremental charges for dental services performed in a hospital, except that benefits are payable for network general dentist charges for covered services performed at a hospital (other associated charges are not covered).
- Services to the extent that you are covered under any group medical plan, unless required under state law.
- The completion of crowns, bridges, dentures, or root canal treatment already in progress when you become eligible for dental benefits.
- The completion of implant-supported prosthesis, including crowns, bridges, and dentures, already in progress when you become eligible for dental benefits, unless specifically listed as covered under the patient charge schedule.
- Bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed as covered under the patient charge schedule.

Dental benefits under the free family dental/vision benefits

- Bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periapical surgery.
- Intentional root canal treatment in the absence of injury or disease solely to facilitate a restorative procedure.
- Services performed by a prosthodontist.
- Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
- Any localized delivery of antimicrobial agent procedures when more than 8 of these procedures are reported on the same date of service.
- Infection control and/or sterilization.
- The recementation of any inlay, onlay, crown, post and core, or fixed bridge within 180 days of initial placement.
- Services to correct congenital malformations, including the replacement of congenitally missing teeth.
- Crowns, bridges, and/or implant-supported prosthesis used solely for splinting.
- Resin-bonded retainers and associated pontics.
- Services or supplies for anyone not considered a dependent under the terms of the Cigna contract.
- Treatment already in progress when you become covered under the dental benefits.
- Any other service or supply not covered under the terms of Cigna's contract.

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Vision benefits under the free family dental/vision benefits

Learn about your vision benefits if you are enrolled in the free family dental/vision benefit:

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

This section only applies to you are enrolled in the free family dental and vision benefits. If you choose the basic vision or vision+ benefit option, please see the applicable section starting on [page D-7](#) or [page D-11](#) for information about your dental benefits.

Vision benefits under the free family dental/vision benefits

This benefit only applies if your CBA requires your employer to contribute for the free family dental and vision benefits.

UNITE HERE HEALTH (the Fund) has contracted with Davis Vision to provide vision benefits to you and your dependents if you choose this benefit option. This part of the Summary Plan Description (SPD) summarizes your vision benefits.

If there is any conflict between this SPD and the contract, the terms of the Davis Vision contract governs. If you want to see the Fund's contract with Davis Vision, please call the Fund at (833) 637-3519. If you have any questions about your vision benefits, please contact Davis Vision.

| VISION BENEFITS— <i>What You Pay</i> | | |
|--|---|---|
| Description of Services <i>Covered once every 12 months</i> | Davis Vision Provider | Non-Network Provider |
| Exam | \$0 copay | \$0 copay Plan benefits limited to \$30 |
| Lenses | \$0 copay | \$0 copay Plan benefits limited to \$175 |
| Frames | \$0 copay for Davis Collection Fashion or Designer frames \$25 copay for Premier level frames \$0 for non-Davis Collection frames; Plan benefits are limited to \$150 | |
| Elective Contact Lenses (instead of glasses) | \$0 copay for Davis Collection contacts \$0 copay for non-Davis Collection contacts; Plan benefits are limited to \$120 | |
| Medically Necessary Contact Lenses | \$0 copay | \$0 copay Plan benefits limited to \$175 for contacts and associated exam combined |

Benefits will be paid once per person every 12 months, starting from the date of service.

Vision benefits under the free family dental/vision benefits

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
(you have to register for an account)

At your appointment, tell them you have Davis Vision. You don't need an ID card. If you'd like a card, you can request one at www.davisvision.com. (You must register for an account.)

See page A-9 for more information about how using network providers can save you time and money.

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 maximum benefit.

Upgrade options and other discounts through network providers

Although the Plan will not pay for any upgrades or options, if you use a network provider, you can get certain upgrades or options for a set fee. Common lens options include but are not limited to anti-reflective coatings, progressive lenses, polycarbonate lenses for adults, and photochromic lenses. Standard scratch resistant coatings and, for children under age 19, polycarbonate lenses, are available with no copay to you.

You can also get discounts on laser eye surgery. (Benefits are not payable for laser eye surgery.)

Get your questions about options answered by contacting Davis Vision, or by asking your network provider. Your cost or discount depends on which option(s) or upgrade(s) you pick.

What the Plan pays

The Plan pays 100% of covered expenses after you make any applicable copay. If you use a non-network provider, the Plan only pays up to the maximum shown in the table for your vision care.

Vision benefits under the free family dental/vision benefits

What's covered

- Exams, consultations, or treatment by a licensed vision care professional. This includes low vision services if you get prior approval from Davis Vision (limits may apply to low vision services).
- Lenses, including single vision, bifocal lenses, trifocal lenses, or lenticular lenses.
- Frames.
- Contact lenses, including separate exams and fittings.

What's not covered

The following treatments, services, and supplies are not covered under the vision benefit:

- Non-prescription lenses.
- Two pairs of glasses instead of bifocals.
- Any type of lenses, frames, services, supplies, or options that are not covered under the Davis Vision contract.
- Orthoptics or vision training or any associated supplemental testing.
- Low vision services or supplies that are not pre-approved, or that are more than the maximum benefits or frequency limits specified in the contract with Davis Vision.
- Replacement of lost, stolen, or broken contacts, lenses, or frames before the beginning of a 12-month benefit period.
- Frames/lenses in addition to contact lenses during the same benefit period.
- Services or materials provided in connection with special procedures such as orthoptics and visual training (including but not limited to “Corneal Refractive Therapy” (“CRT), or “orthokeratology”), or in connection with medical or surgical treatment (including laser vision correction).
- Materials which do not correct vision.
- Sickness or injury covered by a workers’ compensation act or other similar legislation.
- Incurred as a direct or indirect result of war (declared or undeclared).
- Incurred as a result of an intentionally self-inflicted injury or injury sustained while committing a crime.
- Services or supplies furnished before your coverage begins, or after your coverage ends.
- Any medical treatment you get outside the United States or Canada.

Vision benefits under the free family dental/vision benefits

- Services rendered by practitioners who do not meet Davis Vision's definition of provider.
- Expenses covered by any other group insurance.
- Expenses covered by a health maintenance organization or hospital or medical services prepayment plan available through an employer, union or association.
- Any expenses covered by any union welfare plan or governmental program or a plan required by law.
- Comprehensive low-vision evaluations, subsequent follow-up visits following such evaluation or low-vision aids for which Davis Vision did not give prior approval.
- Medically necessary contact lenses for which Davis Vision did not give prior approval.
- Refraction-only claims.

Basic vision benefits

Learn about your benefits if you are enrolled in the basic vision benefit:

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

This section only applies to you if you choose the basic vision benefit option. If you are enrolled in the free family dental/vision benefit option or the vision+ benefit option, please see the section starting on [page D-1](#) or [page D-11](#) for information about your vision benefits.

