



Plan 185



Summary Plan Description

Your Health and Welfare Benefits

UNITE HERE HEALTH

Summary Plan Description Hospitality Plan (185)

Effective January 2016

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

Table of Contents

Using this book A-1

How can I get help? A-5

How do I get the most from my benefits?..... A-7

Prior authorization program B-1

Gold medical benefits..... C-1

Silver medical benefits..... C-15

Prescription drug benefits C-29

Dental benefits C-37

Vision benefits C-47

Short-term disability benefits C-51

Life and AD&D insurance benefits C-55

General exclusions and limitations C-61

Coordination of benefits D-1

Subrogation D-5

Eligibility for coverage..... E-1

Termination of coverage..... E-11

Re-establishing eligibility..... E-15

COBRA continuation coverage..... E-19

Claim filing and appeal provisions..... F-1

Definitions G-1

Other important information G-9

Your rights under ERISA G-14

Important contact information G-16

UNITE HERE HEALTH Board of Trustees..... G-17

Using this book

Learn:

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

Please take some time to review this book.

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

What is UNITE HERE HEALTH?

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

Your Plan, the Hospitality Plan, is part of UNITE HERE HEALTH. The Hospitality Plan has been adopted by the Trustees to pay for medical and other health and welfare benefits through the Fund.

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

If information contained in this SPD is inconsistent with the Plan Document, the Plan Document will govern.

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

How do I use my SPD?

This SPD is broken into sections. You can get more information about different topics by carefully reading each section. A summary of the topics is shown at the start of each section. When you have questions, you should always contact the Fund at **(855) 405-FUND (3863)**. The Fund can help you understand your benefits.

Read your SPD for important information about 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, you can get more information about your medical benefits in the section titled

“Medical Benefits.” If you want to know more about your life and AD&D insurance benefit, read the section titled “Life and AD&D Insurance Benefits.”

Remember, this SPD may describe benefits that do not apply to you. Your CBA determines which benefit options you have (see below).

Some terms are defined for you in the section titled “Definitions” starting *on page G-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 (*see page A-5*).

What are my benefit options?

The benefits described in this SPD describe the terms of all of the benefit options available under the Hospitality Plan. However, your CBA and your enrollment elections determine which benefit options you have. For example, if dental benefits are available to you, but you don’t want dental benefits, the part of the SPD that explains dental benefits does not apply to you. If your CBA does not include short-term disability benefits, the part of the SPD that explains short-term disability benefits does not apply to you.

The benefits you elect apply to both you and your enrolled dependents. You cannot elect coverage for your dependents only. You must elect coverage for yourself in order to elect coverage for your dependents.

You can change your coverage choices at certain times during the year, called “enrollment periods.” *See page E-8* for more information about enrollment periods.

When you have questions about your benefit options, contact the Fund at **(855) 405-FUND (3863)**.

Medical benefits

The Hospitality Plan has a Silver Plan and a Gold Plan. You enrolled in one of these plans during your enrollment period. You can check your ID card or call the Fund at **(855) 405-FUND (3863)** to see in which plan you are enrolled. The amount of money you pay for your benefits depends on your CBA, which medical plan you choose, and whether or not you enroll your dependents. The benefits you elect apply to both you and your enrolled dependents.

Dental/Vision benefits

Based on the terms of your CBA, you have the choice to add dental and vision benefits to your medical benefits. If you want dental, you have to take vision, and vice versa. For example, you can’t choose dental but waive vision. The amount of money you pay for your dental and vision benefits depends on your CBA and whether or not you enroll your dependents.

Your CBA may also let you choose whether or not to cover your dependents under the dental and vision benefit option. If it is allowed under your CBA, you can choose different benefit options for

dental and vision coverage than you choose for medical. For example, you can choose the medical benefit option for just yourself, but elect the dental and vision benefit option for yourself and all of your dependents.

However, if your CBA doesn't let you choose different options for your dependents than you choose for medical, the options you choose for your dependents for your medical benefits also applies to your dental/vision benefits. For example, if your CBA says your medical, dental, and vision options all have to be the same, if you choose family medical coverage, your dependents will also get dental and vision coverage.

Other benefits

Depending on the terms of your CBA, you may also get life and AD&D insurance benefits and/or short-term disability benefits. If your CBA requires your employer to make contributions for life and AD&D insurance benefits and/or short-term disability benefits, you will get the benefit option even if you don't enroll in the medical benefits.

UNITE HERE HEALTH (855) 405-FUND (3863)

Call the Fund:

- When you have questions about your benefits.
- When you have questions about your eligibility.
- When you have questions about your claim—including whether the claim has been received or paid.
- To update your address.
- To request new ID cards.
- To get forms or a new SPD.

You can also visit UNITE HERE HEALTH's website to get forms, get another copy of your SPD, or ask for other information: www.uhh.org.

This booklet contains a summary in English of your plan rights and benefits under the Hospitality Plan of UNITE HERE HEALTH. If you have difficulty understanding any part of this booklet, you can visit or contact any of the regional offices shown below. Office hours are from 9:00 A.M. to 4:30 P.M. Monday through Friday. You may also call UNITE HERE HEALTH at (855) 405-FUND for assistance. Phones are answered from 9:00 A.M. to 5:00 P.M. local time.

Este folleto contiene un resumen en inglés de sus derechos y beneficios bajo el Plan Hospitality de UNITE HERE HEALTH. Si tiene dificultad para entender cualquier parte de este folleto, puede ponerse en contacto o visitar cualquiera de las oficinas regionales que se muestran a continuación. Los horarios de oficina son de 9:00 a.m. a 4:30 p.m. de lunes a viernes. También puede ponerse en contacto con UNITE HERE HEALTH al (855) 405-FUND para asistencia. Las llamadas son contestadas de 9:00 a.m. a 5:00 p.m. hora local.

Regional offices (Llame para consulta médica)

- 218 S. Wabash Ave., Suite 800, Chicago, IL 60605.
- 1801 Atlantic Ave, Suite 200 Atlantic City, NJ 08401.
- 33 Harrison Ave, Suite 500, Boston, MA 02111.
- 13252 Garden Grove Boulevard Suite 200, Garden Grove, CA 92843.
- 130 S. Alvarado St, 2nd Floor, Los Angeles, CA 90057.
- 702 Forest Ave, Suite B, Pacific Grove, CA 93950.
- 275 Seventh Avenue, Suite 1504, New York, NY 10001.

How do I get the most from my benefits?

Learn:

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

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, answer questions for you, and help coordinate your care with specialists. Your PCP also helps you keep track of when you need preventive care.

You are encouraged to have a PCP, but the Fund doesn’t track your PCP. You don’t need to tell the Fund who your PCP is, and you don’t need to tell the Fund if you change PCPs.

- ✓ Call Blue Cross Blue Shield at **(800) 810-BLUE (2583)** to find a network PCP. Your network is the Participating Provider Organization (PPO) network.
- ✓ You can also call the Fund **(855) 405-FUND** to get help finding a PCP.

Get preventive care

Your Plan pays 100% for most types of preventive care. Getting preventive care helps you stay healthy by looking for signs of serious medical conditions. If preventive care or tests show there is a problem, the sooner you get diagnosed, the sooner you can start treatment.

Get prior authorization for your care

You or your provider must call before you get certain types of care. *See page B-2* for information about the list of services and supplies that require prior authorization. If you don’t call first, you may pay more for your healthcare—you may even have to pay all of the cost. Be sure you get prior authorization for your care!

- ✓ Call Nevada Health Solutions at **(855) 487-0353** to get prior approval for your care.

Re-think emergency room care

Is it really an emergency? If not, you pay less when you go to an urgent care center. You pay much less when you go to a network urgent care center than when you go to the emergency room.

If you use a network hospital emergency room for routine care your PCP could provide, you pay your deductible (if applicable) plus 50% of the allowable charges. If you use a non-network hospital emergency room for routine care your PCP could provide, you pay the entire cost of the visit. (*See page G-4* for a definition of “emergency.”)

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

Call the Fund

The Fund is here to help you. Fund staff can help you find a provider, answer your questions about your benefits, get you in touch with Nevada Health Solutions to get prior authorization for your care, and answer other questions for you. *See page B-2* for more information.

- ✓ Call the Fund at **(855) 405-FUND (3863)**.

Use your smart phone or the internet to talk to a doctor

(800) 997-6196

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

You pay only \$15 per telehealth visit. *See page C-6* for more information.

Call for medical advice / Llama para consulta médica

(855) 785-7885

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!

Use network providers

Reduce your costs with a network provider

The Plan generally pays higher benefits 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 Plan's allowable charge) and what the Plan pays for covered services. The network provider cannot charge you for the difference between the allowable charge and his or her actual charges (sometimes called balance billing). This means that you will usually pay less out-of-pocket if you choose a network provider.

Look in the medical benefits section for an example of how using a network provider can save you money.

The Plan will apply network benefits to treatment provided by non-network healthcare providers who specialize in emergency medicine, radiology, anesthesiology, or pathology, as well as for in-hospital consultations with non-network providers. However, the allowable charge will be

determined 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.**

This rule also applies if there is no network provider in that specialty.

Easier claims filing with a network provider

The other advantage to using a network provider is that the network provider will usually file a claim for you. You generally don't have to fill out a claim form or submit your receipts.

If you choose a non-network provider, you may have to pay the entire cost of your care. The non-network provider may or may not file a claim for you. If you choose a non-network provider, you can file a claim to get paid back for the Plan's share of your covered care. *See page F-2* for more information about filing claims.

How do I stay in the network?

- Blue Cross Blue Shield of Illinois provides access to a national network of doctors, hospitals, and other healthcare providers. Your network is the Participating Provider Organization (PPO) network.

To find a network provider:
BCBSIL
(800) 810-BLUE (2583)

- True Choice provides access to a select national network of participating pharmacies that you must use in order to get benefits for prescription drugs. Not all pharmacies are in the network. For example, **Walgreens is in your network** while **CVS and Wal-Mart are not**.

To find a network pharmacy:
UNITE HERE HEALTH
(855) 405-FUND (3863)

- If you are enrolled in the vision benefit option, Vision Service Plan (VSP) provides access to a national network of vision care providers. You can stay in the network by using any participating VSP Choice provider.

To find a network vision provider:
VSP
(800) 877-7195

- If you are enrolled in the dental benefit option, Cigna provides access to a national health maintenance organization (HMO) network of dental care providers. Your network is the Cigna Dental Care HMO network.

To find a network dental provider:
Cigna
(800) 244-6224

If you have questions about your benefits, or if you need help finding a network provider, call the Fund at **(855) 405-FUND (3863)**.

