



## **Food Service Plan II**

*Plan Unit 376 - Northern & Southern California*



**Summary Plan Description**  
*Your Health and Welfare Benefits*



# **UNITE HERE HEALTH**

**Summary Plan Description**

**Food Service Plan II**

**Plan Unit 376**

***Northern & Southern California***

*Effective January 1, 2018*

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

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# ***Using this book***

## Learn:

- What UNITE HERE HEALTH is.
- What this book is and how to use it.
- 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 Northern California and Southern California subgroups 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—National PPO and Mid-Atlantic.

**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 Northern & Southern California 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 chose the PPO medical benefits, the portion of this SPD describing the PPO medical benefits will apply to you. The portion describing the Kaiser HMO 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 (National PPO, Northern California, Southern California, and Mid-Atlantic). 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](http://www.uhh.org/fsp).

*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。

# ***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. ***If you are in the Kaiser HMO option, you must get a referral from your PCP to see a specialist.***

- ✓ **If you are in the PPO option (Gold+ or Silver+):** Call the Fund at **(833) 637-3519** to get help finding a PCP or a specialist.
- ✓ **If you are in the Kaiser option:** Call Kaiser at **(800) 464-4000** or visit [www.kp.org/searchdoctors](http://www.kp.org/searchdoctors) to get help finding a PCP.

### Get preventive healthcare

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

- ✓ **If you are in the PPO benefit option (Gold+ or Silver+):** *See page B-17 and page J-7* for more information about preventive healthcare.
- ✓ **If you are in the Kaiser benefit option:** Call Kaiser at **(800) 464-4000** or visit [www.kp.org](http://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.

**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.

- ✓ **If you are in the PPO benefit option (Gold+ or Silver+):** Call NHS at **(855) 487-0353** to get prior authorization.

- ✓ **If you are in the Kaiser HMO benefit option:** Your Kaiser PCP will get prior authorization for you.

### Use network providers

- ✓ In some cases, the Plan will pay benefits only if you use a network provider. For example, ***if you are in the Kaiser 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?

If you need help finding a network provider, 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. You can also go to [www.uhh.org/fsp](http://www.uhh.org/fsp) for shortcuts.

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

### Join Better Living!

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

Join the program, and you will learn how to:

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

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

### **Workshop leaders**

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

### **Support along the way**

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

Contact the Fund at **(833) 637-3519** for more information about the Better Living Program!

# ***PPO medical benefits***

Learn about your medical benefits if you are enrolled in one of the PPO options:

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

*This section only applies to you if you choose one of the PPO benefit options (Gold+ or Silver+).  
If you choose the Kaiser HMO benefit option, please see the section starting on **page B-33**  
for information about your medical benefits.*

## PPO medical benefits

The Fund determines which benefit options are available under each subgroup of the Plan Unit (National PPO, Northern California, Southern California, and Mid-Atlantic). 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.

**Please call the Fund with questions about your benefits: (833) 637-3519.**

## PPO MEDICAL AND PRESCRIPTION DRUG BENEFIT OPTIONS

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

<i>If you are enrolled in</i>	<i>Your medical &amp; prescription drug benefits summary starts on</i>
Gold+ PPO	<i>See page B-7</i>
Silver+ PPO	<i>See page B-3</i>

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

If you do not call NHS for prior authorization, your claim could also be denied entirely. *See page B-11* for more information. Avoid surprise bills, and call NHS at: **(855) 487-0353**.

### **Commencement of Legal Action**

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

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

## Gold+ PPO Medical Benefits

### GOLD+ PPO MEDICAL BENEFITS—What You Pay

	Network Provider	Non-Network Provider
<b>Calendar Year Deductibles</b>		
Calendar Year Deductibles	None	
<b>Annual Out-of-Pocket Limits for Medical Care</b>		
For Network Medical Care	\$5,000/person & \$10,000/family	n/a
<b>Office Visits</b>		
Preventive Healthcare Services— <i>See page B-17 and page J-7</i>	\$0	Not covered (except for non-hospital grade breast pumps and related supplies)
ConsejoSano – 24/7 Spanish Health Advice Line		Not covered
Doctor on Demand – 24/7 Telehealth Services	\$20 copay/visit	Not covered
Primary Care Provider (PCP) Office Visit	\$20 copay/visit	50%
Specialist Visit	\$40 copay/visit	
Mental Health/Substance Abuse Office Visits	\$20 copay/visit	
Chiropractic Care— <i>up to 12 visits per person per year</i>	\$20 copay/visit	Not covered
Non-Routine Podiatry	\$40 copay/visit	50%
Allergy Injections in an Office	\$0 copay/visit	
<b>Urgent and Emergency Care</b>		
Urgent Care Center	\$40 copay/visit	50%

## PPO medical benefits

B

<b>GOLD+ PPO MEDICAL BENEFITS—What You Pay</b>		
	<b>Network Provider</b>	<b>Non-Network Provider</b>
Hospital Emergency Room	\$150 copay/visit <i>waived if admitted</i>	
Hospital Emergency Room for Routine Care	50%	Not covered
Professional Ambulance Services	\$150 copay/trip	
<b>Laboratory and Imaging Services</b>		
<b>Laboratory Services:</b>		50%
Office/Non-Hospital	\$20 copay/visit	
Hospital Outpatient	\$80 copay/visit	
<b>Radiology Services:</b>		
Office/Non-Hospital	\$20 copay/visit	
Hospital Outpatient	\$80 copay/visit	
<b>Diagnostic Imaging &amp; Cardiac Testing:</b>		
Office/Non-Hospital	\$150 copay/visit	
Hospital Outpatient	\$250 copay/visit	
<b>Outpatient Services</b>		
<b>Outpatient Surgery:</b>		50%
Ambulatory Surgical Center	\$150 copay/visit	
Hospital Outpatient	\$250 copay/visit	
<b>Physical, Speech, or Occupational Therapy:</b>		
Office/Non-Hospital	\$20 copay/visit	
Hospital Outpatient	\$40 copay/visit	
<p><i>Up to 60 total visits per person each year for physical and occupational therapies combined, and up to 30 total visits per person each year for speech therapy.</i></p>		

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## PPO medical benefits

B

<b>GOLD+ PPO MEDICAL BENEFITS—What You Pay</b>		
	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Kidney Dialysis:</b>		
Home/Office/Non-Hospital	\$0	Not covered
Hospital Outpatient	20% (\$200 maximum copay per visit)	
<b>Chemotherapy or Infusion Medication:</b>		
Home	\$0	50%
Office/Non-Hospital Infusion Center	\$20 copay/visit	
Hospital Outpatient	20% (\$200 maximum copay per visit)	
<b>Radiation Therapy</b>	20%	
<b>Diabetes Education</b>		
<b>Nutritional Counseling — up to 4 visits per person per year</b>	\$0	Not covered
<b>Inpatient Treatment</b>		
<b>Inpatient Hospitalization</b>		
<b>Inpatient Hospitalization for Mental Health/Substance Abuse Treatment (including residential treatment)</b>	\$250 copay/day (\$750 maximum copay per admission)	50%
<b>Skilled Nursing Facility — up to 60 total days per person each year</b>	\$250 copay/admission	
<b>Other Services and Supplies</b>		
<b>Podiatric Orthotics— up to \$500 per person every 24 months</b>	\$0	Not covered
<b>Home Healthcare Services— up to 30 total visits per person each year</b>	\$10 copay/visit	50%
<b>Hospice Care</b>	\$0	
<b>Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment</b>	\$40 copay/day (\$750 maximum copay per episode of care)	

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## PPO medical benefits

B

<b>GOLD+ PPO MEDICAL BENEFITS—What You Pay</b>		
	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Durable Medical Equipment</b>	25%	Not covered
<b>Travel and Lodging— <i>see page B-20 for information</i></b>	Reimburse 100% up to \$250/day and \$10,000/episode	
<b>Medical Foods— <i>see page B-20 for information</i></b>	Reimburse 100%	
<b>All Other Covered Expenses</b>	20%	50%

<b>Gold+ Prescription Drug Benefits</b>	
	<b>Your Cost per Fill</b>
<b>Formulary Preventive Healthcare Prescription Drugs and Supplies, including immunizations <i>see page J-7</i></b>	\$0
<b>Formulary Generic Drugs</b>	\$10
<b>Formulary Brand Name Drugs</b>	\$30
<b>Formulary Specialty and Biosimilar Drugs</b>	25%, up to a maximum of \$50
<b>Out-of-Pocket Limit for Network Prescription Drugs</b>	\$1,600/person & \$3,200/family
<b>Prescription Drugs and Supplies NOT on the Formulary</b>	Not covered