Basic vision benefits

VISION CARE BENEFITS—What the Plan Pays

Vision Care Services and Supplies—
available every 24 months

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

What the Plan pays

- ✓ When you get vision care, you will have to pay your provider out-of-pocket. Then, submit a claim form to the Fund to get reimbursed for covered expenses.

The Plan pays up to \$200 per employee for all covered services during a 24-month period. Each 24-month period begins on January 1 of even numbered years, and ends on December 31 of odd-numbered years. For example, if covered expenses are first furnished February 20, 2018, the 24-month benefit period would begin again January 1, 2020.

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

What's covered

- Complete vision examinations, limited to once every 12 months.
- Single vision, bifocal, trifocal, or aphakic eyeglass lenses, limited to once every 12 months.
- Contact lenses.
- Frames.
- The following lens options:
 - Anti-reflective coatings
 - Hi-index lenses
 - Plastic photosensitive lenses
 - Polarized lenses
 - Progressive addition lenses
 - Scratch resistant coatings/protection
 - Tinting of plastic lenses
 - Ultraviolet coating

What's not covered

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

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

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Vision+ benefits

Learn about your benefits if you are enrolled in the vision+ benefit:

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

This section only applies to you if you choose the vision+ benefit option. If you are enrolled in the free family dental/vision benefit option or the basic vision benefit option, please see the section starting on [page D-1](#) or [page D-7](#) for information about your vision benefits.

Vision+ benefits

UNITE HERE HEALTH (the Fund) has contracted with Vision Services Plan (VSP) to provide vision benefits to you and your dependents if you choose this benefit option. This part of the Summary Plan Description (SPD) summarizes your vision benefits.

If there is any conflict between this SPD and the contract, the terms of the VSP contract governs. If you want to see the Fund's contract with VSP, please call the Fund at **(833) 637-3519**. If you have any questions about your vision benefits, please contact VSP .

| VISION+ BENEFITS— <i>What You Pay</i> | | |
|--|---|--|
| Description of Services <i>Covered once every 12 months</i> | VSP Provider | Non-Network Provider |
| Exam | \$0 copay | \$0 copay Plan benefits limited to \$45 |
| Lenses | \$25 copay Plan benefits limited to \$175 allowance for frames (lenses are covered in full) | \$25 copay Plan benefits limited to: \$30 for single vision lenses \$50 for bifocal lenses \$65 for trifocal lenses \$100 for lenticular lenses |
| Frames | | \$25 copay Plan benefits limited to \$70 |
| Elective Contact Lenses (instead of glasses) | 100% of the exam (up to \$50) \$0 copay for the contacts; Plan benefits limited to \$175 allowance for contacts | \$0 copay Plan benefits limited to \$120 |
| Medically Necessary Contact Lenses | \$0 copay | \$0 copay Plan benefits limited to \$210 |

Benefits will be paid once per person every 12 months, starting from the date of service.

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:

VSP
toll free: **(800) 877-7195**
www.vsp.com
(You must register for an account.)

At your appointment, tell them you have VSP. You don't need an ID card. If you'd like a card as a reference, you can print one on www.vsp.com.

See page A-9 for more information about how using network providers can save you time and money.

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 maximum benefit.

Upgrade options and other discounts through network providers

Although the Plan will not pay for any upgrades or options, if you use a network provider, you can get certain upgrades or options for a set fee. Common lens options include but are not limited to anti-reflective coatings, progressive lenses, polycarbonate lenses for adults, and photochromic lenses. Standard scratch resistant coatings and, for children under age 19, polycarbonate lenses, are available with no copay to you.

You can also get discounts on laser eye surgery. (Benefits are not payable for laser eye surgery.)

Get your questions about options answered by contacting VSP, or by asking your network provider. Your cost or discount depends on which option(s) or upgrade(s) you pick.

What the Plan pays

The Plan pays 100% of covered expenses after you make any applicable copay. If you use a non-network provider, the Plan only pays up to the maximum shown in the table for your vision care.

What's covered

- Exams, consultations, or treatment by a licensed vision care professional.
- Lenses, including single vision, lined bifocal lenses, lined trifocal lenses, or lenticular lenses.
- Frames.
- Contact lenses. You must get prior approval from VSP in order to get medically necessary contacts.

You can also get low vision services if a network provider believes you need additional treatment. VSP must pre-approve any low vision services. Generally, the Plan pays 100% of low vision tests, up to 2 tests per year, and 75% for supplemental aids, up to \$1,000 every 2 years, regardless of whether you use a network or a non-network provider. Your VSP provider must prescribe the low vision services, and you must meet VSP's criteria for eligibility for low level vision services. Contact VSP for more information about low vision services.

What's not covered

The following treatments, services, and supplies are not covered under the vision benefit:

- Non-prescription lenses.
- Two pairs of glasses instead of bifocals.
- Any type of lenses, frames, services, supplies, or options that are not covered under the VSP contract.
- Exams or eyewear required for employment.
- Missed appointment charges.
- Orthoptics or vision training or any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens modification, polishing or cleaning.
- Low vision services or supplies that are not pre-approved, or that are more than the maximum benefits or frequency limits specified in the contract with VSP.
- Replacement of lost or broken contacts, lenses, or frames before the beginning of a 12-month benefit period.
- Frames/lenses in addition to contact lenses during the same benefit period.
- Any other service or supply excluded under the VSP contract.

Short-term disability benefit

Learn about your benefits if you are enrolled in the short-term disability benefit:

- ▶ How the Plan determines your short-term disability benefit.
- ▶ What isn't covered under the short-term disability benefit

Short-term disability benefit

This benefit is available for employees only. No short-term disability benefits are payable for dependents.

The Fund determines which benefit options are available under each subgroup of the Plan Unit. Your CBA will determine which benefit option(s) from your subgroup are available to you. You may not be able to elect all of the benefit option(s) offered under your subgroup.

| <i>SHORT-TERM DISABILITY BENEFITS</i> <i>What the Plan Pays—Employees only</i> | |
|---|-------------------------------|
| \$200 Option | |
| Amount of Benefit | \$200/week for up to 26 weeks |
| Day Benefits Start: | |
| Due to Injury | 1st day |
| Due to Sickness | 8th day |
| \$300 Option | |
| Amount of Benefit | \$300/week for up to 26 weeks |
| Day Benefits Start: | |
| Due to Injury | 1st day |
| Due to Sickness | 8th day |
| \$400 Option | |
| Amount of Benefit | \$400/week for up to 26 weeks |
| Day Benefits Start: | |
| Due to Injury | 1st day |
| Due to Sickness | 8th day |

Short-Term disability (STD) provides money when you cannot work due to non-work-related illness or injury. (For work-related illness or injury, you may be able to file for Workers' Compensation through your employer.) You must submit a completed short-term disability claim form, and your doctor must certify your disability BEFORE benefits will be paid. The maximum benefit period for a disability is 26 weeks. The actual number of weeks you can get disability benefits depends on your specific illness/injury.