Prior authorization program

Learn when and why you should call Nevada Health Solutions:

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

B

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

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

To get prior authorization, call toll free:
Nevada Health Solutions
(855) 487-0353

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

Get prior authorization for medical and surgical treatment

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

Nevada Health Solutions
toll free: (855) 487-0353

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

When to call for prior authorization

You or your healthcare provider should contact Nevada Health Solutions before any of the following:

- Air ambulance transportation.
- Clinical trials.

B-2

B

- 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).
- Dialysis.
- 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
- Hyperbaric treatment.
- Inpatient admissions, including mental health/substance abuse inpatient and residential care, 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.
- Physical, speech, or occupational therapy.
- Sleep studies.
- TMJ procedures.
- Transplant services, including consultations.
- Travel and lodging.
- Varicose vein procedures.

You should contact Nevada Health Solutions before receiving any of the above types of services and supplies. If you need emergency care, you should contact Nevada Health Solutions as soon as possible after you get the service or supply. If you are hospitalized because you are having a baby,

B-3

B

you must call Nevada Health Solutions if your stay will be longer than 48 hours for normal childbirth, or 96 hours for a Cesarean section.

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

You do not need prior authorization in order to access obstetrical or gynecological care from a network healthcare provider who specializes in obstetrics or gynecology. The healthcare provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For help finding participating healthcare providers who specialize in obstetrics or gynecology, contact the Fund at **(855) 405-FUND (3863)**.

See [page F-2](#) for information about when Nevada Health Solutions must respond to your request for prior authorization and for information about how to appeal a prior authorization denial.

Case management program

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

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

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

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

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

B-4

B

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.

B-5

Gold medical benefits

Learn:

- What you pay for healthcare.
- How the network out-of-pocket limits protect you from large out-of-pocket expenses.
- What types of medical healthcare the plan covers.
- What types of medical healthcare are not covered.

Gold Plan Medical Benefits	
In general, what you pay for medical care is based on what kind of care you get, where you get your care, and whether you go to a network or a non-network provider. For example, you pay less using an urgent care center instead of going to the emergency room.	
Unless shown otherwise, this table shows what you pay for your care (called your “cost-sharing”). You pay any copays, your coinsurance share, any amounts over a maximum benefit, and any expenses that are not covered, including any charges that are more than the allowable charge.	
Annual Deductibles	None

Gold Plan Medical Plan Payments	BCBS PPO Network	Non-Network
Office Visits		
Preventive Healthcare (<i>See page G-7</i>)	\$0	Not covered
Primary Care Provider (PCP) Office Visits	\$20 copay/visit	50%
Doctor on Demand Telehealth Visits	\$15 copay/visit	n/a
ConsejoSano Medical Advice Calls	\$0 copay/visit	n/a
Specialist Office Visits	\$40 copay/visit	50%
Mental Health/Substance Abuse Office Visits	\$20 copay/visit	50%
Chiropractic Services — up to 12 total visits per person each year	\$20 copay/visit	Not covered
Emergency and Urgent Care		
Urgent Care Center	\$40 copay/visit	50%
Hospital Emergency Room		
Emergency Care Provided in an ER	\$150 copay/visit <i>waived if admitted</i>	\$150 copay/visit <i>waived if admitted</i>
Routine Care Provided in an ER	50%	Not covered
Professional Ground Ambulance Services	\$150 copay/trip <i>limited to 2 trips/year</i>	\$150 copay/trip <i>limited to 2 trips/year</i>
Professional Air Ambulance Services	\$150 copay/trip	\$150 copay/trip
Outpatient Services		
Laboratory Services		
Provider’s Office or Non-Hospital Facility	\$20 copay/visit	50%
Hospital Outpatient Department	\$80 copay/visit	50%
Radiology (X-ray, Ultrasound, Fetal Monitoring)		
Provider’s Office or Non-Hospital Facility	\$20 copay/visit	50%
Hospital Outpatient Department	\$80 copay/visit	50%
Diagnostic Imaging (CT, MRI, PET) and Cardiac Imaging Testing		
Provider’s Office or Non-Hospital Facility	\$150 copay/visit	50%
Hospital Outpatient Department	\$250 copay/visit	50%

Gold Plan Medical Plan Payments	BCBS PPO Network	Non-Network
Outpatient Surgery		
Ambulatory Surgical Center	\$150 copay/visit	50%
Hospital Outpatient Department	\$250 copay/visit	50%
Physical, Speech, Occupational Therapy — 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		
Provider’s Office or Non-Hospital Facility	\$20 copay/visit	50%
Hospital Outpatient Department	\$40 copay/visit	50%
Radiation Therapy	20%	50%
Dialysis		
Provider’s Office or Non-Hospital Dialysis Center	\$0	50%
Hospital Outpatient Department	20%, maximum of \$200/visit	50%
Chemotherapy or Infusion Medication		
Home	\$0	50%
Provider’s Office or Non-Hospital Infusion Center	\$20 copay/visit	50%
Hospital Outpatient Department	20%, maximum of \$200/visit	50%
Inpatient Treatment		
Inpatient Hospitalization, including for Mental Health/Substance Abuse Treatment	\$250 copay/day, up to \$750 per admission	50%
Skilled Nursing Facility — up to 30 total days per person each year	\$250 copay/day, up to \$750 per admission <i>less any copay for inpatient hospitalization</i>	50%
Other Services and Supplies		
Diabetes Education	\$0	Not covered
Nutrition Education — up to 4 total visits per person each year	\$0	Not covered
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment	\$40 copay/day, up to \$750 per episode of treatment	50%
Home Healthcare Services — up to 30 total visits per person each year	\$10 copay/visit	50%
Hospice Care	\$0	50%
Podiatric Orthotics — up to \$500 total per person every 24 months	\$0	Not covered
Durable Medical Equipment	25%	Not covered

Gold Plan Medical Plan Payments	BCBS PPO Network	Non-Network
Medical Foods for Inborn Metabolic Errors	The Plan will reimburse you 100%, up to \$2,500 per person each year	
Transportation and Lodging for Certain Serious Medical Conditions	The Plan pays 100% up to \$250 per day, and up to \$10,000 per episode of care	
All Other Types of Medical Care	20%	50%
Medical Out-of-Pocket Limits – The most you pay out-of-pocket for copays and coinsurance for certain covered medical expenses in a calendar year	\$5,000 per person/\$10,000 per family	

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. The internal appeal procedures do not include your right to an external review by an independent review organization (“IRO”) under the Affordable Care Act.

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

Network providers

The Plan pays benefits based on whether treatment is rendered by a network provider or a non-network provider. To find network providers, contact:

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

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

www.bcbsil.com

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

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

See page A-10 for more information about how staying in the network can help you save time and money.

Sample claim—outpatient surgery in an ambulatory surgical facility		
	Network Provider	Non-Network Provider
A. Total charge	\$10,000	\$20,000
B. Network discount	- \$5,000	n/a
C. Plan’s allowable charge (See page G-2)	\$5,000	\$5,000
What you pay		
D. Amount over allowable charge	\$0 (A minus B minus C)	\$15,000 (A minus C)
E. Deductible	\$0	\$0
F. Your copay share of the cost	\$150	\$2,500 (50% of C)
Your total payment	\$150 (D plus E plus F)	\$17,500 (D plus E plus F)

What you pay

You must pay your cost share (such as copays, and coinsurance for your share of covered ex-penses. You must also pay any expenses that are not considered covered expenses (see page G-3 for information about excluded expenses), including any amounts over the allowable charge, or charges once a maximum benefit or limitation has been met.

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

Copays

The copay covers all 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. You only pay one emer-gency room copay for all emergency care received during the emergency room visit.

If you have multiple types of care during one visit, you only have to pay the highest cost sharing amount. You do not have to pay a separate copay for each procedure. For example, if you get an x-ray, a CT scan, and lab services all at the same time at the same network non-hospital facility, you pay only the \$150 CT scan copay.

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

Out-of-Pocket limit for network services and supplies

Your out-of-pocket cost sharing for most network medical covered expenses is limited to \$5,000 per person (\$10,000 per family) each 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 year.

Only your out-of-pocket cost sharing for medical healthcare applies to your \$5,000 out-of-pocket limit (\$10,000 limit for your family). Amounts you pay out of pocket for prescription drugs, vision care, or dental care will not apply to the \$5,000 or \$10,000 out-of-pocket limits. The only exception is that amounts you pay out-of-pocket for pediatric vision exams will count towards your out-of-pocket limit. A separate out-of-pocket limit applies to prescription drug benefits (*see page C-31*).

See page G-7 for more information about what an out-of-pocket limit is.

Telehealth

Doctor on Demand
(800) 997-6196
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 \$15 copay for each telehealth visit with Doctor on Demand.

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

- **Internet:** visit 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.

You can then video chat with a Board-certified healthcare provider. A Doctor on Demand health-care 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 (for non-emergency medical advice in Spanish)
(855) 785-7885
www.consejosano.com

ConsejoSano provides access to non-emergency medical advice in Spanish 24/7. You can call or chat with a health advisor any time. This is a free service for you! *See page A-9* for more information.

Call for:

- Medical advice on common ailments: colds, allergies, pain, and more.
- Support for first time mothers: from nursing to answers about your baby's health.
- Emotional and mental support: stress, relationships, self-image and more.
- Diabetes and obesity: help you understand lab results and provide advice.
- Nutrition and weight loss: personalized diets and meal plans.

ConsejoSano le da acceso a consultas médicas que no son de emergencia las 24 horas al día, 7 días de la semana. Usted puede llamar o chatear con un asesor de salud en cualquier momento. ¡Este es un servicio gratis para usted! *Consulte la página A-9* para obtener más información.

Llame para:

- Consulta médica sobre enfermedades comunes: resfriados, alergias, dolor y más.
- El apoyo a madres primerizas: desde la lactancia hasta respuestas sobre la salud de su bebé.
- Apoyo emocional y mental: estrés, relaciones, imagen de sí mismo y más.
- Diabetes y obesidad: para ayudarle a entender los resultados de exámenes de laboratorio y proporcionarle consejos.
- Nutrición y pérdida de peso: dietas personalizadas y planes de alimentación.

Covered Benefits

What's covered

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

- **Preventive healthcare services** (*see page G-7*) when a network provider is used. The following limits apply to specific types of preventive care (other limits may apply to other types of preventive care based on your gender, age, and health status):
 - Cervical cancer screening (pap smears) 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.
 - Routine mammograms for women are covered every 1-2 years if you are age 40 through age 74. Routine mammograms for women under 40, or older than 75, may be covered if you are at high-risk for breast cancer.