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## Silver+ PPO Medical Benefits

### SILVER+ PPO MEDICAL BENEFITS—What You Pay

	Network Provider	Non-Network Provider
<b>Calendar Year Deductibles</b>		
Calendar Year Deductibles	\$1,500/person & \$3,000/family	
<b>Annual Out-of-Pocket Limits for Medical Care</b>		
For Network Medical Care	\$5,000/person & \$10,000/family	n/a
<b>Office Visits</b>		
Preventive Healthcare Services— <i>See page B-17 and page J-7</i>	\$0	Not covered (except for non-hospital grade breast pumps and related supplies)
ConsejoSano – 24/7 Spanish Health Advice Line	\$0	Not covered
Doctor on Demand – 24/7 Telehealth Services	\$25 copay/visit	
Primary Care Provider (PCP) Office Visit	\$25 copay/visit	50% after deductible
Specialist Visit	\$50 copay/visit	
Mental Health/Substance Abuse Office Visits	\$25 copay/visit	
Chiropractic Care— <i>up to 12 visits per person per year</i>	\$25 copay/visit	Not covered

#### Commencement of Legal Action

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

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

## PPO medical benefits

B

<b>SILVER+ PPO MEDICAL BENEFITS—What You Pay</b>		
	<b>Network Provider</b>	<b>Non-Network Provider</b>
Non-Routine Podiatry Visits	\$50 copay/visit	50% after deductible
Allergy Injections in an Office	\$0 copay/visit	
<b>Urgent and Emergency Care</b>		
Urgent Care Center	\$50 copay/visit	50% after deductible
Hospital Emergency Room	\$200 copay/visit <i>waived if admitted</i>	\$150 copay/visit <i>waived if admitted</i>
Hospital Emergency Room for Routine Care	50% after deductible	Not covered
Professional Ambulance Services	30% after deductible	30% after deductible
<b>Laboratory and Imaging Services</b>		
<b>Laboratory Services:</b>		50% after deductible
Office/Non-Hospital	\$25 copay/visit	
Hospital Outpatient	\$100 copay/visit	
<b>Radiology Services:</b>		
Office/Non-Hospital	\$25 copay/visit	
Hospital Outpatient	\$100 copay/visit	
<b>Diagnostic Imaging &amp; Cardiac Testing:</b>		
Office/Non-Hospital	\$175 copay/visit	
Hospital Outpatient	\$300 copay/visit	
<b>Outpatient Services</b>		
<b>Outpatient Surgery:</b>		50% after deductible
Ambulatory Surgical Center	20% after deductible	
Hospital Outpatient	30% after deductible	

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<b>SILVER+ PPO MEDICAL BENEFITS—What You Pay</b>		
	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Physical, Speech, or Occupational Therapy:</b>		50% after deductible
Office/Non-Hospital	\$30 copay/visit	
Hospital Outpatient	\$60 copay/visit	
<i>Up to 60 total visits per person each year for physical and occupational therapies combined, and up to 30 total visits per person each year for speech therapy.</i>		
<b>Kidney Dialysis:</b>		Not covered
Home/Office/Non-Hospital	\$0	
Hospital Outpatient	30% after deductible (\$250 maximum copay per visit)	
<b>Chemotherapy or Infusion Medication:</b>		50% after deductible
Home	\$0	
Office/Non-Hospital Infusion Center	\$25 copay/visit	
Hospital Outpatient	30% after deductible (\$250 maximum copay per visit)	
<b>Radiation Therapy</b>	30% after deductible	50% after deductible
<b>Diabetes Education</b>		Not covered
<b>Nutritional Counseling —</b> <i>up to 4 visits per person per year</i>	\$0	
<b>Inpatient Treatment</b>		
<b>Inpatient Hospitalization</b>		50% after deductible
<b>Inpatient Hospitalization for Mental Health/Substance Abuse Treatment</b> <i>(including residential treatment)</i>	30% after deductible	
<b>Skilled Nursing Facility —</b> <i>up to 60 total days per person each year</i>	30% after deductible	

## PPO medical benefits

B

<b>SILVER+ PPO MEDICAL BENEFITS—What You Pay</b>		
	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Other Services and Supplies</b>		
<b>Podiatric Orthotics—</b> <i>up to \$500 per person every 24 months</i>	\$0	Not covered
<b>Home Healthcare Services—</b> <i>up to 30 total visits per person each year</i>	\$15 copay/visit	50% after deductible
<b>Hospice Care</b>	\$0	
<b>Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment</b>	\$0	
<b>Durable Medical Equipment</b>	25% after deductible	Not covered
<b>Travel and Lodging—</b> <i>see page B-20 for information</i>	Reimburse 100% up to \$250/day and \$10,000/episode	
<b>Medical Foods—</b> <i>see page B-20 for information</i>	Reimburse 100%	
<b>All Other Covered Expenses</b>	30% after deductible	50% after deductible

<b>Silver+ Prescription Drug Benefits</b>	
	<b>Your Cost per Fill</b>
<b>Formulary Preventive Healthcare Prescription Drugs and Supplies, including immunizations</b> <i>see page J-7</i>	\$0
<b>Formulary Generic Drugs</b>	\$10
<b>Formulary Brand Name Drugs</b>	\$30
<b>Formulary Specialty and Biosimilar Drugs</b>	25%, up to a maximum of \$50
<b>Out-of-Pocket Limit for Network Prescription Drugs</b>	\$1,600/person & \$3,200/family
<b>Prescription Drugs and Supplies NOT on the Formulary</b>	Not covered

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## Network providers

Benefits are paid based on whether you use a network provider or a non-network provider. To find a network provider, contact:

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

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

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

*(Choose “Find a Doctor or Hospital” to get started. You are in the “Participating Provider Organization (PPO)” network.)*

- ✓ **BlueShield of California providers are not in your network.** Only BlueCross of California providers are considered network providers.

The Plan will apply network benefits to: emergency treatment; professional ambulance transportation; treatment provided by non-network healthcare providers who specialize in anesthesiology, emergency medicine, pathology, or radiology; inpatient consultations with non-network providers; and when the network doesn't have a provider in the required specialty. However, the allowable charge will be based on whether or not the provider is in the network. You must still pay the difference between the Plan's allowable charge and what the non-network provider charges.

*See page A-9* for more information about how staying in the network can help you save money.

## Prior Authorization

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

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

To get prior authorization, call toll free:

**NHS**

toll free: **(855) 483-0353**

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

### **Get prior authorization for medical and surgical treatment**

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

#### **NHS**

toll free: **(855) 483-0353**

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

### **When to call for prior authorization**

You should make sure your healthcare provider contacts NHS before any of the following:

- Air ambulance transportation.
- Clinical trials.
- The following radiology services:
  - CT or CTA scans (computed tomography or computed tomography angiography).
  - Discography.
  - MRA or MRI (magnetic resonance imaging or magnetic resonance angiography).
  - PET-Scan (positron emission tomography scintiscan).
- Durable medical equipment rentals or purchases over \$500. (This includes breast pumps costing over \$500.)
- Genetic testing.
- Skilled services provided in a home setting, including home healthcare and home infusion.
- Habilitative therapy for children with autism spectrum disorder.
- Hyperbaric treatment.
- Inpatient admissions, other than for treatment of mental health/substance abuse, admissions following observation or an emergency room visit, and admissions for skilled nursing facility care, acute rehabilitation care, and long-term acute facility care.

- Medical foods for inborn errors of metabolism.
- Oncology and hematology services.
- Orthotic and prosthetic appliance rentals or purchases of over \$500.
- Orthognathic surgery.
- Outpatient surgery or procedures performed in an ambulatory surgical center, and surgery or invasive diagnostic procedures performed in the outpatient hospital surgery area. However, colonoscopies or sigmoidoscopies do not require prior authorization.
- Sleep studies.
- TMJ procedures.
- Transplant services, including consultations.
- Travel and lodging.
- Varicose vein procedures.

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

- Dialysis.
- Physical, speech, or occupational therapy.

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

- All inpatient and residential mental health/substance abuse treatment

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

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

## PPO medical benefits

No prior authorization is required if you are receiving treatment in an emergency room or are in observation in the hospital.