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 any occupation for wages or profit, for which you are reasonably qualified by education, training, or experience. You must submit a completed application for benefits and a doctor's statement establishing total disability before benefits can begin. Contact the Fund for the required forms, or visit www.uhh.org/fsp.

What the Plan pays

The Plan pays the applicable weekly benefit for as long as you are disabled—up to 26 weeks during any 1 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; or
- The 8th day of disability caused by sickness.

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 1 period of disability unless you have returned to work for at least 2 weeks.

Periods of disability due to unrelated causes will be treated as 1 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 F-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

**Life and AD&D benefits are for employees only.
Dependents are not eligible for life and AD&D benefits.**

The Fund determines which benefit options are available under each subgroup of the Plan Unit. Your CBA will determine which benefit option(s) from your subgroup are available to you. You may not be able to elect all of the benefit option(s) offered under your subgroup.

| Event | Amount of Benefit | Who Receives |
|---------------------------------------|-------------------|--------------------------------------|
| \$10,000 Option | | |
| Life Insurance | \$10,000 | Your beneficiary |
| AD&D Insurance (<i>full amount</i>) | | You (or your beneficiary if you die) |
| \$20,000 Option | | |
| Life Insurance | \$20,000 | Your beneficiary |
| AD&D Insurance (<i>full amount</i>) | | You (or your beneficiary if you die) |
| \$30,000 Option | | |
| Life Insurance | \$30,000 | Your beneficiary |
| AD&D Insurance (<i>full amount</i>) | | 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 Life Insurance Company, branded as Blue Cross and Blue Shield of Illinois (BCBSIL). The terms and conditions of your and your dependents' life and AD&D insurance coverage are contained in a certificate of insurance. The certificate describes, among other things:

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

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

Life insurance benefit

Your life insurance benefit depends on which option is available to you under your CBA. The options are shown in the table on the previous page. Your life insurance benefit 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 BCBSIL 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

Life and AD&D benefits

about conversion coverage, contact BCBSIL:

BCBSIL
701 E. 22nd St., Suite 300
Lombard, IL 60148
(800) 348-4512

Terminal illness benefit

If you have a terminal illness (an illness so severe that you have a life expectancy of 24 months or less or if you are continuously confined in an eligible institution, as defined by BCBSIL, because of a medical condition and you are expected to remain there until your death), your life insurance pays a cash lump sum up to 75% of the death benefit in force on the day you were diagnosed with a terminal illness. The remaining portion of your death benefit will be paid to your named beneficiaries after your death. Certain exceptions may apply. See your certificate or call BCBSIL for more details.

Accidental death & dismemberment insurance benefit

If you die or suffer a covered loss within 365 days of an accident that happens while you are eligible for coverage, AD&D benefits will be paid as shown below. However, the total amount payable for all losses resulting from one accident is your full amount (the amount your beneficiary would receive if you died).

| Your AD&D Benefit for a loss (death or dismemberment) within 365 days of an accident | | | | |
|--|-----------------|-----------------|-----------------|------------------|
| Event | \$10,000 Option | \$20,000 Option | \$30,000 Option | Who Receives |
| Death | \$10,000 | \$20,000 | \$30,000 | Your beneficiary |
| Loss of both hands or feet | \$10,000 | \$20,000 | \$30,000 | 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 | \$5,000 | \$10,000 | \$15,000 | |
| Loss of the sight in one eye | \$2,500 | \$5,000 | \$7,500 | |
| Loss of index finger and thumb on same hand | | | | |

AD&D exclusions

AD&D benefits do not cover losses caused by:

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

See your certificate for complete details.

Additional accidental death & dismemberment insurance benefits

The additional insurance benefits described below have been added to your AD&D benefits. The full terms and conditions of these additional insurance benefits are contained in a certificate made available by BCBSIL. 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.

Life and AD&D benefits

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

Naming a beneficiary

Your beneficiary is the person or persons you want BCBSIL to pay if you die. Beneficiary designation forms are available on www.uhh.org/fsp 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, BCBSIL 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, BCBSIL may make payments to that person's legal guardian.

Additional services

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

- **Travel Resources Services** help you and your dependents if you travel 100 miles or more from your home. For example, you can access translation and travel information services, get help finding medical services, replace eyeglasses or medications, or get help finding legal assistance, among other services. Travel resources are provided by Generali Global Assistance, Inc. (GGA).

Generali Global Assistance, Inc.
(877) 715-2593 (U.S. and Canada)
(202) 659-7807 (call collect outside of the U.S. and Canada)
ops@us.generaliglobalassistance.com

- **Beneficiary Resource Services** provides grief counseling, online will preparation, help planning a funeral, and other services to your beneficiaries (and to you if you are eligible for the terminal illness benefit). Services are provided by telephone, face-to-face contact, online, or through referrals to local resources. Limits may apply to certain services. Beneficiary resources are provided by Morneau Shepell.

Morneau Shepell

(800) 769-9187

www.beneficiaryresource.com (username: beneficiary)

John Wilhelm Scholarship

Learn:

- ▶ What the John Wilhelm Scholarship is.
- ▶ Who can apply.
- ▶ How to apply.

John Wilhelm Scholarship

The John Wilhelm Endowed Scholarship Benefit (John Wilhelm Scholarship) helps you or your dependents get an undergraduate degree (bachelor's degree) in the health sciences field at the University of Nevada, Las Vegas (UNLV).

Who is eligible

You or your dependents must meet the following rules in order to be eligible to apply for the scholarship.

You must meet the following requirements:

- Fund eligibility. You must either be:
 - A current employee, both currently eligible under the Fund and have been eligible for at least 36 continuous months. (You may meet this rule based on months you were eligible under any plan or fund that merges into UNITE HERE HEALTH.)
 - An eligible dependent of a current employee who meets the above rule.
- Be admitted to UNLV, and pursuing an undergraduate degree in Public Health, Nursing, or other major within the School of Allied Health Sciences.
- Have a 3.0 or higher cumulative grade point average (GPA).
- Be enrolled as a part-time or full-time student, and have a class standing of a junior or higher.

How to apply

You may apply for the scholarship through the UNLV financial aid and scholarship office by completing the Free Application for Federal Student Aid (FAFSA) and any other required materials. Contact UNLV for help getting or completing the required application materials, or for information on application deadlines.

You must apply for the scholarship each year, even if you have received it in the past. You may re-apply each year, even if you did not receive it in prior years.

Scholarship decisions

Based on numerous factors, the Fund will determine the amount and number of scholarships, if any, awarded for each academic year. The Fund will also determine if you meet the Fund eligibility requirement described above. Determinations regarding the eligibility requirement will be made in the sole and independent discretion of the Fund and shall be final and binding for all persons who apply for the scholarship.