C

- ▶ PSA tests for men are covered every year if you are between ages 40 and 69.
- **Professional medical and surgical services of a healthcare provider.** The following rules apply:
 - ▶ If more than one surgery or procedure is done through the same incision or natural body cavity during the same operation, covered expenses are limited to the allowable charge for the major surgery or procedure.
 - ▶ Covered expenses do not include incidental procedures performed through the same incision during one surgery.
- **Telehealth services** when provided by Doctor on Demand.
- **Non-routine surgical podiatric services.** If more than one surgery is done during the same operation, covered expenses are limited to the allowable charge for the major procedure.
 - ▶ Non-routine podiatric care, excluding x-rays. Podiatric orthotics provided by a network provider, limited to a total of \$500 per person every 24 months. Non-network podiatric orthotics are not covered.
 - ▶ Non-routine podiatric office visits are considered a specialist visit.
- Treatment of **mental health conditions and substance abuse**, including inpatient and residential care, outpatient care, partial hospitalization, intensive outpatient care, and ambulatory detoxification.
- **Chiropractic care** provided by a network provider, excluding x-rays, up to a total of 12 visits per person each year. Non-network chiropractic care is not covered.
- **Outpatient services** in a clinic or urgent care center.
- Transportation by a **professional ambulance service** to an area medical facility that is able to provide the required treatment. If you have no control over the ambulance getting 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 ([see page A-5](#)) if you had no control over an ambulance being called.
- **X-rays and laboratory work**, including x-rays and laboratory work for chiropractic and non-routine podiatric care.
- **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. However, professional services for surgical procedures that would normally be performed in a provider's office are not covered.
- Outpatient rehabilitation services for **physical and occupational therapy**, limited to a total of 60 combined visits per person each year for network and non-network treatment combined.

C

- Outpatient **speech therapy services**, limited to a total of 30 visits per person each year for network and non-network treatment combined.
 - ▶ For adults, only speech therapy to restore speech lost as the result of injury or sickness is covered.
 - ▶ For dependent children, speech therapy is only covered to:
 - Screen, detect, and treat pervasive developmental disorders, such as autism and Asperger's.
 - Restore or improve speech for speech-language and developmental delay disorders caused by a non-chronic sickness, intra-uterine trauma, hearing loss, difficulty swallowing or acute sickness or injury.
 - Treat a speech delay associated with a specific disease, injury, or congenital defect, such as cleft lip and palate.
- **Radiation therapy.**
- **Kidney dialysis services.**
- **Chemotherapy and infusion services.**
- For employees and spouses only, **pregnancy** and pregnancy-related conditions, including childbirth, miscarriage, or abortion. However, routine preventive healthcare for a dependent child's pregnancy will also be considered a covered expense. Non-preventive care for a dependent child's pregnancy, including but not limited to ultrasounds, charges associated with a high-risk pregnancy, abortions, and maternity and delivery charges will not be covered.
- **Hospital charges** for room and board, and other inpatient or outpatient services.
 - ▶ Professional services provided during your inpatient stay, including professional consultations, will generally be paid at 100% of allowable charges (you pay only amounts over the allowable charge).
- **Mastectomies**, including reconstruction of the breast upon which the mastectomy is performed, surgical treatment of 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.

- ▶ The Fund or its representative must get prior authorization for the transplant.
- ▶ Donor expenses for your transplant are only covered if the donor has no other coverage.
- ▶ Transplant coverage does not include your expenses if you are giving an organ instead of getting an organ.
- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- **Skilled nursing facility care**, limited to a total of 30 days per person each year for network and non-network care combined. All of the following rules must be met:
 - ▶ The person must be under the care of a healthcare provider during the confinement.
 - ▶ The person must be confined as a regular bed patient.
- Network professional services for **diabetes education** and training for the care, monitoring, or treatment of diabetes. Non-network expenses are not covered.
- Network professional services for **nutrition counseling**, limited to a total of 4 visits per person each year. Non-network expenses are not covered.
- **Home healthcare services**, limited to a total of 30 visits per person each year for network and non-network services combined. General housekeeping services or custodial care is not covered.
- **Hospice** services and supplies for a person who is terminally ill. The services must be authorized by a healthcare provider.
- **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, including supplies for the DME. Non-network DME is not covered.
 - ▶ Rental fees are covered if the DME can only be rented, and the purchase price is covered if the DME can only be bought.
 - ▶ However, if DME can be either rented or bought, and if the rental fees for the course of treatment are likely to be more than the equipment’s purchase price, benefits may be limited to the equipment’s purchase price.
 - ▶ If DME is bought, costs for repair or maintenance are also covered.
- **Medical 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, up to a total of \$2,500 per person each year. 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 will also be covered. (Two other people will be covered if the patient is a child.)
 - ▶ Reimbursement is limited to \$10,000 per episode of care for you and your traveling companion(s) combined. Up to \$250 each day will be reimbursed 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.
 - **Anesthesia** and its administration.
 - **Blood and blood plasma** and their administration.
 - **Oxygen** and rental equipment for its administration.
 - **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 Plan and within six months of the injury. You may have additional dental coverage under your dental benefits, if applicable—see the dental benefits sections.
 - **Sterilization procedures** for employees and spouses, and female dependent children.
 - **Services of a surgical nurse** (a nurse who works under a surgeon to provide specialized nursing services before, during, and after surgery).
 - **Surgical supplies and dressings**, including casts, splints, prostheses, braces, canes, crutches, and trusses.
 - Treatment of **tumors, cysts and lesions** not considered a dental procedure.

What’s not covered

See page C-62 for a list of the Plan’s general exclusions and limitations. In addition to that list, the Plan will not pay benefits for, or in connection with, the following treatments, services, and supplies:

C

- Ambulatory surgical facility fees for procedures normally performed in a provider's office.
- Prescription drugs and medications, other than those used where they are dispensed. Prescription drugs may be covered under the prescription drug benefit shown *on page C-30*.
- Any elective procedure, except sterilization or abortion, that is not to treat a bodily injury or sickness. The Trustees have the sole right and discretion to decide if a procedure is elective.
- Acupuncture.
- Routine foot care (routine podiatry).
- Any services or supplies for or in connection with the treatment of teeth, natural or otherwise, and supporting structures. However, charges made by a hospital or other facility for dental procedures covered under the dental benefit provisions, if applicable (see the dental benefits sections), will be covered if the procedure requires the patient to be treated in an institutional setting to safely receive the care. For example, if you suffer from a medical or behavioral condition, such as autism or Alzheimer's, that severely limits your ability to cooperate with the dentist providing the care, charges made by a hospital or other facility will be considered a covered expense. Benefits for other types of dental care may be covered under the dental benefit as described in the dental section, if applicable.
- Treatment of temporomandibular joint (TMJ) disorders, craniofacial disorders or orthognathic disorders, unless UNITE HERE HEALTH or its representative provides written prior approval.
- Surgery to modify jaw relationships including, but not limited to, osteoplasty and genioplasty procedures. However, Le Fort-type operations are covered when primarily to repair birth defects of the mouth, conditions of the mid-face (over or under development of facial features), or damage caused by accidental injury.
- Hospital charges for personal comfort items, including but not limited to telephones, televisions, cosmetics, guest trays, magazines, and bed or cots for family members or other guests.
- Private duty nursing care.
- Routine care that could be provided in an office or urgent care center if that care is provided in the emergency room of a non-network hospital.
- 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, if applicable.
- Any dental treatment of teeth or their supporting structures, other than those services covered under the dental benefit, unless otherwise specifically listed as a covered expense.
- Eye refractions, eyeglasses, or contact lenses. However, these expenses may be covered under the vision benefits, if applicable.

C-12

C

- Services or supplies provided by a non-network provider if benefits are only payable for such services or supplies when a network provider is used.

C-13

Silver medical benefits

Learn:

- What you pay for healthcare.
- How the network out-of-pocket limits protect you from large out-of-pocket expenses.
- About Doctor on Demand and Consejo Sano.
- What types of medical healthcare the plan covers.
- What types of medical healthcare are not covered.

Silver Plan Medical Benefits	
In general, what you pay for medical care is based on what kind of care you get, where you get your care, and whether you go to a network or a non-network provider. For example, you pay less using an urgent care center instead of going to the emergency room.	
Unless shown otherwise, this section shows what you pay for your care (called your “cost-sharing”). You pay any copays, deductibles, your coinsurance share, any amounts over a maximum benefit, and any expenses that are not covered, including any charges that are more than the allowable charge.	
Annual Deductibles — <i>applies to both network and non-network services combined.</i>	\$1,500/person & \$3,000/family

Silver Plan Medical Plan Payments	BCBS PPO Network	Non-Network
Office Visits		
Preventive Healthcare – <i>See page G-7</i>	\$0	Not covered
Primary Care Provider (PCP) Office Visits	\$25 copay/visit	50% (after deductible)
Doctor on Demand Telehealth Visits	\$15 copay/visit	n/a
ConsejoSano Medical Advice Calls	\$0 copay/visit	n/a
Specialist Office Visits	\$50 copay/visit	50% (after deductible)
Mental Health/Substance Abuse Office Visits	\$25 copay/visit	50% (after deductible)
Chiropractic Services — up to 12 total visits per person each year	\$25 copay/visit	Not covered
Emergency and Urgent Care		
Urgent Care Facility	\$50 copay/visit	50% (after deductible)
Hospital Emergency Room		
Emergency Care Provided in an ER	\$200 copay/visit <i>waived if admitted</i>	\$200 copay/visit <i>waived if admitted</i>
Routine Care Provided in an ER	50% (after deductible)	Not covered
Professional Ground Ambulance Services	30% (after deductible) <i>limited to 2 trips/year</i>	30% (after deductible) <i>limited to 2 trips/year</i>
Professional Air Ambulance Services	20% (after deductible)	20% (after deductible)
Outpatient Services		
Laboratory Services		
Provider’s Office or Non-Hospital Facility	\$25 copay/visit	50% (after deductible)
Hospital Outpatient Department	\$100 copay/visit	50% (after deductible)
Radiology (X-ray, Ultrasound, Fetal Monitoring)		
Provider’s Office or Non-Hospital Facility	\$25 copay/visit	50% (after deductible)
Hospital Outpatient Department	\$100 copay/visit	50% (after deductible)