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

### Case management program

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

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

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

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

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

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

## What you pay for your medical care

You must pay any cost share (such as copays, coinsurance, or deductibles) for your share of covered expenses. You must also pay any expenses that are not covered expenses (*see page B-21* for information about what's not covered), including any amounts over the allowable charge when you use non-network providers, or charges once a maximum benefit or limitation has been met.

See the summary of benefits for your medical benefit option at the beginning of this section.

### Deductibles—Silver+ PPO option only

Your calendar year deductible applies to both network and non-network expenses. You only have

to pay the deductible once each year. Once you have paid your deductible (sometimes called “satisfying your deductible”), you do not have to make any more payments toward your deductible for the rest of that year. The \$1,500 individual deductible applies to each person covered by the Plan. However, once your \$3,000 family deductible has been satisfied, no one else in your family has to pay deductibles for the rest of that year.

Your \$1,500 individual and \$3,000 family deductibles only apply to the medical benefits (including mental health and substance abuse benefits). Amounts you pay for prescription drugs, vision care, or dental care will not apply toward the deductibles. In addition, the deductibles do not apply to certain medical benefits. *See the applicable medical option benefit summary* to see which services require the deductible and which services are covered before you satisfy the deductible.

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

### Copays

The copay covers your cost sharing for all of the healthcare you receive at the time of the service. For example, you only pay one office visit copay for all healthcare you receive during the office visit, even if you received other services at the same time.

If you are in the Silver+ PPO benefit option, in certain situations, you may pay the cost-sharing (deductible, coinsurance, copay) required for each of the services you receive. Sometimes this means you pay both a copay and coinsurance. However, you will never be required to pay multiple copays—you pay the highest copay amount. This could apply when you go to an office, but don't see the doctor or your doctor doesn't bill an office visit.

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

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

Your out-of-pocket cost-sharing (deductibles, coinsurance, and copays) for most covered network medical (including mental health/substance abuse) expenses is limited to \$5,000 per person (\$10,000 per family) each calendar year. Once your out-of-pocket costs for covered expenses meet these limits, the Plan will usually pay 100% for your (or your family's) network medical covered expenses during the rest of that calendar year.

Amounts you pay out-of-pocket for prescription drug expenses under the section of this SPD titled “*PPO prescription drug benefits*” **do not** count toward this out-of-pocket limit. (There is a separate out-of-pocket limit for your prescription drug cost-sharing—*see page B-25*.)

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

## **Doctor on Demand – 24/7 Telehealth Services**

**(800) 997-6196**

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

If you need to see a healthcare provider but can't get into the office, you can video chat with one through Doctor on Demand. You pay a \$20 copay under the Gold+ benefit option, and a \$25 copay under the Silver+ benefit option.

You can access Doctor on Demand by internet or through your smart phone.

- **Internet:** visit [www.doctorondemand.com](http://www.doctorondemand.com) using Google Chrome (you must use Google Chrome to access Doctor on Demand). Select “Get started” and follow the on-screen instructions.
- **Smart phone:** download the Doctor on Demand app to your smartphone through an app store or through [www.doctorondemand.com](http://www.doctorondemand.com).

You can then video chat with a Board-certified healthcare provider. A Doctor on Demand healthcare provider can even prescribe prescription drugs for you in many cases.

Doctor on Demand can treat many common sicknesses, like colds and flu, skin issues, diarrhea and vomiting, and eye conditions. However, if you want to discuss a complex condition like cancer, or a serious injury, you should not use Doctor on Demand.

## **ConsejoSano – 24/7 Spanish Health Advice Line (Spanish speakers only) / Llame para consulta médica**

**(855) 785-7885**

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

**¡Llama GRATIS hoy mismo!**

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

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

### ¡Ahora es más fácil cuidar de tu salud!

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

### Habla hoy con un asesor médico en Español

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

## What's covered

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

- **Preventive healthcare services** (*see page J-7*) when a network provider is used. Non-network preventive care is not covered. However, non-hospital grade breast pumps (limited to one per pregnancy) and breast pump supplies will be covered when obtained from a non-network provider. Certain limits or rules may apply to when and how you get preventive healthcare based on your gender, age, and health status.
  - ▶ PSA tests for men are covered annually for men ages 40 through 69.
  - ▶ Cervical cancer screening (pap smear) is covered once every 36 months for just the pap smear, or once every 60 months if both a pap smear and human papillomavirus screening are done together. Cervical cancer screenings are only covered for women from age 21 to age 65.
  - ▶ Routine mammogram screenings for women age 40 through 74 years are covered once each calendar year. Routine mammogram screenings are also covered once each calendar year for women under age 40, or age 75 and older, who are diagnosed as high risk for breast cancer.
- **Professional services** of a healthcare provider.

- **General nursing services.**
- **Injectable medications**, including immunizations provided by a healthcare provider.
- Treatment of **mental health conditions and substance abuse**, including inpatient and residential treatment, outpatient care, partial hospitalization, intensive outpatient care, and ambulatory detoxification.
- **Non-routine podiatry.**
- **Chiropractic care**, provided by a network provider, up to 12 visits per person each year.
- **Outpatient services** in a clinic or urgent care center.
- Hospital **emergency room** services.
- Transportation by a **professional ambulance service** to an area medical facility that is able to provide the required treatment.

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

- **Ambulatory surgical facility services**, including general supplies, anesthesia, drugs, and operating and recovery rooms. If you have multiple surgeries, covered expenses are limited to charges for the primary surgery.
- **Radiology**, including but not limited to x-rays, ultrasounds, and fetal monitoring.
- **Diagnostic imaging**, including but not limited to MRIs, MRAs, CT scans, PET scans.
- **Laboratory services.**
- **Radiation therapy.**
- **Chemotherapy and infusion services.**
- **Hospital charges** for room and board, and other inpatient or outpatient services. The Plan's benefits for a private room will be limited to the semi-private room rate. Hospital charges include intensive care unit accommodations, and routine nursery charges for a covered newborn child.
- **Pregnancy** and pregnancy-related conditions for employees and spouses, including childbirth, miscarriage, abortions, and preventive healthcare (*see page J-7*). Generally, no benefits are payable for pregnancy or pregnancy-related conditions for a dependent child, unless the care is considered preventive healthcare. Non-preventive healthcare services for a dependent child's pregnancy, including but not limited to ultrasounds, charges associated with a high-risk pregnancy, abortions, and delivery charges will not be covered.

- **Mastectomies**, including reconstruction of the breast upon which the mastectomy is performed, surgery and reconstruction on the other breast to produce a symmetrical appearance, breast implants, and treatment of physical complications resulting from a mastectomy, including swollen lymph glands.
- **Medical services for organ transplants** if the following rules are all met:
  - ▶ The transplant must be covered by Medicare, including meeting Medicare's clinical, facility, and provider requirements.
  - ▶ You must use any case management program recommended by the Fund or its representative.
  - ▶ You must get prior authorization for the transplant.
  - ▶ Donor expenses for your transplant are only covered if the donor has no other coverage.
  - ▶ Transplant coverage does not include your expenses if you are giving an organ instead of getting an organ.
- **Dental procedures** for treatment otherwise covered under a dental benefit, including charges made by a hospital, or other facility, when those procedures require treatment in an institutional setting to safely administer the care, including for treatment if you are suffering from medical or behavioral conditions, such as autism or Alzheimer's, that severely limit your ability to cooperate with the necessary care.
- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- **LeFort type operations** when intended to repair birth defects of the mouth, conditions of the mid-face (over or under development of facial features), or damage caused by accidental injury.
- **Skilled nursing facility care**, up to a total of 60 days per person each year, as long as you are under the care of a doctor, and are confined as a regular bed patient.
- **Blood and blood plasma**, and their administration.
- **Home healthcare services**, up to a total of 30 visits per person each year. General housekeeping services or custodial care is not covered.
- Inpatient and outpatient **hospice** services and supplies if you are terminally ill.
- **Anesthesia**, and its administration.
- **Durable medical equipment**, and supplies, for all non-disposable devices or items prescribed by a healthcare provider, such as wheelchairs, hospital-type beds, respirators and associated support systems, infusion pumps, home dialysis equipment, monitoring devices, home traction units, and other similar medical equipment or devices.