UNLV will select the final scholarship recipients and will give preference based on financial need and past receipt of the scholarship. All decisions regarding the recipients will be made in the sole and independent discretion of UNLV and shall be final and binding for all persons who apply.

Other important information

- The scholarship may only be used for tuition at UNLV. You cannot use the scholarship for registration fees, student body fees, activity fees, books, supplies, equipment, tools, meals, lodging, parking, or transportation.
- The scholarship cannot be applied towards post-graduate degrees.
- Scholarships are not guaranteed each year and may not be awarded in any particular year.
- Scholarship amounts will be applied to tuition only after all other financial aid, such as public or private financial assistance, fellowships, scholarships, or grants, is applied.

Appeal rights

If you or your dependent(s) do not get the scholarship benefit because you do not meet the Fund eligibility requirement described in “Who is eligible,” you may appeal the denial within 60 days of receiving the denial notice. Submit your appeal to:

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

See page I-13 for more information about the subcommittee’s review of your appeal, and when you will be notified of the Appeal Subcommittee’s decision.

General exclusions and limitations

Learn:

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

General exclusions and limitations

This section does not apply to benefits provided under the Kaiser HMO benefits, the Cigna HMO and PPO dental benefits, the vision benefits under the free family dental/vision benefits, or the vision+ benefits.

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 the basic vision benefit and the short-term disability benefits. No benefits will be paid under this Plan for charges incurred for or resulting from any of the following:

- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a healthcare provider.
- Any injury, sickness, or dental or vision treatment which arises out of or in the course of any occupation or employment, or for which you have gotten or are entitled to get benefits under a workers' compensation or occupational disease law, whether or not you have applied or been approved for such benefits.
- Any treatment, services, or supplies:
 - ▶ For which no charge is made.
 - ▶ For which you, your spouse or your child is not required to pay.
 - ▶ Which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish, or municipal hospital when there is no legal requirement to pay for such treatment, services, or supplies.
- Any charge which is more than the Plan's allowable charge (*see page J-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 J-5*).
- Experimental treatment (*see page J-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

General exclusions and limitations

on active duty or in training in the Armed Forces, National Guard, or Reserves of any state or any country.

- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault.
- Any expense greater than any maximum benefit, or any expense incurred before eligibility for coverage begins or after eligibility terminates, unless specifically provided for under this Plan.
- Preventive medicine, unless specifically included as covered services.
- Any charges incurred for education or training, unless specifically included as covered services.
- Ambulatory surgical facility fees for procedures normally performed in a doctor's office.
- Cosmetic services.
- To the extent of any penalty assessed for any treatment or services requiring prior authorization, when this mandatory program is not used as required.
- Any elective procedure (other than sterilization or abortion, or as otherwise specifically stated as covered) that is not for the correction or cure of a bodily injury or sickness.
- Procedures to reverse a voluntary sterilization.
- Treatment for or in connection with infertility.
- Any treatment, services or supplies for or in connection with the pregnancy of a dependent child except for preventive healthcare services. For example, ultrasounds, treatment associated with a high-risk pregnancy, non-preventive care, and delivery charges are not covered with respect to the pregnancy of a dependent child.
- Hospital charges for personal comfort items, including but not limited to telephone, television, cosmetics, guest trays, magazines, and bed or cots for family members or other guests.
- Supplies or equipment for personal hygiene, comfort, or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, tanning bed, or water bed.
- Home construction for any reason.
- Any expense or charge by a rest home, old age home, or a nursing home.
- Any charges incurred while you are confined in a hospital, nursing home, or other facility or institution (or a part of such facility) which are primarily for education, training, or custodial care.

General exclusions and limitations

- Weight loss programs or treatment, except to treat morbid obesity if the program is under the direct supervision of a healthcare provider, or as specifically stated as covered (for example, diabetes education, nutrition counseling, or preventive healthcare services).
- Any smoking cessation treatment, drug, or device to help you stop smoking or using tobacco, other than preventive healthcare services or as otherwise stated as covered.
- Eye or hearing exams, except as specifically stated as covered, or unless the exam is for the diagnosis or treatment of an accidental bodily injury or an illness. However, eye exams may be covered under the vision benefits.
- Hearing aids.
- Massage therapy, rolfing, acupressure, or biofeedback training.
- Naturopathy or naprapathy.
- Athletic training.
- Services provided by or through a school, school district, or community or state-based educational or intervention program, including but not limited to any part of an Individual Education Plan (IEP).
- Court-ordered or court-provided treatment of any kind, including any treatment otherwise covered by this Plan when such treatment is ordered as a part of any litigation, court ordered judgment or penalty.
- Treatment, therapy, or drugs designed to correct a harmful or potentially harmful habit rather than to treat a specific disease, other than services or supplies specifically stated as covered.
- Megavitamin therapy, primal therapy, psychodrama, or carbon dioxide therapy.
- Christian Science.
- A service or item that is not covered under the Plan's claims processing guidelines or any other internal rule, guideline, protocol or similar criterion that the Plan relies upon.
- Charges or claims incurred as a result, in whole or in part, of fraud, false information, or misrepresentation.

Coordination of benefits

Learn:

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

Coordination of benefits

This section only applies if you have the basic vision benefits (See page D-7).

No coordination of benefits applies to prescription drug benefits, to the vision+ benefits, or to life and AD&D benefits.

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

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

This Plan coordinates benefits with the following types of plans:

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

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

Which plan pays first

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

Order of payment

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

- Plans that do not contain COB provisions always pay before those that do.
- Plans that have COB and cover a person as an employee always pay before plans that cover the person as a dependent.

Coordination of benefits

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

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

Coordination of benefits

COB and prior authorization

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

Special rules for Medicare

I am an active employee

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

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

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

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

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

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

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

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

I have COBRA coverage or retiree coverage

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

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

How to get help with Medicare

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

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

If you and your spouse are both employees under this Plan

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

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

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Subrogation

Learn:

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

Subrogation

This section only applies if you have the basic vision benefits (*See page D-7*).

The Plan's right to recover payments

When injury is caused by someone else

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

Typical examples include injuries sustained:

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

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

Statement of facts and repayment agreement

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

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

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

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

Settling your claim

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

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

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

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

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

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

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Eligibility

Learn:

- ▶ Who is eligible for coverage (who is considered a dependent).
- ▶ How you enroll yourself and your dependents.
- ▶ When and how you become eligible for coverage.
- ▶ How you stay eligible for coverage from an accident or an act caused by someone else.

Eligibility

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

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

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

Who is eligible for coverage

Employees

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

- You work for an employer who is required by a CBA to contribute to UNITE HERE HEALTH on your behalf.
- The contributions required by that CBA are received by UNITE HERE HEALTH. Contributions include any amounts you must pay for your share of the coverage.
- You meet the Plan's eligibility rules.