Silver Plan Medical Plan Payments	BCBS PPO Network	Non-Network
Diagnostic Imaging (CT, MRI, PET) and Cardiac Imaging Testing		
Provider’s Office or Non-Hospital Facility	\$175 copay/visit	50% (after deductible)
Hospital Outpatient Department	\$300 copay/visit	50% (after deductible)
Outpatient Surgery		
Ambulatory Surgical Center	20% after deductible	50% (after deductible)
Hospital Outpatient Department	30% after deductible	50% (after deductible)
Physical, Speech, Occupational Therapy — 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		
Provider’s Office or Non-Hospital Facility	\$30 copay/visit	50% (after deductible)
Hospital Outpatient Department	\$60 copay/visit	50% (after deductible)
Radiation Therapy	30% (after deductible)	50% (after deductible)
Dialysis		
Provider’s Office or Non-Hospital Dialysis Center	\$0	50% (after deductible)
Hospital Outpatient Department	30% (no deductible), maximum of \$250/visit	50% (after deductible)
Chemotherapy or Infusion Medication		
Home	\$0	50% (after deductible)
Provider’s Office or Non-Hospital Infusion Center	\$25 copay/visit	50% (after deductible)
Hospital Outpatient Department	30% (no deductible), maximum of \$250/visit	50% (after deductible)
Inpatient Treatment		
Inpatient Hospitalization, including for Mental Health/Substance Abuse Treatment	30% (after deductible)	50% (after deductible)
Skilled Nursing Facility — up to 30 total days per person each year	30% (after deductible)	50% (after deductible)
Other Services and Supplies		
Diabetes Education	\$0	Not covered
Nutrition Education — up to 4 total visits per person each year	\$0	Not covered
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment	\$0	50% (after deductible)
Home Healthcare Services — up to 30 total visits per person each year	\$15 copay/visit	50% (after deductible)
Hospice Care	\$0	50% (after deductible)
Podiatric Orthotics — up to \$500 total per person every 24 months	\$0	Not covered

Silver Plan Medical Plan Payments	BCBS PPO Network	Non-Network
Durable Medical Equipment	25% (after deductible)	Not covered
Medical Foods for Inborn Metabolic Errors	The Plan will reimburse you 100%, up to \$2,500 per person each year (no deductible applies)	
Transportation and Lodging for Certain Serious Medical Conditions	The Plan pays 100% up to \$250 per day, and up to \$10,000 per episode of care (no deductible applies)	
All Other Types of Medical Care	30% (after deductible)	50% (after deductible)
Medical Out-of-Pocket Limits – The most you pay out-of-pocket for copays, coinsurance, and deductibles for certain covered medical expenses in a calendar year	\$5,000 per person/\$10,000 per family	

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. The internal appeal procedures do not include your right to an external review by an independent review organization (“IRO”) under the Affordable Care Act.

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

Network providers

The Plan pays benefits based on whether treatment is rendered by a network provider or a non-network provider. To find network providers, contact:

Blue Cross and Blue Shield of Illinois (BCBSIL)—PPO Network
toll free: (800) 810-BLUE (2583)

www.bcbsil.com

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

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

See page A-10 for more information about how staying in the network can help you save time and money.

Sample claim—outpatient surgery in an ambulatory surgical facility		
	Network Provider	Non-Network Provider
A. Total charge	\$10,000	\$20,000
B. Network discount	- \$5,000	n/a
C. Plan’s allowable charge (See page G-2)	\$5,000	\$5,000
What you pay		
D. Amount over allowable charge	\$0 (A minus B minus C)	\$15,000 (A minus C)
E. Deductible	\$1,500	\$1,500
F. Your coinsurance share of the cost	\$700 (20% of C minus E)	\$1,750 (50% of C minus E)
Your total payment	\$2,200 (D plus E plus F)	\$18,250 (D plus E plus F)

What you pay

You must pay your cost share (such as copays, and coinsurance for your share of covered ex-penses. You must also pay any expenses that are not considered covered expenses (see page G-3 for information about excluded expenses), including any amounts over the allowable charge, or charges once a maximum benefit or limitation has been met.

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

Copays

The copay covers all 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. You only pay one emergency room copay for all emergency care received during the emergency room visit.

If you have multiple types of care during one visit, you only have to pay the highest cost sharing amount. You do not have to pay a separate copay for each procedure. For example, if you get an x-ray, a CT scan, and lab services all at the same time at the same network non-hospital facility, you pay only the \$150 CT scan copay.

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

Deductibles

Your 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 same rule applies if two or more members of your family satisfy the \$3,000 family deductible. Once your family deductible has been satisfied, no one else in your family has to pay deductibles for the rest of that year.

Your \$1,500 individual and \$3,000 family deductibles only apply to the medical benefits. Amounts you pay for prescription drugs, vision care, or dental care will not apply to the \$1,500 and \$3,000 deductibles. A separate deductible applies to dental benefits (see the dental benefits sections).

Any allowable charges that apply to your (or your family’s) deductible during October, November, or December of a year will apply to your (or your family’s) deductible during the next calendar year. For example, if you pay \$500 toward your deductible in November, your deductible for the next year will be \$1,000 (\$1,500 minus the \$500 you paid in November).

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

Out-of-Pocket limit for network services and supplies

Your out-of-pocket cost sharing for most network medical covered expenses is limited to \$5,000 per person (\$10,000 per family) each 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 year.

Only your out-of-pocket cost sharing for medical healthcare applies to your \$5,000 out-of-pocket limit (\$10,000 limit for your family). Amounts you pay out of pocket for prescription drugs, vision care, or dental care will not apply to the \$5,000 or \$10,000 out-of-pocket limits. The only exception is that amounts you pay out-of-pocket for pediatric vision exams will count towards your out-of-pocket limit. A separate out-of-pocket limit applies to prescription drug benefits (see page C-31).

See page G-7 for more information about what an out-of-pocket limit is.

Telehealth

Doctor on Demand

(800) 997-6196
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 \$15 copay for each telehealth visit with Doctor on Demand.

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

- **Internet:** visit 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.

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 (for non-emergency medical advice in Spanish)

(855) 785-7885
www.consejosano.com

ConsejoSano provides access to non-emergency medical advice in Spanish 24/7. You can call or chat with a health advisor any time. This is a free service for you! See page A-9 for more information.

Call for:

- Medical advice on common ailments: colds, allergies, pain, and more.
- Support for first time mothers: from nursing to answers about your baby’s health.
- Emotional and mental support: stress, relationships, self-image and more.
- Diabetes and obesity: help you understand lab results and provide advice.
- Nutrition and weight loss: personalized diets and meal plans.

ConsejoSano le da acceso a consultas médicas que no son de emergencia las 24 horas al día, 7 días de la semana. Usted puede llamar o chatear con un asesor de salud en cualquier momento. ¡Este es un servicio gratis para usted! Consulte la página A-9 para obtener más información.

Llame para:

- Consulta médica sobre enfermedades comunes: resfriados, alergias, dolor y más.
- El apoyo a madres primerizas: desde la lactancia hasta respuestas sobre la salud de su bebé.

- Apoyo emocional y mental: estrés, relaciones, imagen de sí mismo y más.
- Diabetes y obesidad: para ayudarle a entender los resultados de exámenes de laboratorio y proporcionarle consejos.
- Nutrición y pérdida de peso: dietas personalizadas y planes de alimentación.

Covered Benefits

What’s covered

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

- **Preventive healthcare services** (*see page G-7*) when a network provider is used. The following limits apply to specific types of preventive care (other limits may apply to other types of preventive care based on your gender, age, and health status):
 - Cervical cancer screening (pap smears) 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.
 - Routine mammograms for women are covered every 1-2 years if you are age 40 through age 74. Routine mammograms for women under 40, or older than 75, may be covered if you are at high-risk for breast cancer.
 - PSA tests for men are covered every year if you are between ages 40 and 69.
- **Professional medical and surgical services of a healthcare provider.** The following rules apply:
 - If more than one surgery or procedure is done through the same incision or natural body cavity during the same operation, covered expenses are limited to the allowable charge for the major surgery or procedure.
 - Covered expenses do not include incidental procedures performed through the same incision during one surgery.
- **Telehealth services** when provided by Doctor on Demand.
- **Non-routine surgical podiatric services.** If more than one surgery is done during the same operation, covered expenses are limited to the allowable charge for the major procedure.
 - Non-routine podiatric care, excluding x-rays. Podiatric orthotics provided by a network provider, limited to a total of \$500 per person every 24 months. Non-network podiatric orthotics are not covered.

- Non-routine podiatric office visits are considered a specialist visit.
- Treatment of **mental health conditions and substance abuse**, including inpatient and residential care, outpatient care, partial hospitalization, intensive outpatient care, and ambulatory detoxification.
- **Chiropractic care** provided by a network provider, excluding x-rays, up to a total of 12 visits per person each year. Non-network chiropractic care is not covered.
- **Outpatient services** in a clinic or urgent care center.
- Transportation by a **professional ambulance service** to an area medical facility that is able to provide the required treatment. If you have no control over the ambulance getting 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 (*see page A-5*) if you had no control over an ambulance being called.
- **X-rays and laboratory** work, including x-rays and laboratory work for chiropractic and non-routine podiatric care.
- **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. However, professional services for surgical procedures that would normally be performed in a provider’s office are not covered.
- Outpatient rehabilitation services for **physical and occupational therapy**, limited to a total of 60 combined visits per person each year for network and non-network treatment combined.
- Outpatient **speech therapy services**, limited to a total of 30 visits per person each year for network and non-network treatment combined.
 - For adults, only speech therapy to restore speech lost as the result of injury or sickness is covered.
 - For dependent children, speech therapy is only covered to:
 - Screen, detect, and treat pervasive developmental disorders, such as autism and Asperger’s.
 - Restore or improve speech for speech-language and developmental delay disorders caused by a non-chronic sickness, intra-uterine trauma, hearing loss, difficulty swallowing or acute sickness or injury.
 - Treat a speech delay associated with a specific disease, injury, or congenital defect, such as cleft lip and palate.
- **Radiation therapy.**

- **Kidney dialysis** services.
- **Chemotherapy and infusion** services.
- For employees and spouses only, **pregnancy** and pregnancy-related conditions, including childbirth, miscarriage, or abortion. However, routine preventive healthcare for a dependent child's pregnancy will also be considered a covered expense. Non-preventive care for a dependent child's pregnancy, including but not limited to ultrasounds, charges associated with a high-risk pregnancy, abortions, and maternity and delivery charges will not be covered.
- **Hospital charges** for room and board, and other inpatient or outpatient services.
 - Professional services provided during your inpatient stay, including professional consultations, will generally be paid at 100% of allowable charges (you pay only amounts over the allowable charge).
- **Mastectomies**, including reconstruction of the breast upon which the mastectomy is performed, surgical treatment of 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.
 - The Fund or its representative must get prior authorization for the transplant.
 - Donor expenses for your transplant are only covered if the donor has no other coverage.
 - Transplant coverage does not include your expenses if you are giving an organ instead of getting an organ.
- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- **Skilled nursing facility care**, limited to a total of 30 days per person each year for network and non-network care combined. All of the following rules must be met:
 - The person must be under the care of a healthcare provider during the confinement.
 - The person must be confined as a regular bed patient.
- Network professional services for **diabetes education** and training for the care, monitoring, or treatment of diabetes. Non-network expenses are not covered.