## PPO medical benefits

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- ▶ Rental fees are covered if the DME can only be rented, and the purchase price is covered if the DME can only be bought.
- ▶ However, if DME can be either rented or bought, and if the rental fees for the course of treatment are likely to be more than the equipment's purchase price, benefits may be limited to the equipment's purchase price.
- ▶ If DME is bought, costs for repair or maintenance are also covered.
- Outpatient rehabilitation services for **physical, speech, occupational therapy**. Benefits are limited to 60 total visits per person each year for physical and occupational therapies combined, and up to 30 total visits per person each year for speech therapy.
- Professional services for **diabetes education** and training for the care, monitoring, or treatment of diabetes provided by a network provider. Non-network services are not covered.
- Professional services for **nutrition counseling** provided by a network provider, up to a total of 4 visits per person each year. Non-network services are not covered.
- **Repair of sound natural teeth** and their supporting structures, if the covered expenses are the result of an injury. Treatment must be received while you are covered under the Fund. You may have additional dental coverage if you are enrolled in a dental benefit option—see the applicable dental benefit option for more information.
- **Sterilization procedures** for employees and spouses. For female dependent children, FDA-approved sterilization procedures considered preventive healthcare (*see page J-7*) are also covered.
- **Surgical supplies and surgical dressings**, including artificial limbs and eyes, and casts, splints, and trusses.
- Treatment of **tumors, cysts and lesions** not considered a dental procedure.
- **Oral surgery**, including surgical removal of impacted teeth.
- **Medical foods** if you have an inborn error of metabolism (IEM). You must get prior authorization for your medical food costs before the Plan will reimburse you. The Plan will reimburse 100% of your costs for medical foods. To be reimbursed, the medical food must be: (1) ordered by and used under the supervision of a healthcare provider; (2) the primary source of your nutrition; and (3) labeled and used for dietary management of your IEM.
- Reimbursement for **travel, lodging, and meal costs** for transportation to get certain treatment more than 50 miles away from your home (as long as you travel within the United States). You must get prior authorization for these expenses before the Plan will reimburse you. Covered expenses only include travel, lodging and meal costs related to: (1) transplants, (2) cancer-related treatments, and (3) congenital heart defect care. The following rules apply:
  - ▶ The travel, lodging, and meal costs of one other person traveling with you will also be

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covered. (Two other people will be covered if the patient is a minor child.)

- ▶ Reimbursement is limited to \$10,000 per episode of care for you and your traveling companion(s) combined. This includes up to \$250 each day for lodging and meal costs.
- ▶ You must provide the Plan with your original receipts.
- ▶ You must participate in any case management programs required by the Fund.
- ▶ You cannot get reimbursed for expenses related to your participation in a clinical trial, or for an organ transplant if you are donating an organ instead of getting an organ.
- ▶ The Fund may prearrange or prepay certain travel or lodging costs instead of requiring you to pay yourself and then file for reimbursement.

More details about the benefit are available upon request.

- **Gender reassignment surgery** for individuals with a diagnosis of gender dysphoria and related charges (e.g., laboratory work, x-rays, office visits, etc.). The Plan will cover surgical procedures, including medically necessary corrective surgeries, to change your gender once (for example, if the Plan covers procedures changing your gender from male to female, the Plan will not then pay to change your gender back to male). You must be at least 18 years of age and obtain prior authorization for surgical services.

## 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 Plan will not pay benefits for, or in connection with, the following medical treatments, services, and supplies:

- Prescription drugs and medications, other than those used where they are dispensed. Prescription drugs may be covered under the prescription drug benefit starting on *page B-23*.
- Ambulatory surgical facility fees for procedures normally performed in a provider's office.
- Preventive healthcare services and supplies that must be purchased through the prescription drug benefits.
- Unless specifically listed as covered, dental services for or in connection with routine care of the teeth and supporting oral tissues, or restorative services to replace natural teeth lost as a result of injury.
- Procedures for the treatment of temporomandibular joint dysfunction, craniofacial disorders or orthognathic disorders, unless prior approval has been received in writing from UNITE HERE HEALTH.

## *PPO medical benefits*

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- Unless specifically listed as covered, surgery to modify jaw relationships including, but not limited to, osteoplasty and genioplasty procedures.
- Eye refractions, eyeglasses, or contact lenses. However, these expenses may be covered under the vision benefits.
- Private duty nursing care.
- With respect to non-network providers, routine care provided in an emergency room when you could get the care in a clinic, urgent care center, or healthcare professional's office.
- Except as specifically covered under the Plan, non-healthcare items or services, including but not limited to oral nutrition or supplements, and disposable supplies, such as bandages, antiseptics, and diapers.
- Acupuncture.
- Routine podiatry.
- Habilitative therapy for children with autism spectrum disorder (ASD).

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# **PPO prescription drug benefits**

Learn about your prescription drug benefits if you are enrolled in one of the PPO options:

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

*This section only applies to you if you choose one of the PPO benefit options (Gold+ or Silver+).  
If you choose the Kaiser HMO benefit option, please see the section starting on **page B-33**  
for information about your medical benefits.*

## PPO prescription drug benefits

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

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

**If you use a pharmacy not in your network, you will have to pay 100% of the cost of the prescription drug.** Be sure you check [www.hospitalityrx.org](http://www.hospitalityrx.org) to make sure you use a network pharmacy. The Plan will not reimburse you for the cost of any prescription drugs you buy at a non-network pharmacy.

### Important Phone Numbers

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

#### Commencement of Legal Action

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

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

## What you pay

You must pay the applicable amount shown below for each fill of a prescription drug. You must also pay any expenses that are not considered covered expenses (*see page B-31* for information about what's not covered).

Prescription Drugs	
	Gold+ or Silver+ PPO
Preventive Healthcare Prescription Drugs and Supplies, Including Immunizations <i>see page J-7</i>	\$0
Generic drugs on the formulary	\$10
Brand name drugs on the formulary	\$30
Specialty and biosimilar drugs on the formulary	25% up to \$50 total copay per fill or refill
Out-of-Pocket Limit for Network Prescription Drugs	\$1,600/person & \$3,200/family
Prescription Drugs and Supplies NOT on the Formulary	Not covered

Drugs and supplies on the formulary are safe, effective and high-quality. No benefits are paid for drugs not on the formulary unless the Fund approves the drug. Ask your healthcare provider to prescribe a drug that is on the formulary. Prescription drugs and supplies may be added to or removed from the formulary from time to time. Use the formulary lookup tool at [www.hospitalityrx.org](http://www.hospitalityrx.org), or call Hospitality Rx at (844) 813-3860, if you or your healthcare provider have questions about which prescription drugs and supplies are on the formulary.

If your healthcare provider wants you to take a drug that is not on the formulary, he or she should reach out to Hospitality Rx at (844) 813-3860 for a formulary exception. The formulary exception allows your healthcare provider to ask for approval for you to get coverage for a prescription drug not on the formulary. Remember, though, that the Fund will not consider a non-formulary drug for coverage until you have tried all of the formulary prescription drug alternatives that are medically appropriate to your situation.

You must use the specialty pharmacy to get specialty and biosimilar prescription drugs. *See page B-30* for more information about the specialty pharmacy.

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

Your out-of-pocket cost-sharing (deductibles, coinsurance, and copays) for most covered network prescription drug expenses is limited to \$1,600 per person (\$3,600 per family) each calendar year.

Once your out-of-pocket costs for covered expenses meet these limits, the Plan will usually pay 100% for your (or your family's) network prescription drug covered expenses during the rest of that calendar year.

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

Amounts you pay out-of-pocket for medical expenses under the section of this SPD titled "*PPO medical benefits*" (see page B-1) **do not** count toward this out-of-pocket limit.

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

### **Generic prescription drug policy**

If you or your provider chooses a covered brand name prescription drug when you could get a generic equivalent instead, you pay the difference in cost between the brand name prescription drug and the generic equivalent. For example, if the brand name prescription drug costs \$80 at retail, and the Fund's cost for the generic equivalent is \$30, you must pay the \$50 difference. You will also have to pay the applicable generic prescription drug copay (\$3 or \$10, depending on your medical benefit option).

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

If you have an exception to the generic prescription drug policy, you will still have to pay the applicable brand name drug copay (\$20 or \$30, depending on your medical benefit option).