Your CBA states whether or not you must pay for part of the cost of your coverage (called a “co-premium”). If so, you should arrange to have your employer take your co-premium out of your paycheck (a payroll deduction) when possible. Your co-premiums are in addition to any cost sharing (for example, deductibles, copays, or coinsurance) you pay for specific healthcare services and supplies.

You may be able to decline coverage under UNITE HERE HEALTH. You can do this during your initial enrollment by agreeing to waive your coverage. You can decline coverage when you are first given the chance to sign up for coverage. However, if you decline coverage, you must wait until an open enrollment period or special enrollment period (*see page H-7*) before you have another chance to sign up. Call the Fund when you have questions about declining coverage, or how to get coverage again if you have declined coverage.

Dependents

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

You can add dependents after your coverage starts, but only at certain times. *See page H-7* for more information about enrollment events.

You must sign up any dependent you want covered and make any required co-premium for your share of the cost of dependent coverage. You may have to pay for part of the cost of your dependents' coverage, called a "co-premium." If so, you should arrange to have your employer take your co-premium out of your paycheck (a payroll deduction). Your co-premiums are in addition to any cost sharing you pay for your specific healthcare services and supplies. Contact your employer when you need more information about the amount of your co-premium for your share of your or your dependent's coverage, or for help setting up your payroll deduction. Contact the Fund for more information about when your dependents' coverage starts.

If you don't sign up your dependent, or don't make any required co-premiums for your dependent, the Plan will not pay benefits for that person.

Who your dependents are

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

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

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

Eligibility

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

You must provide proof of the mental or physical handicap within 30 days after the date coverage would end because the child becomes age 26. The Fund may also require you to provide proof of the handicap periodically. (Special rules apply to children with a mental or physical handicap when a new employer begins participation in the Food Service Plan. Contact the Fund with questions.) Contact the Fund for more information on how to continue coverage for a child with a serious handicap.

Enrollment requirements

Employees

You or your employer must provide the Fund with any required information before benefits will be paid on your behalf. You choose the level of coverage right for you:

- Coverage for just yourself (the employee)
- Coverage for yourself and your spouse
- Coverage for yourself and your children
- Coverage for yourself and your family (you, your spouse, and at least one child)

Dependents

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

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

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

- A certified copy of the marriage certificate.
- A commemoration of marriage from a generally recognized denomination of organized religion.
- A certified copy of the birth certificate.
- A baptismal certificate.

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

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

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

When your coverage begins (initial eligibility)

You are eligible for coverage during the same month for which your employer makes contributions on your behalf. Your coverage begins at 12:01 a.m. on the first day of the month for which your employer is first required to contribute on your behalf.

Example: Establishing Initial Eligibility

| Your employer must contribute for your work in | You are covered in |
|--|--------------------|
| January | January |

Suppose employer contributions are first required on your behalf for your work in January. Your coverage will begin on January 1 and will continue for the rest of that month.

Continuing eligibility

Once you establish eligibility, your eligibility continues each month for which your employer is required to make a contribution on your behalf under the terms of your CBA.

Example: Continuing Eligibility

| Your employer must contribute for your work in | You are covered in |
|--|--------------------|
| February | February |
| March | March |
| April | April |

Eligibility

Suppose you became covered January 1 because your employer was required to make contributions on your behalf for January. If a contribution is required on your behalf for February, your coverage continues during February. A contribution for March continues your coverage during March, April continues your coverage during April, and so on.

When dependent coverage starts

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

When you become eligible for dependent coverage, you can choose coverage for just yourself, for yourself plus your children, for yourself plus your spouse, or for yourself and your family. Your cost for providing coverage may depend on which option you choose. Remember, you must enroll your dependents before the Plan will pay benefits for your dependents' claims.

If you enroll dependents when you become initially eligible

Coverage for your dependents begins the same time yours does, as long as you provide any required enrollment materials by the deadline to enroll, plus begin making payroll deductions for the cost of your dependents' coverage.

If you add dependents after you become initially eligible

- If you only chose coverage for yourself when you became initially eligible, you have to wait until the next open enrollment or special enrollment period (*see page H-7*) to enroll dependents.
- If you only chose coverage for yourself and your spouse when you became initially eligible, you have to wait until the next open enrollment or special enrollment period (*see page H-7*) to enroll children.
- If you only chose coverage for yourself and your children when you became initially eligible, you have to wait until the next open enrollment or special enrollment period to enroll a spouse.
- If you elected coverage for yourself and your children, or coverage for yourself and your family, when you became initially eligible, you can add a child at any time. The child's coverage will start as explained below:
 - ▶ If you have a new child (a child is born, adopted or placed with you for adoption, or moves to the US to live with you), this is considered a special enrollment event, and the rules for special enrollment events (*see page H-7*) will determine when the child becomes covered.
 - ▶ You can enroll a child who meets the Fund's definition of "child" any time during the year. You don't have to wait for an open enrollment or special enrollment event. As

long as you provide all required proof documentation within 30 days of telling the Fund you want to add the child, coverage for the child will start on the first day of the month following the date you tell the Fund about the child.

Continued coverage for dependents

Your dependents will remain covered as long as you remain eligible and you make any required payments for your share of your dependents' coverage. Payments for your share of the cost of dependent coverage must be made by payroll deduction. However, if you are on a temporary layoff or an approved leave of absence, you must make any payments for your share of your dependents' coverage directly to your employer.

Self-payments during remodeling or restoration

If your work place closes or partially closes because it's being remodeled or restored, you may make self-payments to continue your coverage until the remodeling or restoration is finished. However, you may only make self-payments for up to 18 months from the date your workplace began remodeling or restoration.

Self-payments during a strike

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

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

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

Enrollment periods

Open enrollment periods

Open enrollment periods give you the chance to elect coverage for yourself and your dependents if you declined coverage. It also gives you a chance to change your coverage tier (for example, you decide to change your election from coverage for just yourself and your children to family coverage so your spouse is also covered), or if you only enrolled some of your dependents. If you want to enroll yourself or more dependents, you must provide the required enrollment material and arrange to make any required payments. Your open enrollment materials will describe the deadlines for enrollment and when coverage will start.

Eligibility

Special enrollment periods

In a few special circumstances, you do not need to wait for the open enrollment period to enroll yourself or your dependents or to change your benefit options. You can enroll yourself or any dependents for coverage within 60 days after any of the following events:

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

As long as you enroll within 60 days and start making any required co-premiums, if you get married or the other coverage terminates (including coverage for Medicaid or a CHIP plan), or become eligible for state financial assistance under a Medicaid or a CHIP, coverage for you and/or your dependents starts the first day of the month following that date.

As long as you enroll within 60 days and start making any required co-premiums, if your child is born, if you adopt a child, if a child is placed with you for adoption, or if a dependent comes to the United States to take up residence with you, coverage for you and/or your dependents starts on the date the child meets the definition of a dependent, or the date the child comes to the United States to take up residence with you.