- Network professional services for **nutrition counseling**, limited to a total of 4 visits per person each year. Non-network expenses are not covered.
- **Home healthcare services**, limited to a total of 30 visits per person each year for network and non-network services combined. General housekeeping services or custodial care is not covered.
- **Hospice** services and supplies for a person who is terminally ill. The services must be authorized by a healthcare provider.
- **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, including supplies for the DME. Non-network DME is not covered.
 - Rental fees are covered if the DME can only be rented, and the purchase price is covered if the DME can only be bought.
 - However, if DME can be either rented or bought, and if the rental fees for the course of treatment are likely to be more than the equipment's purchase price, benefits may be limited to the equipment's purchase price.
 - If DME is bought, costs for repair or maintenance are also covered.
- **Medical 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, up to a total of \$2,500 per person each year. 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 will also be covered. (Two other people will be covered if the patient is a child.)
 - Reimbursement is limited to \$10,000 per episode of care for you and your traveling companion(s) combined. Up to \$250 each day will be reimbursed 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.
- **Anesthesia** and its administration.
- **Blood and blood plasma** and their administration.
- **Oxygen** and rental equipment for its administration.
- **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 Plan and within six months of the injury. You may have additional dental coverage under your dental benefits, if applicable—see the dental benefits sections.
- **Sterilization procedures** for employees and spouses, and female dependent children.
- **Services of a surgical nurse** (a nurse who works under a surgeon to provide specialized nursing services before, during, and after surgery).
- **Surgical supplies and dressings**, including casts, splints, prostheses, braces, canes, crutches, and trusses.
- Treatment of **tumors, cysts and lesions** not considered a dental procedure.

What’s not covered

See [page C-62](#) for a list of the Plan’s general exclusions and limitations. In addition to that list, the Plan will not pay benefits for, or in connection with, the following treatments, services, and supplies:

- Ambulatory surgical facility fees for procedures normally performed in a provider’s office.
- Prescription drugs and medications, other than those used where they are dispensed. Prescription drugs may be covered under the prescription drug benefit shown [on page C-30](#).
- Any elective procedure, except sterilization or abortion, that is not to treat a bodily injury or sickness. The Trustees have the sole right and discretion to decide if a procedure is elective.
- Acupuncture.
- Routine foot care (routine podiatry).
- Any services or supplies for or in connection with the treatment of teeth, natural or otherwise, and supporting structures. However, charges made by a hospital or other facility for dental procedures covered under the dental benefit provisions, if applicable (see the dental benefits sections), will be covered if the procedure requires the patient to be treated in an institutional setting to safely receive the care. For example, if you suffer from a medical or behavioral condition, such as autism or Alzheimer’s, that severely limits your ability to cooperate with the dentist providing the care, charges made by a hospital or other

- facility will be considered a covered expense. Benefits for other types of dental care may be covered under the dental benefit as described in the dental section, if applicable.
- Treatment of temporomandibular joint (TMJ) disorders, craniofacial disorders or orthognathic disorders, unless UNITE HERE HEALTH or its representative provides written prior approval.
 - Surgery to modify jaw relationships including, but not limited to, osteoplasty and genioplasty procedures. However, Le Fort-type operations are covered when primarily to repair birth defects of the mouth, conditions of the mid-face (over or under development of facial features), or damage caused by accidental injury.
 - Hospital charges for personal comfort items, including but not limited to telephones, televisions, cosmetics, guest trays, magazines, and bed or cots for family members or other guests.
 - Private duty nursing care.
 - Routine care that could be provided in an office or urgent care center if that care is provided in the emergency room of a non-network hospital.
 - 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, if applicable.
 - Any dental treatment of teeth or their supporting structures, other than those services covered under the dental benefit, unless otherwise specifically listed as a covered expense.
 - Eye refractions, eyeglasses, or contact lenses. However, these expenses may be covered under the vision benefits, if applicable.
 - Services or supplies provided by a non-network provider if benefits are only payable for such services or supplies when a network provider is used.

Prescription drug benefits

Learn:

- What you pay for your covered prescription drugs.
- How the out-of-pocket limit protects you from high-cost prescription drugs.
- How you can save money by using generic prescription drugs.
- What types of prescription drugs the Plan covers.
- How the safety and cost containment programs help save you money and help protect your health.
- The limits on the quantity 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.

The Plan has contracted with HospitalityRx to administer your prescription drug benefits.

The Plan will only pay benefits if you buy your prescription drugs at a pharmacy that participates in the True Choice network. **Not all retail pharmacies are in your pharmacy network. Retail pharmacies like Walgreens are in your network.**

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

What you pay

You must pay the applicable copay shown below for each fill of a prescription drug. You must also pay any expenses that are not considered covered expenses (see page C-35) for information about excluded expenses), including any amounts over the allowable charge.

Gold Plan and Silver Plan Prescription Drug Benefits	Your Copay for Each Fill or Refill
Preventive prescriptions or supplies (see page G-7), including immunizations	\$0
Generic prescription drugs	\$10
Preferred brand name prescription drugs on the formulary, including insulin and formulary diabetic supplies (such as OneTouch or TrueTest)	\$30
Specialty and biosimilar prescription drugs	25% of the cost, maximum of \$50

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. The internal appeal procedures do not include your right 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.

Brand name drugs and supplies on the formulary are safe, effective, high-quality drugs and supplies that do not have generic equivalents. No benefits are paid for brand name drugs not on the formulary unless the Fund approves the drug. Ask your healthcare provider to prescribe a drug that is on the formulary. Prescription drugs and supplies may be added to or removed from the

formulary from time to time. Contact the Fund at (855) 405-FUND (3863) if you or your health-care provider have questions about which prescription drugs and supplies are on the formulary.

If your healthcare provider wants you to take a brand name drug that is not on the formulary, he or she should call the Fund (877) 266-9991 to get prior authorization. If the Fund makes an exception and allows the non-preferred brand name drug, you will have to pay the \$30 copay for preferred brand name drugs.

You must use the specialty pharmacy to get specialty and biosimilar prescription drugs. See page C-35 for more information about the specialty pharmacy.

Prescription drug out-of-pocket limit

Your copays for prescription drugs purchased through the prescription drug benefit are limited to \$1,600 per person each year (\$3,200 per family). Once your prescription drug copays total \$1,600 (\$3,200 for your family’s prescription drugs copays), the Plan will pay 100% for your (or your family’s) covered prescription drugs and supplies during the rest of that year.

Amounts you pay for prescription drugs or supplies that are not covered do not count toward your out-of-pocket limit. Only your copays for prescription drugs or supplies apply to your \$1,600 out-of-pocket limit (\$3,200 limit for your family). Out-of-pocket payments you pay for medical healthcare, vision, or dental care will not apply to the \$1,600 or \$3,200 out-of-pocket limits for prescription drugs. A separate out-of-pocket limit applies to medical healthcare (see page C-5).

Generic prescription drug policy

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

The generic prescription drug policy does not apply to certain prescription drugs that need to be closely monitored, or if very small changes in the dose could be extremely harmful. The policy will also not apply if the prior authorization program makes an exception. 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 the Fund. Your healthcare provider will need to get prior approval in order to ask for an exception.

If you have an exception to the generic prescription drug policy, you will still have to pay the \$30 copay for preferred brand name drugs.

What’s covered

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

- FDA-approved prescription drugs which can legally be purchased only with a written prescription from a healthcare provider. This includes oral and injectable contraceptives, vitamins, and drugs mixed to order by a pharmacist, if it contains at least one medicinal substance and one prescription drug.
- Insulin and diabetic test strips.
- Disposable syringes and needles, and lancets.
- Thyrogen (a prescription drug used to help identify the existence of thyroid cancer).
- Prescription drugs and supplies that are preventive healthcare (see page G-7).
- Non-prescription (over-the-counter) preventive healthcare services and supplies, including immunizations (see page G-7).

Free glucometers

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

(800) 227-8862 for OneTouch (LifeScan) products

(866) 788-9618 for TrueTest (Nipro) products

You can only get a free glucometer through the Fund. If you don’t want one of the Fund’s free glucometers, you have to pay the full cost of the glucometer and then submit a claim to the Fund. The claim will be paid based on the rules for durable medical equipment under the medical benefits.

Safety and cost containment programs for prescription drugs

The Fund provides extra protection through several safety and cost containment programs. These programs may change from time to time, and the prescription drugs or types of prescription drugs that are part of these programs may also change from time to time. You and your healthcare provider can always get the most current information by contacting the Fund at (855) 405-FUND (3863) or visiting www.uhh.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 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 will 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 F-6 for information about appealing a request for prior authorization and for appealing a denial of prescription drug benefits.

Prior authorization

Call HospitalityRx at (877) 266-9991 for prior authorization.

If you have a prescription for certain drugs, your healthcare provider must be asked for your medical records to find out if 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 (877) 266-9991 for a list of drugs on the prior authorization list.

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

Step therapy

In many cases, effective lower-cost alternatives are available for certain prescription drugs. A step therapy program will ask you to try over-the-counter, generic, or preferred formulary versions of prescription drugs first. If the first level of prescription drugs does not work for you, or causes serious side effects, you are “stepped up” to another level of prescription drugs.

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

The list of prescription drugs that require step therapy changes from time to time. Contact the Fund (see page A-5) 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 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. If you are taking certain prescription drugs, including high-cost prescription drugs or prescription drugs for conditions that will not respond well to treatment if you don’t take the prescription drugs as prescribed, you may be required to use the case management program. If you don’t use the case management program when it’s required, the Fund may stop paying benefits for 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 amount prescribed by your healthcare provider. However, a prescription filled at a retail pharmacy will not be filled for more than a 34-day supply at one time (you can get refills up to the total amount your doctor prescribes). However:

- Birth control drugs that are only available in 90-day quantities (such as Seasonale®) or that use a steady hormone release over time (such as NuvaRing®) will be filled based on one application or one unit, whichever applies.
- If you use the mail order pharmacy, you can get up to a 60-day supply at a time.