### What's covered

The Plan pays benefits only for the types of expenses listed below that are on the formulary:

- FDA-approved prescription drugs which can legally be purchased only with a written prescription from a healthcare provider. This includes oral and injectable contraceptives and drugs mixed to order by a pharmacist, as long as at least one part of the mixed-to-order drug is an FDA-approved prescription drug.
- The following diabetic supplies: insulin, diabetic test strips, control solution for glucometers, disposable syringes and needles, and lancets.
- Prescription and non-prescription (over-the-counter) preventive healthcare services and supplies, including immunizations.
- The following single-source vitamins: ferrous sulfate, vitamin D, cyanocobalamin, vitamin K, potassium chloride, bicarbonate, phosphate, calcium acetate, niacin, and Galzin (zinc).
- Hormone therapy, including both infused hormone therapy and hormones you get at a pharmacy. The hormones must be FDA approved and only available by prescription. Prior authorization is required for certain hormone therapy. Hormone therapy for individuals with gender dysphoria is not subject to an age restriction; however, the prior authorization process for individuals under age 18 will include an additional requirement that the treating physician have documentation showing sexual maturity of Tanner stage 2 or more.

### Free glucometers

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

**(888) 883-7091** for **OneTouch (LifeScan)** products

or visit [www.OneTouch.orderpoints.com](http://www.OneTouch.orderpoints.com)

*use order number 739WDRX01*

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

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

### **Safety and cost containment programs for prescription drugs**

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

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

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

*See page I-1* for information about appealing a denial for prior authorization or appealing a denial of prescription drug benefits.

#### **Prior authorization**

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

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

#### **Step therapy**

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

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

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

### Case management

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

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

### Fill and refill limits

#### Quantity limits

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

- Birth control drugs that are only available in 90-day quantities or that use a steady hormone release over time (such as NuvaRing®) will be filled based on one application or one unit, as applicable.
- Male impotency drugs are limited to 6 applications per month and to a 3-month initial supply.
- If you use the mail-order pharmacy, you can get up to a 60-day supply at a time.
- If a safety or cost containment program limits the drug to a smaller quantity, the drug will only be filled up to the amount allowed under that program.

You generally cannot refill a prescription earlier than allowed under any applicable guidelines, safety or cost containment programs, or other Plan rules, but in some cases, you may be able to refill a prescription sooner than is usually allowed. For example, you may get an early refill if:

- You show you will be out of the country when you will run out of a prescription drug.
- Your drug is lost or stolen.
- You run out of a drug too soon because you misunderstood the instructions or accidentally used too much (limited to one early refill per lifetime for that drug).

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

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

### **Exceptions to the standard quantity limits**

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

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

### **Mail-order pharmacy**

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

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

**WellDyneRx Home Delivery**

**(844) 813-3860**

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

### **Specialty pharmacy**

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

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

**AllianceRx Walgreens Prime**

**(877) 647-5807**

(TTY) 866-830-4366

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

AllianceRx Walgreens Prime specialty pharmacy is different than Walgreens retail phar-

### 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 prescription drug treatments, services, and supplies are not covered under the prescription drug benefit:

- Prescription drugs that have not been approved by the FDA. However, the Fund may cover prescription drugs not approved by the FDA in certain situations. You or your healthcare professional may ask for an exception through the Fund's prior authorization program.
- Specialty prescription drugs, other than those used to treat HIV/AIDS, if you do not use the specialty pharmacy.
- Experimental or investigational drugs.
- Fertility drugs.
- Prescriptions or refills in amounts over the quantity limits (*see page B-29*).
- Non-sedating antihistamines or histamine receptor blockers.
- Over-the-counter proton pump inhibitors.
- Diagnostics (drugs used to help in the process of diagnosing certain medical conditions) or biologicals (preparations made from living organisms or their products and used as a diagnostic, preventive, or therapeutic agent).
- Vitamins, dietary supplements, or dietary aids, except those specifically listed as a covered expense.
- New-to-market prescription drugs until the Fund or its representative has reviewed and approved the prescription drug.
- High-cost "me too" drugs, unless the Fund or its representative approves the drug for purchase. "Me-too" drugs usually have only very small differences in how they work, but are considered "new" drugs with no generic equivalent. Often, the manufacturer charges high prices for these drugs even though there are other drugs available that work just as well for a lower cost. You can find out if a "me too" drug is covered by contacting Hospitality Rx.
- Drugs that require review under a safety or cost containment program (such as a drug that requires prior authorization, or a drug subject to the step therapy program) if that safety or cost containment program is not followed, or does not approve the drug.
- Drugs, medications, or supplies that are not for an FDA-approved indication, that are not covered under the Plan's or Plan's designee's claims processing guidelines or any other internal rule, including but not limited to any national guidelines used by the medical community.
- Glucometers, other than those the Fund gives to you for free. You may be able to get a

## *PPO prescription drug benefits*

**B**

glucometer through the medical benefits if you do not want one of the free ones, but you will usually have to pay part or all of the cost.

- Rogaine and other drugs to prevent hair loss.
- Drugs or medications used, consumed or administered at the place where dispensed, other than immunizations. (These drugs may be covered under your medical benefits.
- Drugs used for cosmetic reasons.
- Weight control drugs, unless for the treatment of morbid obesity under the direct supervision of a healthcare provider, and authorized in writing by the Fund.
- Human growth hormone, except to treat emaciation due to AIDS.
- Drugs or other covered supplies not purchased from a network pharmacy.
- Medical foods (medical foods may be covered under the medical benefits).

# ***Kaiser HMO medical and prescription drug benefits***

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

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

This section only applies to you if you choose the Kaiser HMO medical benefit option. If you choose one of the PPO medical benefit options, please see the applicable section starting on *page B-3* or *page B-23* for information about your medical and prescription drug 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](http://www.kp.org)

Member Services  
**(800) 464-4000**

Kaiser Advice Nurse  
Southern California: **(888) KPONCALL (576-6225)**  
Northern California: **(866) 454-8855**

## **Using your benefits if you chose the Kaiser HMO option**

If you enroll in the Kaiser HMO option, 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 certificate of coverage. You can get a certificate of coverage by contacting Kaiser or UNITE HERE HEALTH.

## **Kaiser Arbitration**

Unless there is an exception (see the next paragraph), any dispute between you, your heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings.

## *Kaiser HMO medical and prescription drug benefits*

**B**

Exceptions to Kaiser's binding arbitration rules are: claims subject to the ERISA claims procedure regulations, a Medicare appeals procedure, and any other claim that cannot be subject to binding arbitration under applicable law. More information about binding arbitration and your rights and obligations to use binding arbitration are explained in your evidence of coverage.

### **Using this SPD if you chose the Kaiser HMO option**

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 Kaiser will explain the rules that apply to your benefits.

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

- PPO medical benefits
- PPO prescription drug 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 if you chose the Kaiser HMO option**

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

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# ***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 or the LA Dental Center benefit option, please see the applicable section starting  
on [page C-21](#) or [page C-21](#) for information about your dental benefits.*

## Dental PPO benefits

UNITE HERE HEALTH has contracted with Cigna to provide dental benefits to you and your dependents. This contract determines what your benefits are and how Cigna pays for your dental benefits. This part of the SPD summarizes your dental benefits; however, if there is any conflict between this SPD and the contract, the terms of the Cigna contract governs.

The contract with Cigna is governed by applicable state law. Depending on the state governing your dental benefits, there may be small differences between this summary of your benefits and how your dental benefits actually work. For example, who your dependent is for dental benefits, how Cigna must pay claims, and the types of benefits that are covered may be slightly different from state to state. (Cigna's rules would only apply to your Cigna dental benefits—not to other benefits provided under the Plan.) **If you have any questions about how your dental benefits work, please contact Cigna.** 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.

### CIGNA PPO DENTAL BENEFITS—What You Pay

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

### CIGNA PPO DENTAL BENEFITS—What You Pay

<b>Major Restorative Services—</b> <i>Including crowns, bridges, implants, dentures</i>	50% after deductible	60% after deductible
<b>Orthodontic Treatment</b>	50% after deductible	50% after deductible

## 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](http://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.

## Dental PPO benefits

### 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.

## Dental PPO benefits

- ▶ 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.
  - ▶ 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.

## Dental PPO benefits

- 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.
- 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-4*).
  - 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.
- 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 of 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 or the LA Dental Center 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 has contracted with Cigna to provide dental benefits to you and your dependents. This contract determines what your benefits are and how Cigna pays for your dental benefits. This part of the SPD summarizes your dental benefits; however, if there is any conflict between this SPD and the contract, the terms of the Cigna contract governs.