If you have questions about special enrollment periods or when coverage becomes effective, contact UNITE HERE HEALTH.

If you do not take advantage of a special enrollment period, you must wait until the next open enrollment period or special enrollment period to enroll yourself or your dependents, or change your benefit coverage. (See page H-6 for an exception if you are already making co-premiums for coverage for all of your children, or for your entire family).

Termination of coverage

Learn:

- ▶ When your coverage and your dependents' coverage ends.

Termination of coverage

Your and your dependents' coverage continues as long as you maintain your eligibility as described *on page H-5* and you make any required payments for your share of your coverage (called a "co-premium"). 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 H-18.*

If you (the employee) are absent from covered employment because of uniformed service, you may elect to continue healthcare coverage under the Plan for yourself and your dependents for up to 24 months from the date on which your absence due to uniformed service begins. For more information, including the effect of this election on your COBRA rights, contact the Fund at **(833) 637-3519**.

When employee coverage ends

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

- The date the Plan is terminated.
- The last day of the month for which your employer was required to make a contribution on your behalf. For example, if your employer's last required contribution on your behalf was for March, your coverage continues through the end of March.
- The last day of the coverage period for which you last made any applicable co-premium.
- The last day of the coverage period for which you last made a timely self-payment, if allowed to do so.

When dependent coverage ends

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

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

You may also ask the Fund to stop covering your dependent (or dependents). Contact the Fund at **(833) 637-3519** for more information about how to stop covering a dependent, or how to re-enroll a dependent if you change your mind.

The effect of severely delinquent employer contributions

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

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

Special termination rules

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

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

Then: Your coverage ends on the last day of the month during which the decertification, disclaimer of interest, or change in your collective bargaining representative is determined to have occurred.

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

Then: Your coverage ends on the last day of month for which contributions were received.

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

Then: Your coverage ends on the last day of the 12th month after the Collective Bargaining Agreement expires, unless the Trustees approve an extension.

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

Then: Your coverage ends on the last day of the month for which your employer has an obligation to make contributions to UNITE HERE HEALTH.

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

Termination of coverage

Certificate of creditable coverage

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

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

Reestablishing eligibility

Learn:

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

Reestablishing eligibility

Portability

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

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

Family and Medical Leave Act (FMLA)

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

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

The effect of uniformed service

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

- You provide your employer with advance notice of your absence, whenever possible.
- Your cumulative length of absence for "eligible service" is not more than 5 years.

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

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

No waiting periods will be imposed on reinstated coverage, and upon reinstatement coverage shall be deemed to have been continuous for all Plan purposes. Your dependents will be re-enrolled upon the employee's return to covered employment.

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

Reestablishing eligibility lost for other reasons

Reestablishing eligibility for employees

If you lose eligibility, and your loss of eligibility is less than 12 months, you can re-establish your eligibility by satisfying the Plan's continuing eligibility rules (*see page H-5*). If your loss of eligibility lasts for 12 months or more you must again satisfy the Plan's initial eligibility rules (*see page H-5*). (As of the date this SPD was printed, the initial eligibility rules are the same as the continuing eligibility rules).

Reestablishing eligibility for dependents

If you remain eligible but your dependents' coverage terminates because you stop making the required payments, you will not be able to re-enroll your dependents until the next special enrollment period or the next open enrollment period (*see page H-7*), whichever happens first.

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COBRA continuation coverage

Learn:

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

COBRA continuation coverage

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

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

Who can elect COBRA continuation coverage?

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

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

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

What is a qualifying event?

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

- Your death.
- Your loss of eligibility due to:
 - ▶ Termination of your employment (except for gross misconduct).
 - ▶ A reduction in your work hours below the minimum required to maintain eligibility.
- The last day of a leave of absence under FMLA if you don't return to work at the end of that leave.
- Divorce or legal separation from your spouse.
- A child no longer meeting the Plan's definition of dependent (*see page H-3*).
- Your coverage under Medicare. (Medicare coverage means you are eligible to receive coverage under Medicare; you have applied or enrolled for that coverage, if an application is necessary; and your Medicare coverage is effective.)
- Your employer withdraws from UNITE HERE HEALTH.

What coverage can be continued?

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

How long can coverage be continued?

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

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

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

- Up to 36 months from the date coverage would have originally ended for all other qualifying events (*see page H-18*), as long as those qualifying events would have resulted in a loss of coverage despite the occurrence of any previous qualifying event.

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

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

COBRA continuation coverage

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

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

Notifying UNITE HERE HEALTH when qualifying events occur

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

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

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

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

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

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

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

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

COBRA continuation coverage

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

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

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

Election and payment deadlines

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

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

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

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

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

COBRA continuation coverage

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

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

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

UNITE HERE HEALTH
P. O. Box 809328
Chicago, IL 60680-9328

Termination of COBRA continuation coverage

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

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

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

If termination of continuation coverage ends for any of the reasons listed above, you will be

COBRA continuation coverage

mailed an early termination notice shortly after coverage terminates. The notice will specify the date coverage ended and the reason why.

To get more information

If you have any questions about COBRA continuation coverage, your rights, or the Plan's notification procedures, please call the Fund at **(833) 637-3519**.

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

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Claim filing and appeal provisions

Learn how you file claims and appeal a denied claim:

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

Claim filing and appeal provisions

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

Filing a benefit claim

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

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

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

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

Claims for life or AD&D benefit claims must include a certified copy of the death certificate. All claims for benefits must be made as shown below. If you need help filing a claim, contact the Fund at **(833) 637-3519**.

Dental PPO claims and dental benefits under the free family dental/vision benefits

If you use a network dentist, the dentist should file a claim for you. No benefits are payable if you use a pharmacy that does not participate in the pharmacy network. However, if you need to file a claim, for example because you used a non-network dentist, all dental PPO dental claims for hospital, medical, or surgical treatment must be mailed to Cigna:

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

Claim filing and appeal provisions

Vision claims under the free family dental/vision benefit

Generally, if you use a Davis Vision provider, you do not need to file a claim for vision care because Davis Vision providers will file the claim on your behalf. However, if you need to file a claim because you used a provider who is not in the Davis Vision network, submit it to:

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

The claim processing rules, time limits, and appeal procedures Davis Vision must follow are described in the Davis Vision contract.

Claims under the vision+ benefit

Generally, if you use a VSP provider, you do not need to file a claim for vision care because VSP providers will file the claim on your behalf. However, if you need to file a claim because you used a provider who is not in the VSP network, submit it to:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

The claim processing rules, time limits, and appeal procedures VSP must follow are described in the VSP contract.

All other claims

All life or AD&D claims, claims under the basic vision option, short-term disability claims, or any claims denied because you are not eligible, should be mailed to UNITE HERE HEALTH.