You generally cannot refill a prescription until you have used at least 75% of the supply. You may be able to refill a prescription sooner. For example, if you plan to be out of the country when you would run out of a prescription drug, the Plan may approve an early refill. However, if your eligibility will terminate, you will only be able to get enough days’ supply to match the number of days of eligibility you have left. For example, if your eligibility terminates in 15 days, you can only get a 15-day supply of the prescription drug, even if UNITE HERE HEALTH allows for an early refill.

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 usually allowed.

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 WellDyneRx mail order pharmacy. If you need a prescription drug to treat a chronic, long-term condition, you can order these prescription drugs through the mail order pharmacy. You can get up to a 60-day supply of your prescription drug (sometimes called a “maintenance” prescription drug) for the same copay you would pay for a 34-day supply at a retail pharmacy.

You can order from the mail order pharmacy by mail, by phone, or on the internet.

WellDyneRx
P.O. Box 90369
Lakeland, FL 33804
(844) 813-3860
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 use the specialty pharmacy for these drugs, but you can get these drugs from any network pharmacy.)

The specialty pharmacy provides prescription drugs for certain chronic or difficult 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 specialty prescription gets refilled on time, and can answer your questions about your prescription drugs and your condition.

Walgreens Specialty Pharmacy
(877) 647-5807

What’s not covered

See page C-62 for a list of the Plan’s general exclusions and limitations. In addition to that list, the following types of treatments, services, and supplies are not covered under the prescription drug benefit:

- Prescription drugs that have not been approved by the FDA. However, you or your healthcare provider may ask for an exception through the Fund’s prior authorization program.
- Any drugs to treat Hepatitis C, other than interferon, ribavirin, Harvoni, or Solvadi.
- Specialty prescription drugs, other than those used to treat HIV/AIDS, if you do not use the specialty pharmacy.
- Experimental or investigational drugs.
- Fertility drugs.
- Prescriptions or refills in amounts over the quantity limits (see page C-34).
- Non-sedating antihistamines.
- Prescription drugs that have an over-the-counter equivalent or are otherwise available over-the-counter (unless the drugs or supplies are preventive healthcare—see page G-7). However, prescription drugs that have a higher dosage than their over-the-counter equivalents will be covered.
- Any prescription drugs that are considered a lifestyle prescription drug. Lifestyle prescription drugs are not primarily intended to prevent, treat, or cure a disease or manage

pain. Examples of lifestyle drugs include but are not limited to prescription drugs used to treat erectile dysfunction, acne, or wrinkles. The Fund or its representative determines whether a prescription drug is considered a lifestyle prescription drug.

- Any prescription drugs that are not self-administered, meaning a prescription drug that you cannot give to yourself. However, this type of prescription drug may be covered under the medical benefits.
- New-to-market prescription drugs until the Fund or its representative has reviewed and approved the drugs.
- High-cost “me too” prescription drugs, unless the Fund or its representative approves the prescription drugs for purchase. “Me-too” drugs usually have only very small differences in how they work, but are considered “new” prescription drugs with no generic equivalent. Often, the manufacturer charges high prices for these prescription drugs even though there are other prescription drugs available that work just as well for a lower cost. You can find out if a “me too” prescription drug is covered by contacting the Fund ([see page A-5](#)).
- Glucometers, other than those available to you at no charge through the Fund. You may be able to get a glucometer through the medical benefits if you do not want one of the free ones, but you will usually have cost sharing. ([See page C-10](#) for information about durable medical equipment under the medical benefit.)
- Rogaine and other drugs to prevent hair loss.
- Drugs used, consumed or administered at the place where it is dispensed, other than immunizations. (These drugs may be covered under your medical benefits.)
- Drugs for which you are required to use the case management program if you do not participate in the program. The Fund or its designated representative has the sole authority to determine whether or not an individual is participating in the case management program.
- Diagnostics or biologicals, other than thyrogen.
- Drugs used for cosmetic reasons.
- Human growth hormone, except to treat emaciation due to AIDS.
- Drugs not purchased from a network pharmacy.

Dental benefits

Learn:

- What you pay for your covered dental care.
- What the maximum benefits are.
- What types of dental care the Plan covers.
- How to find out what your dental care will cost you before you get treatment.
- What types of dental care are not covered.

This section applies only if you have elected dental benefits. If you are not sure if you have elected dental benefits, please call UNITE HERE HEALTH to find out.

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
(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	\$0 copay
Regular Periodic Cleaning (adult or child prophylaxis) — up to 2 total per person each year	\$0 copay
Topical Application of Fluoride — up to 2 total per person each year	\$0 copay
Sealants	\$17 copay/tooth
Periodontal Scaling and Root Planing— up to 4 quadrants total per person every 12 months	\$60 - \$110 copay per quadrant
Periodontal Maintenance— up to 4 total per person each year	\$77 copay
Amalgam Fillings	\$6 - \$18 copay, depending on number of surfaces
Onlays (metallic)	\$370 - \$440 copay, depending on type of onlay
Crowns — one replacement per person every 5 years	\$370 - \$460 copay, depending on type of crown
Gingectomy or Gingivoplasty (other than for restorative procedure)	\$105 - \$240 copay, depending on teeth per quadrant

Dental Benefits—Dental Health Maintenance Organization	
Pulp Cap	\$14 copay
Root Canal	\$275 - \$440 copay, depending on type of root canal
Full Denture (Upper or Lower) — one set per person every 5 years	\$535 copay each
Denture Reline or Rebase — one reline or rebase per person every 36 months	\$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	

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. The internal appeal procedures do not include your right 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.

Using your benefits

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-40) 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.

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 (*see page F-9*). 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, 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.

- **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’ compensation, occupational disease or similar law.
- Services provided or paid by or through a Federal or state governmental agency or

authority, political subdivision or a public program, other than Medicaid.

- 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.

Vision benefits

Learn:

- What you pay for your covered vision care.
- Why network providers can save you time and money.
- What types of vision care are covered.
- What types of vision care are not covered.

This section applies only if you have elected vision benefits. If you are not sure if you have elected vision benefits, please call UNITE HERE HEALTH to find out.

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 Care Benefits		
Benefits payable every 12 months	VSP Provider	Non-Network Provider
Exam	\$10 copay	\$0 copay <i>The Plan only pays up to \$45</i>
Frames	\$25 copay <i>The Plan only pays up to \$160 allowance for frames; you get an extra \$20 off certain name brands, and a 20% discount on other frames over the allowance</i>	\$0 copay <i>The Plan only pays up to \$70</i>
Lenses		\$0 copay <i>The Plan only pays up to \$30 single vision, \$50 for lined bifocal, \$65 for lined trifocal, and \$100 for lenticular lenses</i>
Elective Contacts (instead of glasses)	100% for exam <i>Your cost for the exam is limited to \$60</i> \$0 for contacts <i>The Plan only pays up to \$160 for contacts</i>	\$0 copay <i>The Plan only pays up to \$120</i>

Benefits will be paid once per person every 12 months. This means that you can get one eye exam and one set of eye wear (glasses or contacts) each year.

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. The internal appeal procedures do not include your right to an external review by an independent review organization (“IRO”) under the Affordable Care Act.

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

Network and non-network vision providers

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

To locate a network provider near you, contact:

VSP
toll free: (800) 877-7195
www.vsp.com

See page A-10 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 ex-penses 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, polycarbonate lenses for adults, and photochromic lenses. Standard scratch resistant coatings and polycarbonate lenses for children 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 pro-vider. Your cost or discount depends on which option 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, bifocal lenses, trifocal lenses, or lenticular lenses.
- Frames.
- Contact lenses.

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.
- 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 benefits

Learn:

- What your short-term disability benefits are.
- What happens if you have more than one disability, or if your disability recurs.
- What types of accidents or sicknesses are ineligible for short-term benefits.

*This section applies only if you have elected short-term disability benefits.
If you are not sure if you have elected short-term disability benefits,
please call UNITE HERE HEALTH to find out.*

Short-term disability benefits are for employees only. Dependents are not eligible for short-term disability benefits.

What the Plan Pays	
Weekly Amount	\$200, payable for up to 26 weeks
When Benefits Start	
Disabled because of an Accident	1st day
Disabled because of a Sickness (including Pregnancy)	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. The internal appeal procedures do not include your right to an external review by an independent review organization (“IRO”) under the Affordable Care Act.

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

You are considered disabled if you are prevented from engaging in the normal activities of your job because of a non-occupational (non-work-related) injury or sickness. If you are disabled, the Plan pays short-term disability benefits directly to you. You must be eligible when your disability starts in order to get short-term disability benefits. No benefits are paid if your disability begins:

- Before you become initially eligible (*see page E-5*); or
- After your employment terminates.

You must submit a completed form and a doctor’s statement showing you are totally disabled before benefits will be paid. You can get the form by contacting the Fund (*see page A-5*).

What the Plan pays

If a non-work-related injury or sickness keeps you from doing your job, the Plan pays \$200 per week, up to 26 weeks for any one period of disability.

If you are disabled for less than a full week (7 days) the Plan pays \$28.57 per day of disability.

Benefits begin:

- The 1st day of disability caused by injury; or
- The 8th day of disability caused by sickness, including for pregnancy.

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

Multiple periods of disability

Benefits are paid per period of disability. If you receive the maximum amount of benefits, you will not be eligible for more short-term disability benefits until you begin a new period of disability.

Multiple periods of disability due to the same cause are considered one period of disability. A new period of disability begins when you return to work for at least 2 weeks, or when you have a new injury or sickness.

If you are disabled for unrelated causes, you must return to work for at least one day before a new period of disability will begin.

What’s not covered

See page C-62 for a list of the Plan’s general exclusions and limitations. No short-term disability benefits will be paid for any disability related to any of the exclusions or limitations on this list.

Life and AD&D insurance benefits

Learn:

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

*This section applies only if you are eligible for life and AD&D insurance benefits.
If you are not sure if you are eligible for these benefits,
please call UNITE HERE HEALTH to find out.*

Life and Accidental Death and Dismemberment (AD&D) insurance benefits are for employees only. Dependents are not eligible for life and AD&D insurance benefits.

Event	Benefit	Who Receives
Life Insurance	\$10,000	Your beneficiary
Accidental Death & Dismemberment Insurance (full amount)	\$5,000	Your beneficiary (if you die)

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. The internal appeal procedures do not include your right to an external review by an independent review organization (“IRO”) under the Affordable Care Act.

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

Life 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 (the employee’s) 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 the Fund or Dearborn National.

Life insurance benefit

Your life insurance benefit is \$10,000 and will be paid to your beneficiary(ies) if you die while you are eligible for coverage or within the 31-day period immediately following the date coverage ends.

Continuation if you become totally disabled

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

AD&D insurance 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.
- You become age 70.