The contract with Cigna is governed by applicable state law. Depending on the state governing your dental benefits, there may be small differences between this summary of your benefits and how your dental benefits actually work. For example, who your dependent is for dental benefits, how Cigna must pay claims, and the types of benefits that are covered may be slightly different from state to state. (Cigna's rules would only apply to your Cigna dental benefits - not to other benefits provided under the Plan.) **If you have any questions about how your dental benefits work, please contact Cigna.** 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.

### Cigna Dental Care HMO

toll free: **(800) 244-6224**

[www.mycigna.com](http://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	\$17 copay/tooth
Periodontal Scaling and Root Planing— <i>up to 4 quadrants total per person every 12 months</i>	\$60 - \$110 copay per quadrant
Periodontal Maintenance— <i>up to 4 total per person each year</i>	\$77 copay
Amalgam Fillings	\$6 - \$18 copay, depending on number of surfaces

Dental Benefits—Dental Health Maintenance Organization	
Onlays (metallic)	\$370 - \$440 copay, depending on type of onlay
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 HMO. 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 HMO 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 HMO 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 7 can use a pediatric dentist as the primary dentist. After a child turns 7, 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](http://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, including implants and abutments) 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.

## Dental HMO 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.

- 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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# ***LA Dental Center benefits***

Learn about your benefits if you are enrolled in the LA Dental Center benefit:

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

*This section only applies to you if you choose the LA Dental Center benefit option. If you choose the dental PPO or the dental HMO benefit option, please see the applicable section starting on [page C-1](#) or [page C-11](#) for information about your dental benefits.*

## LA Dental Center benefits

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

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

In case of a true dental emergency:  
**(800) 436-3702**

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

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

DENTAL BENEFITS		
Description of Services	LA Dental Center	Dentists Other than the LA Dental Center
Maximum Benefit Payable Each Calendar Year	n/a	
Calendar Year Deductible	n/a	
<b>What You Pay for Dental Care</b>		
Diagnostic & Preventive Services		Not covered
Emergency Services— <i>including to treat severe pain</i>	\$0	
Diagnostic X-ray Services		
Basic Restorative Services		
Periodontic Services	10%	
Endodontic Services		
Major Restorative Services		
Oral Surgery	15%	
Prosthodontic Services & Repairs		

You usually will have to pay your share of the dental cost at the end of your visit. However, services requiring laboratory work (such as dentures, bridges, crowns, etc.) must be paid in advance

of the final appointment and delivery. Future appointments may not be made if your account has an unpaid balance.

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

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

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

### What's covered

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

- **Diagnostic and preventive services:** services and procedures to evaluate existing conditions and/or to prevent dental abnormalities or disease, including examinations, routine cleanings and consultations with a non-treating dentist.
- **Emergency palliative treatment:** nonspecific treatment by a dentist to temporarily relieve pain and discomfort.
- **Radiographs:** x-rays as required or as part of the diagnosis of a specific condition.
- **Oral surgery services:** extractions and other surgical dental procedure, including preoperative and post-operative care, and general anesthesia.
- **Endodontic services:** services and procedures for the treatment of teeth with diseased or damaged nerves (for example, root canals).

#### Commencement of Legal Action

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

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

## LA Dental Center benefits

- **Periodontic services:** services and procedures for the treatment of diseases of the gums and supporting structures of the teeth.
- **Restorative services:** services and procedures to rebuild, repair, or reform the tissues of the teeth, including but not limited to:
  - Minor restorative services: amalgam or resin restorations.
  - Major restorative services: crowns and restorations involving gold when the teeth cannot be restored with another filling.
- **Prosthodontic services:** services and appliances that replace missing natural teeth, including bridges, partial dentures, and complete dentures.
- **Prosthodontic repairs:** repairs and relines to prosthetic appliances.

### What's not covered

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

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

- Services for injuries or conditions compensable under Workers' Compensation or Employer's Liability laws.
- Services that are available from:
  - Any federal or state government agency, other than programs provided under Medicaid.
  - Any municipality, county, or other political subdivision.
  - Any community agency, foundation, or similar entity.
- Services designed to correct developmental malformations.
- Cosmetic surgery or dentistry for cosmetic reasons.
- Services or appliances, including, but not limited to, prosthodontics (including crowns and bridges), completed before you became covered under the Plan.
- Services of anesthetists or anesthesiologists.
- Services performed on primary teeth when loss is imminent.
- Major oral maxillofacial surgery.
- Charges for completion of forms.
- Sealants for persons age 16 or older.
- Orthodontic services.
- Services:
  - That are not necessary and/or customary as determined by the standards of generally accepted dental practice.
  - For which no valid dental need can be demonstrated.
  - That are experimental or investigational in nature.
  - That are otherwise limited or excluded according to the processing procedures developed by the LA Dental Center.
- Appliances, surgical procedures, and restorations for:
  - Altering vertical dimension.
  - Replacing tooth structure loss resulting from attrition, abrasion, or erosion.
  - Correcting congenital or developmental malformations.
  - Aesthetic or cosmetic purposes.

## *LA Dental Center benefits*

- ▶ Implantology techniques or edentulous ridge enhancement.
- ▶ Anticipation of future fractures.
- Treatment by anyone other than a healthcare professional, except for the scaling or cleaning of teeth and topical application of fluoride by a licensed dental hygienist (or other licensed provider) under the supervision and guidance of a dentist in accordance with generally accepted dental standards.
- Services performed as a component of another procedure.
- Services and supplies covered under a medical HMO.
- Placement of an additional appliance in the same dental arch less than 60 months following placement of the initial appliance.

### **Pre-estimate of dental needs**

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

### **Dental benefits after eligibility ends**

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

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

# ***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 choose the vision+ benefit option, please see the section starting on **page D-5** 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

### Commencement of Legal Action

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

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

- ▶ 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 choose the basic vision benefit option, please see the section starting on **page D-1** for information about your vision benefits.*

## Vision+ benefits

UNITE HERE HEALTH has contracted with Vision Service Plan (VSP) to administer the vision benefits provided to you and your dependents. The terms of this contract governs your vision benefits. If there are any conflicts between this SPD and the contract, the terms of the contract will govern.

Certain state laws will govern how VSP pays your benefits. Your vision benefits and who is considered your dependent for vision benefits may be slightly different than described in this SPD. (VSP's rules would only apply to your VSP vision benefits - not to other benefits provided under the Plan.)

VISION+ BENEFITS— <i>What You Pay</i>		
Description of Services <i>Covered once every 12 months</i>	VSP Provider	Non-Network Provider
<b>Exam</b>	\$10 copay	\$10 copay Plan benefits limited to \$45
<b>Lenses</b>	\$25 copay Plan benefits limited to \$160 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
<b>Frames</b>		\$0 copay Plan benefits limited to \$70
<b>Elective Contact Lenses</b> (instead of glasses)	100% of the exam (up to \$50)  \$0 copay for the contacts; Plan benefits limited to \$160 allowance for contacts	\$0 copay Plan benefits limited to \$120
<b>Medically Necessary Contact Lenses</b>	\$0 copay	\$25 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](http://www.vsp.com)

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](http://www.vsp.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 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.

### SHORT-TERM DISABILITY BENEFITS What the Plan Pays—Employees only

<b>\$200 Option</b>	
<b>Amount of Benefit</b>	\$200/week for up to 26 weeks
<b>Day Benefits Start:</b>	
Due to Injury	1st day
Due to Sickness	8th day
<b>\$300 Option</b>	
<b>Amount of Benefit</b>	\$300/week for up to 26 weeks
<b>Day Benefits Start:</b>	
Due to Injury	1st day
Due to Sickness	8th day
<b>\$400 Option</b>	
<b>Amount of Benefit</b>	\$400/week for up to 26 weeks
<b>Day Benefits Start:</b>	
Due to Injury	1st day
Due to Sickness	8th day

#### Commencement of Legal Action

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

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

## Short-term disability benefit

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

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

You are considered disabled if you are prevented by injury or sickness from engaging in 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](http://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 E-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
<b>\$10,000 Option</b>		
Life Insurance	\$10,000	Your beneficiary
AD&D Insurance ( <i>full amount</i> )		You (or your beneficiary if you die)
<b>\$20,000 Option</b>		
Life Insurance	\$20,000	Your beneficiary
AD&D Insurance ( <i>full amount</i> )		You (or your beneficiary if you die)
<b>\$30,000 Option</b>		
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 National. The terms and conditions of your and your dependents' life and AD&D insurance coverage are contained in a certificate of insurance. The certificate describes, among other things:

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

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

### Life insurance benefit

Your life insurance benefit 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 Dearborn National within 31 days after the date your coverage under the Plan ends.