UNITE HERE HEALTH
P.O. Box 6020
Aurora, IL 60598-0020
(833) 637-3519

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

Claim filing and appeal provisions

Deadlines for filing a benefit claim

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

| Deadline for filing a claim | |
|--|---|
| Type of claim | Deadline to file |
| Dental PPO claims and dental claims under the free family dental/vision benefits | 1 year following the date the claim was incurred |
| Vision claim under the free family dental/vision benefits | <ul style="list-style-type: none">• <i>Notice</i> must be filed within 20 days of the date of the claim (or as soon as possible).• <i>Proof of loss</i> must be received within 90 days of the date of the claim (or as soon as possible). |
| Vision+ claim | 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 of loss</i> 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 basic vision claims, and 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.

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,

Claim filing and appeal provisions

you and the person you want to be your authorized representative must complete and sign a form acceptable to the Fund. Call UNITE HERE HEALTH to obtain a form and submit it to:

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

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

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

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

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

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

Determination of claims

Post-service healthcare claims not involving concurrent care decisions

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

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

Concurrent care decisions

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

Claim filing and appeal provisions

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

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

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

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.

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. BCBSIL will notify you in writing if it requires more processing time before the end of the first 90-day period.

Rules for prior authorization of benefits

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

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

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

Claim filing and appeal provisions

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

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

Special rules for decisions involving urgent concurrent care

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

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

If a request for prior authorization is denied

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

Appealing a benefit prior authorization denial

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

If a benefit claim is denied

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

Life and AD&D claims

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

Claim filing and appeal provisions

or appeal, or have questions about how BCBSIL's claim and appeal process works, contact BCBSIL.

BCBSIL
1020 31st Street
Downers Grove, IL 60515
(800) 367-6401

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

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

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

Dental PPO benefit option and dental benefits under the free family dental/vision benefits: one level of appeal

You may file an appeal with Cigna within one year of Cigna's original claim decision. Cigna will usually make a decision within 15 days of receipt of your appeal if the denial is for a pre-service claim. Cigna will usually make a decision within 30 days of receipt of your appeal for all other denials. Cigna may take an additional 15 days to determine your claim; if so, you will be notified in writing of the need for more time. You have the right to file a second level appeal if your claim is still denied in whole or in part under the first level appeal. Cigna will make a decision on your second level appeal within 30 days. Cigna may take an additional 15 days to determine your claim; if so, you will be notified in writing of the need for more time. You also have the right to an expedited review under both levels of appeals if your claim is for urgent or emergency care. If Cigna determines expedited review is necessary, Cigna will provide a decision on your appeal within 72 hours.

Vision claims under the free family dental/vision benefits: one level of appeal

Generally, if a claim is denied, you must request a review within 180 days of the denial. Davis Vision will respond to your appeal within 60 days (120 days if there are special circumstances that require more time). If you need help filing a claim or appeal, or have questions about how Davis Vision's claim and appeal process works, contact Davis Vision.

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

Vision+ benefit option: one level of appeal

Generally, if a claim is denied, you must request a review within 180 days of the denial. VSP will respond to your appeal within 30 days. If you appeal the first-level appeal, you can file a second-level appeal within 60 days of VSP's decision on your first-level appeal. VSP will generally respond to your second-level appeal within 30 days. If you need help filing a claim or appeal, or have questions about how VSP's claim and appeal process works, contact VSP.

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

John Wilhelm Scholarship benefits: one level of appeal

If you or your dependent(s) do not get the scholarship benefit because you do not meet the Fund eligibility requirement as described *on page E-14*, you may appeal the denial within 60 days of receiving the denial notice to:

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

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

All other claims: one level of appeal

If you disagree with all or any part of a claim denial under the basic vision benefit option, short-term disability benefits, life or AD&D 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 60504-4197

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

- You could not reasonably file the appeal within the 12-month filing limit because of:
 - Circumstances beyond your control, as long as you file the appeal as soon as you can.
 - Circumstances in which the claim was not processed according to the Plan's claim processing rules.

Claim filing and appeal provisions

- The Appeals Subcommittee would have overturned the original benefit denial based on its standard practices and policies.

Appeals involving urgent care claims

If you are appealing a denial of benefits that qualifies as a request for emergency treatment/urgent care, you can orally request an expedited (accelerated) appeal of the denial by calling **(630) 699-4372**.

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

Appeals under the sole authority of the plan administrator

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

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

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

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

Review of appeals

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

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

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

Claim filing and appeal provisions

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

Notice of the decision on your appeal

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

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

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

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

Claim filing and appeal provisions

Independent external review procedures

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

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

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

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

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

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

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

Internal appeal exception

In certain situations, if the Plan fails to follow its claims procedures, you are deemed to have exhausted the Plan's internal appeals process and may immediately seek an independent external review or pursue legal action under Section 502(a) of ERISA. Please note this exception does not apply if the Plan's failure is de minimis; non-prejudicial; based on good cause or matters beyond the Plan's control; part of a good faith exchange of information between you and the Plan; and not reflective of a pattern or practice of plan non-compliance. If you believe the Plan violated its own internal procedures, you may ask the Plan for a written explanation of the violation. The Plan will provide you with an answer within ten (10) days. To use this exception, you must request external review or commence a legal action no later than 180 days after receipt of the initial adverse determination. If the court or external reviewer rejects your request for immediate review, the Plan will notify you (within 10 days) of your right to pursue internal appeal. The applicable time limit for you to now file your internal appeal will begin to run when you receive that notice from the Plan.

Non-assignment of claims

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

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

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

Commencement of legal action

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

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

Claim filing and appeal provisions

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.

These definitions explain how the Fund uses certain terms.

These terms may mean different things for benefits provided through the HMO option, the dental HMO, the dental PPO, the free family dental/vision benefits, and the vision+ benefit option.

Call the Fund at (833) 637-3519 if you aren't sure what a word or phrase means.

Definitions

Allowable charges

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

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

- **Allowable charges** for services furnished by network providers are based on the rates specified in the contract between UNITE HERE HEALTH and the provider network. Providers in the network usually offer discounted rates to you and your family. This means lower out-of-pocket costs for you and your family.
- Treatment by a non-network provider means you pay more out-of-pocket costs. Except where a different allowable charge is required by federal law for non-network emergency medical treatment, the Plan calculates benefits for non-network providers based on an independent metric, 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.")

A different definition may apply to benefits provided through the medical HMO, the dental HMO, the dental PPO, the free family dental/vision benefits, or the vision+ benefit option.

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.

You can get more information about your medical and prescription drug copays in the appropriate section of this SPD. (See the beginning of the SPD for the table of contents.)

Coinsurance

Your share of the costs of a covered expense, calculated as a percent (for example, 10% or 20%) of the allowable charge for the service. You pay your **coinsurance** plus any deductibles or copays.

Cosmetic services

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

A different definition may apply to benefits provided through the medical HMO, the dental HMO, the dental PPO, the free family dental/vision benefits, or the vision+ benefit option.