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

You must provide a completed application for benefits plus a doctor’s statement establishing your total disability. The form and the doctor’s statement must be provided to UNITE HERE HEALTH within 12 months of the start of your total disability. (Forms are available from the Fund.) UNITE HERE HEALTH must approve this statement and your disability form. You must also provide a written doctor’s statement every 12 months, or as often as may be reasonably required based on the nature of the total disability. During the first two years of your disability, UNITE HERE HEALTH has the right to have you examined by a doctor of its choice as often as reasonably required. After two years, examinations may not be more frequent than once a year.

Converting to individual life insurance coverage

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

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

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

Terminal illness benefit

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

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 insurance benefits will be paid as shown below.

Event	Benefit	Who Receives
Death	\$5,000	Your beneficiary
Loss of both hands or feet	\$5,000	You
Loss of sight in both eyes	\$5,000	You
Loss of one hand and one foot	\$5,000	You
Loss of one hand and sight in one eye	\$5,000	You
Loss of one hand or one foot	\$2,500	You
Loss of the sight in one eye	\$2,500	You
Loss of index finger and thumb on same hand	\$1,250	You

AD&D exclusions

AD&D insurance 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 while sane or insane.
- Losses caused while you are under the influence of narcotics or other controlled substances, gas or fumes.
- Losses caused while intoxicated.
- Losses caused by active participation in a riot.
- Losses caused by war or an act of war while serving 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. You will have to provide proof of dependent status. See the certificate of coverage for more information about how to file a claim.

- Seat Belt Benefit**—If you are wearing a seat belt at the time of an accident resulting in your death, your additional AD&D coverage pays a benefit equal to 10% of the amount of your life insurance benefit, with a minimum benefit of \$1,000 and a maximum benefit of \$25,000. If it is not clear that you were wearing a seat belt at the time of the accident, your additional AD&D coverage will only pay a benefit of \$1,000.
- Air Bag Benefit**—If you are wearing a seat belt at the time of an accident resulting in your death and an air bag deployed, your additional AD&D coverage pays a benefit equal to 5% of the amount of your life insurance benefit, with a minimum benefit of \$1,000 and a maximum benefit of \$5,000. If it is not clear that the air bag deployed, your additional AD&D coverage will only pay a benefit of \$1,000.
- Transportation Benefit**—If you die more than 75 miles from your home, your additional AD&D coverage pays up to \$5,000 to transport your remains to a mortuary.

Naming a beneficiary

Your beneficiary is the person or persons you want Dearborn National to pay if you die. Beneficiary designation forms are available from 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 up to \$2,000 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.

- **Online Will Preparation**—Online will preparation gives you the ability to easily and quickly create a will, free of charge. Online will preparation services are administered by ComPsych®, a major provider of global employee assistance programs.
- **Beneficiary Resource Services**—Beneficiary Resource Services is available to beneficiaries of an insured person who dies and to an insured person who qualifies for the Terminal Illness Benefit. The program combines grief, legal, and financial counseling provided by Bensinger, DuPont & Associates, a nationwide organization utilizing masters degreed grief counselors, licensed attorneys, and Certified Consumer Credit Counselors. Services are provided via telephone, face-to-face contact, and referrals to local support resources.
- **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 drugs or eyeglasses. Other non-medical related travel services are also available. Europ Assistance USA, Inc. arranges and pays for covered services up to the program maximum.

Contact the Fund when you have questions about these benefits.

General exclusions and limitations

Learn:

- About the types of care that are not covered by the Plan.

This section does not apply to dental or vision benefits. Exclusions and limitations under the dental benefits or the vision benefits will be based on the contract with Cigna or with VSP, as applicable.

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

- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a healthcare provider.
- Any injury or sickness 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 G-2).
- Treatment, services, or supplies not recommended or approved by the attending healthcare provider, or not medically necessary in treating the injury or sickness as defined by UNITE HERE HEALTH (see page G-6).
- Experimental treatment (see page G-4), or treatment that is not in accordance with generally accepted professional medical standards as defined by UNITE HERE HEALTH .
- Any service or supply not covered or denied because prior authorization was required when such prior authorization was not received.
- 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 that is denied or not covered because you did not get prior authorization for the care as required.
- 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 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.
- Any treatment, services, or supplies for or in connection with the child of your dependent child, unless such child meets the definition of a dependent (see page E-2) or the Fund is required to provide benefits for such individual under applicable state law.
- Sex transformation.
- Reversal of a voluntary sterilization.
- Treatment for or in connection with infertility, including but not limited to fertility treatment with the goal of becoming pregnant (including but not limited to in vitro fertilization or similar procedures intended to promote conception).
- Weight loss programs or treatment, except to treat morbid obesity if the program is under the direct supervision of a healthcare provider, or as covered as a preventive healthcare service.
- 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. UNITE HERE HEALTH or its designated representative must provide prior authorization for such elective procedures.
- Services for preventive care or preventive treatment, other than preventive healthcare services listed as covered.
- Any smoking cessation treatment, drug, or device to help you stop smoking or using tobacco, other than preventive healthcare services.
- Hearing aids.
- Home construction for any reason.
- Supplies or equipment for personal hygiene, comfort or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, tanning bed, or water bed.
- 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.

- Cosmetic, plastic, or reconstructive surgery, unless that surgery is for any of the following: (1) to treat an accidental injury, and the surgery is performed within 24 months after the accidental; (2) breast reconstruction following a mastectomy; (3) related to domestic violence; or (4) medically necessary treatment, as determined by the Fund or its designated representative, which is provided by a network provider for a life-threatening condition (such as a medical complication). The Fund has the sole and exclusive judgment and discretion to determine when and if exception No. 4 applies to a particular situation.
- Any charges incurred for treatment, services, or supplies as a result of a declared or undeclared war or any act thereof; or any loss, expense or charge incurred while a person is on active duty or in training in the Armed Forces, National Guard, or Reserves of any state or any country.
- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault.
- 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.
- Applied Behavioral Analysis therapy (ABA therapy) or similar programs, including, but not limited to, ABA therapy, discrete trial training, pivotal response training, verbal behavioral intervention, early intensive behavioral intervention, or the Early Start Denver Model.
- Genetic testing or counseling unless the result of the test will directly impact the treatment of a patient with a diagnosed medical condition, including pregnancy. The decision about whether genetic testing will be covered is based on the medical policies established by or selected by the Fund or its designated representative. However, in all cases, UNITE HERE HEALTH makes the final determination as to whether genetic testing affects the patient's medical treatment. Genetic testing will not be covered for individuals not covered by the Plan, to establish paternity, for administrative purposes, or for legal purposes. Genetic testing on embryos will also not be covered.

- Christian Science practitioners and treatment.
- Any expense greater than the Plan's maximum benefits, or any expense incurred before eligibility for coverage begins or after eligibility terminates, unless specifically provided for under the Plan.

Coordination of benefits

Learn:

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

The Plan’s coordination of benefits provisions only apply to medical benefits. No coordination of benefits applies to prescription drug benefits, life or AD&D insurance benefits, or short-term disability benefits. Any coordination of benefits under the dental or vision benefits will be based on the contract with Cigna or with VSP, as applicable.

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 be more than 100% of allowable expenses.

This Plan coordinates benefits with the following types of plans:

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

This Plan will not coordinate benefits with Health Maintenance Organizations (HMOs) or reimburse an HMO for services provided.

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. Contact the Fund (see page A-5) for more information about how the Plan determines allowable expenses when it is secondary.

Order of payment

The general rules that determine which plan pays first are summarized below. Contact the Fund (see page A-5) when you have any questions.

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

cover the person as a retired or laid off employee.

- 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:
 1. The plan of the parent with custody.
 2. The plan of the stepparent with custody.
 3. The plan of the parent without custody.
- With respect to plans that have COB and cover adult dependent children age 18 and older under both parents’ plans, regardless of whether these parents are separated or divorced, or not separated or divorced, the plan that covers the parent whose birthday falls earlier in a year pays before the plan covering the parent whose birthday falls later in the year, unless a court order requires a different order.
- With respect to plans that have COB and cover adult dependent children age 18 and older under one or more parents’ plan and also under the dependent child’s spouse’s plan, the plan that has covered the dependent child the longest will pay first.

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

COB and prior authorization

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

Special rules for Medicare

If you are entitled to Medicare while covered by the Plan, Medicare is secondary to the Plan except as shown below:

- The Plan is primary for the first 30 months a person is eligible for and entitled to Medicare because of end stage renal disease (ESRD).
- Medicare is primary with respect to any coverage under the Plan provided for you after employment ends (such as COBRA coverage - [see page E-20](#)).

If you are entitled to Medicare benefits, the Plan will pay its benefits as if you have enrolled in both Medicare Part A (Hospital Benefits) and Part B (Doctor's Benefits), even if you have not enrolled in Part A and/or Part B. If you are entitled to Medicare but do not enroll in Medicare, you will have to pay 100% of the costs that would have been paid for under Medicare had you enrolled.

If you and your dependent 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, the 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 the Plan.

Subrogation

Learn:

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

The Plan’s subrogation provisions only apply to medical and prescription drug benefits. No subrogation applies to life or AD&D insurance benefits, or short-term disability benefits. Any subrogation under the dental benefits or the vision benefits will be based on the contract with Cigna or with VSP, as applicable.

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 an automobile accident caused by someone else; or
- On someone else’s property, if that person is also responsible for causing the injury.

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

Statement of facts and repayment agreement

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

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

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

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

Settling your claim

Before you settle your claim with a third party, you or your attorney should contact UNITE HERE HEALTH (see page A-5) to obtain the total amount of medical bills paid. Upon settlement, UNITE HERE HEALTH is entitled to reimbursement for the amount of the benefits it has paid or the full amount of the settlement or other recovery you or a dependent receive, whatever is less.

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

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

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

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

Eligibility for coverage

Learn:

- Who is eligible for coverage (who your dependents are).
- How you enroll yourself and your dependents.
- When and how you become eligible for coverage.
- How you stay eligible for coverage.
- When your dependents become eligible.
- When you can add and drop dependents.

You establish and maintain eligibility by working for an employer required by a Collective Bargaining Agreement (CBA) to make contributions to UNITE HERE HEALTH on your behalf. There may be a waiting period under your CBA before your employer is required to begin making those contributions. You may also have to satisfy other rules or eligibility requirements described in your CBA 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 described in your CBA do not count toward establishing your eligibility under UNITE HERE HEALTH. You should look at your CBA—it will tell you when your employer will start making contributions for your coverage, as well as any other rules you may have to follow, or criteria you may have to meet, in order to become eligible.

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.