## Life and AD&D benefits

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

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

### Accidental death & dismemberment insurance benefit

If you die or suffer a covered loss within 365 days of an accident that happens while you are eligible for coverage, AD&D benefits will be paid as shown below. However, the total amount payable for all losses resulting from one accident is 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	\$5,000	\$10,000	\$15,000	
Loss of one hand or one foot				
Loss of the sight in one eye				
Loss of index finger and thumb on same hand	\$2,500	\$5,000	\$7,500	

### AD&D exclusions

AD&D benefits do not cover losses caused by:

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

See your certificate for complete details.

### Additional accidental death & dismemberment insurance benefits

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

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

## 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 Dearborn National to pay if you die. Beneficiary designation forms are available on [www.uhh.org/fsp](http://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, Dearborn National may pay benefits, up to any applicable limits, to anyone who pays expenses for your burial. The remainder will be paid in the order described above.

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

### Additional services

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

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

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

# ***General exclusions and limitations***

Learn:

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

## General exclusions and limitations

Each specific benefit section has a list of the types of treatment, services, and supplies that are not covered. In addition to those lists, the following types of treatment, services and supplies are also excluded for all medical care under the PPO benefit options, prescription drugs under the PPO benefit option, the LA Dental Center benefits, 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-6*).
- Experimental treatment (*see page J-4*), or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH.
- Any expense or charge for failure to appear for an appointment as scheduled, or charge for completion of claim forms, or finance charges.
- Any treatment, services, or supplies provided by an individual who is related by blood or marriage to you, your spouse, or your child, or who normally lives in your home.
- Any treatment, services, or supplies purchased or provided outside of the United States (or its Territories), unless for a medical emergency. The decision of the Trustees in determining whether an emergency existed will be final.
- Any charges incurred for treatment, services, or supplies as a result of a declared or undeclared war or any act thereof; or any loss, expense or charge incurred while a person is on active duty or in training in the Armed Forces, National Guard, or Reserves of any state or any country.

## *General exclusions and limitations*

- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault.
- 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.
- Weight loss programs or treatment, except to treat morbid obesity if the program is under the direct supervision of a healthcare provider, or as specifically stated as covered (for example, diabetes education, nutrition counseling, or preventive healthcare services).

## *General exclusions and limitations*

- Any smoking cessation treatment, drug, or device to help you stop smoking or using tobacco, other than preventive healthcare services or as otherwise stated as covered.
- Eye or hearing exams, except as specifically stated as covered, or unless the exam is for the diagnosis or treatment of an accidental bodily injury or an illness. 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

These coordination of benefits provisions only apply to the medical benefits offered under the sections titled “*PPO medical benefits*” and “*Basic vision benefits*.” If you have questions about how your benefits are coordinated, contact the Fund.

No coordination of benefits applies to prescription drug benefits, to the HMO benefits, to the LA Dental Center 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 trusteed plans, employee organization benefit plans, or employer organization benefit plans.
- Any coverage under governmental programs or provided by any statute, except Medicaid.
- Any automobile insurance policies (including “no fault” coverage) containing personal injury protection provisions.

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

### Which plan pays first

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

### Order of payment

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

- Plans that do not contain COB provisions always pay before those that do.

## Coordination of benefits

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

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

## 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](http://www.SocialSecurity.gov)
- Contacting your local Social Security office

### **If you and your spouse are both employees under this Plan**

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

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

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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 does not apply to benefits provided under the HMO benefit option, the Cigna HMO and PPO dental benefits, or the vision+ benefits.**

### The Plan's right to recover payments

#### When injury is caused by someone else

Sometimes, you or your dependent suffer injuries and incur medical expenses as a result of an accident or act for which someone other than UNITE HERE HEALTH is financially responsible. For benefit repayment purposes, "subrogation" means that UNITE HERE HEALTH 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-8*) 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-8* 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.
- *If and only if you are enrolled in the Kaiser HMO benefit option, your domestic partner may be considered your spouse* if you provide a copy of the Declaration of Domestic Partnership from the state of California. Any child of your domestic partner may also be considered a dependent if he or she meets the definition of "child" below.

If you enroll a domestic partner, you will have to pay any federal, state, or local taxes owed on the value of the domestic partner benefits to UNITE HERE HEALTH on a quarterly basis. Contact UNITE HERE HEALTH at (833) 637-3519 with questions about covering domestic partners.

- Your **children** who are under age 26, including any of the following:
  - ▶ Biological children.
  - ▶ Step-children.
  - ▶ Adopted children or children placed with you for adoption, if you are legally responsible for supporting the children until the adoption is finalized.
  - ▶ Children for whom you are the legal guardian or for whom you have sole custody under a state domestic relations law.
  - ▶ Children entitled to coverage under a Qualified Medical Child Support Order.

## Eligibility

- ✓ Federal law requires UNITE HERE HEALTH to honor Qualified Medical Child Support Orders. UNITE HERE HEALTH has established procedures for determining whether a divorce decree or a support order meets federal requirements and for enrollment of any child named in the Qualified Medical Child Support Order. To obtain a copy of these procedures at no cost, or for more information, contact the Fund.

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

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

You must provide proof of the mental or physical handicap within 30 days after the date coverage would end because the child becomes age 26. The Fund may also require you to provide proof of the handicap periodically. (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.
- *If you are enrolling in an HMO and have a domestic partner, you **must** provide the Fund with a copy of your Declaration of Domestic Partnership from California in order to enroll your domestic partner.*

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

No benefits of any kind will be 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.

## Eligibility

<i>Example: Establishing Initial Eligibility</i>	
<b>Your employer must contribute for your work in</b>	<b>You are covered in</b>
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.

<i>Example: Continuing Eligibility</i>	
<b>Your employer must contribute for your work in</b>	<b>You are covered in</b>
February	February
March	March
April	April

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-8*) 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-8*) 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-8*) 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.

## *Eligibility*

### **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.

### **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-7* for an exception if you are already making co-premiums for coverage for all of your children, or for your entire family).

# H-10

# ***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-6* 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-20.*

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

### The effect of severely delinquent employer contributions

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

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

### Special termination rules

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

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

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

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

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

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

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

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

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

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

## *Termination of coverage*

### **Certificate of creditable coverage**

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

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

# ***Reestablishing eligibility***

## Learn:

- ▶ 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 continuing to make the required co-premium payments. If you stop making co-premium 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 co-premium 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

## Reestablishing eligibility

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-6*). 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-8*), 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-20*), as long as those qualifying events would have resulted in a loss of coverage despite the occurrence of any previous qualifying event.

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

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

## *COBRA continuation coverage*

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

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

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

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

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

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

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

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

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

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

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

## COBRA continuation coverage

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

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

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

### Election and payment deadlines

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

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

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

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

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

## *COBRA continuation coverage*

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

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

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

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

## **Termination of COBRA continuation coverage**

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

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

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

## *COBRA continuation coverage*

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

### **To get more information**

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

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

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# ***Claim filing and appeal provisions***

Learn how you file claims and appeal a denied claim:

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

## Claim filing and appeal provisions

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

### Filing a benefit claim

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

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

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

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

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

**PPO medical benefit options: Medical/surgical and mental health/substance abuse claims**  
Network providers usually will file the claim for you. However, if you need to file a claim, for example because you used a non-network provider, all claims for hospital, medical, or surgical treatment must be mailed to Blue Cross and Blue Shield of Illinois.

**Blue Cross and Blue Shield of Illinois**

P. O. Box 805107

Chicago, IL 60680-4112

## *Claim filing and appeal provisions*

### **PPO medical benefit options: prescription drug claims**

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

#### **WellDyneRx Claim Reimbursement**

P.O. Box 90369  
Lakeland, FL 33804

### **Dental PPO claims**

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

### **LA Dental Center claims**

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

### **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**

3333 Quality Drive  
Rancho Cordova, CA 95670

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**

## Claim filing and appeal provisions

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

### Deadlines for filing a benefit claim

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

Deadline for filing a claim	
Type of claim	Deadline to file
Dental PPO claims	1 year following the date the claim was incurred
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"><li>• Written <i>notice</i> must be received within 31 days of loss (or as soon as possible).</li><li>• Written <i>proof</i> of loss must be received within 90 days of loss (or as soon as possible). Other deadlines may apply to your additional AD&amp;D insurance benefits—your insurance certificate provides more information.</li></ul>
All other claims— Including PPO healthcare claims, prescription drug claims, LA Dental Center claims, 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.