Covered expense

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

Deductible

The amount you owe for covered expenses before benefits are payable on your claims.

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

Emergency medical treatment

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

Experimental, investigational, or unproven (experimental or investigational)

Experimental, investigational, or unproven procedures or supplies are those procedures or supplies which are classified as such by agencies or subdivisions of the federal government, such as the Food and Drug Administration (FDA) or the Office of Health Technology Assessment of the Centers for Medicare & Medicaid Services (CMS); or according to CMS’s Medicare Coverage Issues Manual. Procedures and supplies that are not provided in accordance with generally accepted medical practice, or that the medical community considers to be experimental or investigative will also meet the definition of **experimental, investigational, or unproven**, as does any

Definitions

treatment, service, and supply which does not constitute an effective treatment for the nature of the illness, injury or condition being treated as determined by the Trustees or their designee.

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

A different definition may apply to benefits provided through the medical HMO, the dental HMO, the dental PPO, the free family dental/vision benefits, or the vision+ benefit option.

Healthcare provider

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

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

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

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

A different definition may apply to benefits provided through the medical HMO, the dental HMO, the dental PPO, the free family dental/vision benefits, or the vision+ benefit option.

Injuries and sicknesses

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

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

A different definition may apply to benefits provided through the medical HMO, the dental HMO, the dental PPO, the free family dental/vision benefits, or the vision+ benefit option.

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 J-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.

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

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

A different definition may apply to benefits provided through the medical HMO, the dental HMO, the dental PPO, the free family dental/vision benefits, or the vision+ benefit option.

Out-of-Pocket limit for network care and treatment

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

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

See your Kaiser EOC for more information about your out-of-pocket limit.

Plan Document

The rules and regulations governing the Plan of benefits provided to eligible employees and dependents participating in Plan Unit 376 (Food Service Plan II).

Preventive healthcare

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

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

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

See your Kaiser EOC for more information about preventive care.

Other important information



Other important information

Who pays for your benefits?

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

What benefits are provided through insurance companies?

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

- Basic vision benefits.

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

- Life insurance benefits through Dearborn Life Insurance Company (branded as BCBSIL).
- HMO medical benefit options through Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
- Dental PPO benefits and dental benefits under the free family dental/vision benefits through Cigna Health and Life Insurance Company (Cigna).
- Dental HMO benefits through Cigna.
- Vision benefits under the free family dental/vision benefits through Davis Vision.
- Vision+ benefits through Vision Service Plan, Inc.

Interpretation of Plan provisions

For claims subject to independent external review (*see page I-13*), the IRO has the authority to make decisions about benefits, and decide all questions about claims, submitted for independent external review.

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

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:

Other important information

- ▶ The exclusive discretion to increase, decrease, or otherwise change Plan provisions for the efficient administration of the Plan or to further the purposes of UNITE HERE HEALTH,
- ▶ The right to obtain or provide information needed to coordinate benefit payments with other plans,
- ▶ The right to obtain second medical or dental opinions or to have an autopsy performed when not forbidden by law;
- Interpret all Plan provisions and associated administrative rules and procedures;
- Authorize all payments under the Plan or recover any amounts in excess of the total amounts required by the Plan.

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

The Plan gives the Trustees full discretion and sole authority to make the final decision in all areas of Plan interpretation and administration, including eligibility for benefits, the level of benefits provided, and the meaning of all Plan language (including this Summary Plan Description). In the event of a conflict between this Summary Plan Description and the Plan Document governing the Plan, the Plan Document will govern.

Restriction of Venue

Any action, claim, controversy, or dispute relating to or arising under the Fund, Plan, Summary Plan Description, and/or Trust Agreement shall be brought and resolved only in the United States District Court for the Northern District of Illinois and in any courts in which appeals from such court are heard.

Amendment or termination of the Plan

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

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

Other important information

If UNITE HERE HEALTH is terminated, in whole or in part, or if your Plan, any other Plan Unit or any schedule of benefits is terminated or suspended, no employer, participant, beneficiary or other employee benefit plan will have any rights to any part of UNITE HERE HEALTH's assets. This means that no employer, plan or other person shall be entitled to a transfer of any of UNITE HERE HEALTH's assets on such termination or suspension. The Trustees may continue paying claims incurred before the termination of UNITE HERE HEALTH or any Plan Unit, as applicable, or take any other actions as authorized by the Trust Agreement. Payment of benefits for claims incurred before the termination of UNITE HERE HEALTH, any Plan Unit, or any schedule of benefits will depend on the financial condition of UNITE HERE HEALTH.

Your Plan and all other Plan Units in UNITE HERE HEALTH are all part of a single employee health plan funded by a single trust fund. No Plan Unit and no schedule of benefits shall be treated as a separate employee benefit plan or trust.

Free choice of provider

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

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

Workers' compensation

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

Type of Plan

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

Employer and employee organizations

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

Plan administrator and agent for service of legal process

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

UNITE HERE HEALTH
Chief Executive Officer
711 North Commons Drive
Aurora, IL 60504-4197
(630) 236-5100

Employer identification number

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

Plan number

The Plan number is 501.

Plan year

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

Other important information

Remedies for fraud

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

Limited retroactive terminations of coverage allowed

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

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

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

Creditable coverage under Massachusetts law

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

If you live in Massachusetts and need help understanding how the Plan meets Massachusetts's rules for minimum creditable coverage, or to get a copy of your MA Form HC-1099, please call the Fund at **(833) 637-3519**.

Your rights under ERISA



Your rights under ERISA

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

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

Receive information about your Plan and benefits

ERISA provides that all Plan participants shall be entitled to:

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

Continue group health Plan coverage

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

Prudent actions by Plan fiduciaries

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

Enforce your rights

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

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

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

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

Assistance with your questions

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

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

Important phone numbers and addresses

Blue Cross and Blue Shield of Illinois (Dearborn)

701 E. 22nd St.
Suite 300
Lombard, IL 60148
(800) 367-6401
www.bcbsil.com/ancillary

Cigna Health and Life Insurance Company (Cigna)

900 Cottage Grove Road
Bloomfield, CT 06002
(800) 244-6224
www.cigna.com

Davis Vision

P.O. Box 1525
Latham, NY 12110
(800) 999-5431
www.davisvision.com

Kaiser Permanente

(800) 777-7902
www.kp.org

Member Service Address

Kaiser Permanente Service Center
2101 East Jefferson Street
Rockville, MD 20849-6831

UNITE HERE HEALTH

711 North Commons Drive
Aurora, IL 60504-4197
(630) 236-5100
www.uhh.org/fsp

Vision Service Plan (VSP)

P.O. Box 385018
Birmingham, AL 35238-5018
(800) 877-7195
www.vsp.com

UNITE HERE HEALTH
Board of Trustees



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