## *Claim filing and appeal provisions*

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

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

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

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

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

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

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

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

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

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

### **Determination of claims**

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

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

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

## *Claim filing and appeal provisions*

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

### **Concurrent care decisions**

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

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

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

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

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

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

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

## **Rules for prior authorization of benefits**

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

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

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

## *Claim filing and appeal provisions*

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

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

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

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

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

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

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

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

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

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

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

## *Claim filing and appeal provisions*

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

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

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

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

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

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

### **PPO medical benefit options: two levels of appeal for prior authorization denials**

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

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

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

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

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

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

### **PPO medical benefit options: two levels of appeals for prescription drug claim denials**

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

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

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

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

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

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

### **Dental PPO benefit option: 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.

## *Claim filing and appeal provisions*

### **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**

3333 Quality Drive  
Rancho Cordova, CA 95670

### **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, LA Dental Center claim, life or AD&D denial, or a healthcare claim denial under the PPO option, and you wish to appeal the decision, you must follow the steps in this section. (See the preceding sections to learn how to appeal a prior authorization denial by NHS under the PPO benefit option, or to appeal a prescription drug denial.)

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

#### **The Appeals Subcommittee**

**UNITE HERE HEALTH**

711 N. Commons Dr.  
Aurora, IL 60504

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

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

### **Appeals involving urgent care claims**

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

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

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

## Claim filing and appeal provisions

### 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-5* for details).

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

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

## Claim filing and appeal provisions

and experience in the field of medicine involved in the medical judgment. This healthcare provider cannot be an individual who was consulted in connection with the initial determination on your claim, nor the subordinate of such individual.

### Notice of the decision on your appeal

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

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

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

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

### Independent external review procedures

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

## Claim filing and appeal provisions

- 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.

## *Claim filing and appeal provisions*

### **Non-assignment of claims**

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

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

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

### **Commencement of legal action**

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

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

# Definitions

Learn:

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

*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, 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. The Plan calculates benefits for non-network providers based on established discounted rates, such as Medicare rates, or the contracted network rates. This Plan will not pay the difference between what a non-network provider actually charges, and what is considered an **allowable charge**. You pay this difference in cost. (This is sometimes called “balance billing.”)

**A different definition may apply to benefits provided through the medical HMO option, the dental HMO, the dental PPO, 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.

- ✓ **If you are in the PPO option (Gold+ or Silver+):** Your medical **copays** apply to your medical out-of-pocket limits (*see page B-1*), and your prescription drug **copays** count toward your prescription drug out-of-pocket limits (*see page B-24*).
- ✓ **If you are in the HMO option:** Both your medical and prescription drug **copays** apply to your out-of-pocket limits (see your Kaiser enrollment book for more information).

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.

- ✓ **If you are in the PPO option (Gold+ or Silver+):** Your medical **coinsurance** apply to your medical out-of-pocket limits (*see page B-15*), and your prescription drug **coinsurance** count toward your prescription drug out-of-pocket limits (*see page B-26*).
- ✓ **If you are in the HMO option:** Your medical **coinsurance** apply to your out-of-pocket limits (see your Kaiser book for more information about your medical benefits).

### Cosmetic services

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

Mastectomies, and reconstruction following a mastectomy, will not be considered a **cosmetic service**.

**A different definition may apply to benefits provided through the medical HMO option, the dental HMO, the dental PPO, 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 the Fund begins paying benefits. No deductibles apply to the Gold+ PPO medical benefit option or to the Kaiser HMO benefit option.

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

## Definitions

### Durable medical equipment (DME)

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

- Mainly treats or monitors injuries or sicknesses.
- Withstands repeated use.
- Improves your overall medical care in an outpatient setting.

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

### Emergency medical treatment

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

### Experimental, investigational, or unproven (experimental or investigational)

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

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

**A different definition may apply to benefits provided through the medical HMO option, the dental HMO, the dental PPO, 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 option, the dental HMO, the dental PPO, 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.

**If you are in the PPO option (Gold+ or Silver+):** The Plan only pays benefits for preventive healthcare for a pregnant dependent child. *Generally, maternity charges for a pregnant dependent child that are not preventive healthcare (see page J-7) are not covered by the Plan.* “Non-preventive maternity care” includes but is not limited to ultrasounds, care for a high-risk pregnancy, and the actual childbirth and delivery. No benefits are payable for the child of your child (unless the child meets the Plan’s definition of a dependent—*see page H-3*).

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

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

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

## Definitions

### 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-4*), nor unproven as determined by appropriate governmental agencies, the organized medical community in the United States, or standards or procedures adopted from time-to-time by the Trustees.

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

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

**A different definition may apply to benefits provided through the medical HMO option, the dental HMO, the dental PPO, 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.

Out-of-pocket costs for non-network care or treatment do not count toward your out-of-pocket limit, except for emergency medical treatment, professional ambulance transportation, treatment provided by non-network healthcare providers who specialize in emergency medicine, radiology, anesthesiology, or pathology, inpatient consultations with non-network providers, and when the

network doesn't have a provider in the required specialty. The Plan will not pay 100% for services or supplies that are not covered, or that are provided by a non-network provider, even if you have met your out-of-pocket limit(s) for the year.

You can get more information about your **out-of-pocket limits** for medical care *on page B-15*. You can get more information about your **out-of-pocket limits** for prescription drugs *on page B-26*.

**If you are covered under the HMO option, see your Kaiser book 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.

Certain **preventive healthcare** may be covered more liberally (for example, more frequently or at earlier/later ages) than required. The Plan also considers routine PSA screening tests (prostate-specific antigen tests) to be preventive healthcare.

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

## *Definitions*

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

**If you are covered under the HMO option, see your Kaiser book 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.

- PPO medical benefit options. Nevada Health Solutions (NHS) provides prior authorization and other utilization review services, case management and chronic condition management.
- Prescription drug benefits under the PPO options: These benefits are administered by Hospitality Rx, LLC, a wholly owned subsidiary of UNITE HERE HEALTH.
- LA Dental Center dental benefits.
- 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 National.
- HMO medical benefit options through Kaiser Foundation Health Plan, Inc. Southern California Region.
- Dental PPO benefits through Cigna Health and Life Insurance Company (Cigna).
- Dental HMO benefits through Cigna.
- Vision+ benefits through Vision Service Plan, Inc.

### Interpretation of Plan provisions

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

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

## Other important information

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

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

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

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

## Amendment or termination of the Plan

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

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

## *Other important information*

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

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

### **Free choice of provider**

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

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

### **Workers' compensation**

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

### **Type of Plan**

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

### Employer and employee organizations

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

### Plan administrator and agent for service of legal process

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

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

### Employer identification number

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

### Plan number

The Plan number is 501.

### Plan year

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

### Remedies for fraud

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

## *Other important information*

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

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

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

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

### **Creditable coverage under Massachusetts law**

UNITE HERE HEALTH believes the medical and pharmacy benefits under the 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**

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

### **ConsejoSano**

5200 Lankershim Blvd., Suite 310  
North Hollywood, CA 91601  
**(855) 785-7885**  
[www.consejosano.com](http://www.consejosano.com)

### **Cigna Health and Life Insurance Company (Cigna)**

900 Cottage Grove Road  
Bloomfield, CT 06002  
**(800) 244-6224**  
[www.cigna.com](http://www.cigna.com)

### **Dearborn National**

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

### **Doctor on Demand**

275 Battery Street, Suite 650  
San Francisco, CA 94111  
**(800) 997-6196**  
[www.doctorondemand.com](http://www.doctorondemand.com)

### **Kaiser Permanente**

**(800) 464-4000**  
[www.kp.org](http://www.kp.org)

#### *Member Service Address*

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

#### *Emergency Claims Address*

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

### **Hospitality Rx**

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

### **LA Dental Center**

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

### **NHS (Nevada Health Solutions)**

P.O. Box 61440  
Las Vegas, NV 89160  
**(833) 637-3519**  
[www.nevadahealthsolutions.org](http://www.nevadahealthsolutions.org)

### **UNITE HERE HEALTH**

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

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



## *Important phone numbers and addresses*

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