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. [See page E-5](#) for more information about the 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). 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 E-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 E-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 legally married [spouse](#).
- Your [children](#) who are under age 26, including:
 - Natural children.
 - Step-children.
 - Adopted children or children placed with you for adoption, if you are legally responsible for supporting the children until the adoption is finalized.
 - Children for whom you are the legal guardian or for whom you have sole custody under a state domestic relations law.
 - Children entitled to coverage under a Qualified Medical Child Support Order.
- ✓ Federal law requires UNITE HERE HEALTH to honor Qualified Medical Child Support Orders. UNITE HERE HEALTH has established procedures for determining whether a divorce decree or a support order meets federal requirements and for enrollment of any child named in the Qualified Medical Child Support Order. To obtain a copy of these procedures at no cost, or for more information, contact the Fund.

Your child may be covered after age 26 if he or she can’t support himself or herself because of a

mental or physical handicap. The handicap must have started before the child turned 19, and the child must have been covered under the Plan on the day before his or her 19th birthday. For more information, [see page E-12](#) . (Special rules apply to children with a mental or physical handicap that were covered under the employer’s plan when a new employer begins participation in the Hospitality Plan. Contact the Fund with questions.)

Enrollment requirements

Employees

You must provide any information and documentation the Fund requires order to enroll. You must provide information and appropriate documentation even if your employer pays the entire cost of your coverage. You choose the level of coverage right for you:

- Coverage for just yourself (the employee),
- Coverage for yourself and your spouse, or
- Coverage for yourself and your children, or
- Coverage for yourself and your family (more than one dependent).

You must provide the required information by the end of your initial enrollment period. The Plan will tell you the date the forms are due. If you don’t provide the required information by the deadline, you will not be covered by UNITE HERE HEALTH. You must wait for the next open enrollment or special enrollment period to sign up ([see page E-8](#) for more information).

Dependents

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

In order to enroll your dependents, you must provide information about them when you enroll. You must provide the requested information during your initial enrollment period. UNITE HERE HEALTH will tell you when this information is due. If you do not provide the requested information by the due date, you may have to wait to enroll your dependents until the next open enrollment or special enrollment period ([see page E-8](#) for more information).

[See page E-6](#) for information about when coverage for your dependents starts.

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.
- Notarized copies of your most recent federal tax return (Form 1040 or its equivalents).
- A certificate of creditable coverage.
- Documentation of dependent status issued and certified by the United States Immigration and Naturalization Service (INS).
- Documentation of dependent status issued and certified by a foreign embassy.

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

You must provide any required dependent proof documents by the date you must provide your enrollment information ([See page E-8](#) information about special enrollment rights). Remember, you must provide any required proof documentation before claims will be paid on behalf of your dependent.

When your coverage begins (initial eligibility)

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

Example: Establishing Initial Eligibility	
Your employer must contribute for your work in . . .	You are covered in . . .
January	January

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

Continuing eligibility

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

Example: Continuing Eligibility	
Your employer must contribute for your work in . . .	You are covered in . . .
February	February
March	March
April	April

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.

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 work place began remodeling or restoration.

Self-payments during a strike

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

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

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

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 these claims (see page E-4).

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 E-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 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 children 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 E-8) will determine when the child becomes covered.
 - You can enroll other children who meet 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 that 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.

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. 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.

Termination of coverage

Learn:

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

Your and your dependents' coverage continues as long as you maintain your eligibility as described [on page E-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 E-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 UNITE HERE HEALTH at **(855) 405-FUND (3863)**.

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 month for which you last made a timely self-payment, if allowed to do so.

[See page E-13](#) for special rules that apply if your employer's CBA expires.

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 for which you made a timely self-payment, if allowed to do so.
- The last day of the month in which your dependent no longer meets the Plan's definition of a dependent.

If your child is age 26 or older, his or her coverage may continue. 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 the disabled child will continue as long as:

- You (the employee) remain eligible;

- The child's handicap began before age 19; and
- 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 of the child reaching age 26. You may also have 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 Hospitality Plan.) Contact the Fund for more information on how to continue coverage for a child with a serious handicap.

Certificate of creditable coverage

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

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 last month in 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 during the 12-month period immediately following the CBA's expiration, 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.

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.

Limited retroactive terminations of coverage allowed

Your coverage under the Plan 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 Plan will provide at least 30 days advance notice before retroactively terminating coverage, and you will have the right to file an appeal.

If the Plan terminates coverage on a prospective basis, the prospective termination of coverage (termination scheduled to occur in the future) is not a rescission. Additionally, the Plan 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.

Re-establishing eligibility

Learn:

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

Re-establishing employee coverage

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 G-5). If your loss of eligibility lasts for 12 months or more you must again satisfy the Plan’s initial eligibility rules (as of the date this SPD was printed, the initial eligibility rules are the same as the continuing eligibility rules). If you lose eligibility because of a leave of absence under the Uniformed Services Employment and Reemployment Rights Act, other rules apply.

Re-establishing dependent coverage

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 E-8), whichever happens first.

However, if you stop making payments for your dependents’ coverage because you lose eligibility, your dependents’ coverage will be re-established as follows:

Uniformed Services Employment and Reemployment Rights Act (USERRA) leaves of absence

For losses of eligibility due to leaves of absence under USERRA, your dependents’ coverage will be reestablished immediately upon your return to covered employment, as long as you also start making any required payments for dependent coverage at the same time.

Family Medical Leave Act (FMLA) leaves of absence

For losses of eligibility due to a leave of absence under FMLA, your dependents’ coverage will be reestablished on the first day of the month for which you once again begin making payroll deductions for dependent coverage, as long as your payroll deductions begin as soon as you return to covered employment.

Loss of eligibility other than termination of employment

For losses of eligibility for reasons other than termination of your employment, your dependents’ coverage will be re-established on the first day of the month for which you once again begin making payroll deductions for dependent coverage, as long as your payroll deductions begin immediately upon your return to covered employment.

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 Services and Operations Department of UNITE HERE HEALTH 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)

- ✓ Eligibility will be continued for you and your dependents during your leave of absence under the Family and Medical Leave Act (FMLA).

If you are making payments for dependent coverage when FMLA leave begins, you can maintain your and your dependents’ coverage during the leave by making the required payments for dependent coverage to your employer. If you stop making payments, your dependents’ coverage will terminate. Your dependents will become eligible again on the first day of the month for which your employer is required to make a contribution on your behalf after your return to work, as long as you start making self-payments for dependent coverage immediately upon your return to work.

The effect of uniformed service

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

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

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

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

No waiting periods will be imposed on reinstated coverage, and upon reinstatement coverage shall be deemed to have been continuous for all Plan purposes.

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

COBRA continuation coverage

Learn:

- ▶ How you can make self-payments to continue your 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 E-2*).
- 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. Your COBRA coverage options are based on which benefit options you had on the day before the qualifying event. For example, if you had declined medical benefits but opted to take dental and vision benefits, your COBRA coverage options will not include medical benefits.

In addition to medical benefits, COBRA continuation coverage includes prescription drug benefits, vision benefits (if you had vision benefits on the day before the qualifying event), and dental benefits (if you had dental benefits on the day before the qualifying event). Life and AD&D and short-term disability benefits cannot be continued. 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, 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.
- 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 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 can inform the Fund by contacting the Fund.

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 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.
- 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.

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: Service & 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.

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

To get more information

If you have any questions about COBRA continuation coverage, your rights, or the Plan’s notification procedures, please call UNITE HERE HEALTH at (855) 405-FUND (3863).

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

Claim filing and appeal provisions

Learn:

- How to file a claim.
- How to appeal a denied claim.

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. The internal appeal procedures do not include your right 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.

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 providers are not permitted to change this rule or make exceptions on their own. If you sign an assignment with a provider 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.

Filing claims (other than dental, vision, or life/AD&D insurance)

This section and the next section describe the steps you can take if your claim for benefits is denied, in whole or in part. It’s important that you review the time limits for filing claims and appeals and make sure you meet them.

In all cases, 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.

All claims for benefits must be made as shown below. If you need help filing a claim, contact the Fund at (855) 405-FUND (3863).

See page F-9 for rules on filing dental, vision, and life insurance appeals.

Healthcare claims

Network providers will generally file the claim for you. However, if you need to file a claim for hospital, medical, or surgical treatment (for example because you used a non-network provider), you should send it to:

Blue Cross and Blue Shield of Illinois
P.O. Box 805107
Chicago, Illinois 60680-4112

Prescription drug claims

If you use a participating 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 claim for a prescription drug purchased at a participating pharmacy, you should send it to:

UNITE HERE HEALTH
Attn: HospitalityRx
P.O. Box 6020
Aurora, IL 60598-0020

All other benefit claims

All short-term disability claims, and any claims for any services or supplies denied because you are not eligible or because you missed a payment or application deadline, should be mailed to:

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

Deadline for filing claims

Only those benefit claims that are filed in a timely manner will be considered for payment. Claims for short-term disability benefits and healthcare benefits, including medical/surgical claims, mental health/substance abuse claims, and prescription drug claims, must be filed no later than 18 months after the date of service.

For claims filed after the time limits shown above to be accepted by the Plan, there must be a demonstration that the claim could not have been filed within the time limits.

Who may file a benefit claims

You, your health care provider, or your authorized representative may file a claim. A spouse or certain other representatives can act for you if you are incapable of doing so for health reasons. Except for an urgent care claim, you must sign a form acceptable to the Fund stating who you want to file the claim for you. You can call the Fund to get this form.

Incomplete claims

If the Plan receives a claim that's missing information or not filed correctly, the Plan will let you know what else is needed within 24 hours for urgent claims, within 5 days for other pre-service claims, and within the time limits described below for post-service or disability claims. Keep in mind that the time limits for deciding a claim or appeal (in this section or the next) are extended during any time the Plan is waiting for additional information requested from you. You will always have at least 45 days (48 hours for urgent claims) to provide the requested information.

When will your claim be decided?

Urgent	Pre-Service Claims	Post-Service Claims	Disability Claims
within 72 hours (or 48 hours after requested missing information is received)	15 days (plus 15 more days if the Plan notifies you of the need for the additional time)	30 days (plus 15 more days if the Plan notifies you of the need for additional time)	45 days (plus 30 more days if the Plan notifies you of the need for additional time; the Plan can also take a second 30-day extension)

For on-going treatment, your claim will be decided before ending your course of treatment or within 24 hours when your request to extend on-going treatment is denied.

The time limits above are different for different types of claims, as explained here:

- Urgent claim is a pre-service claim where any delay could seriously jeopardize the patient's life, health, or ability of the claimant to regain maximum bodily function or cause severe pain, and the claim indicates the claim is urgent.
- Pre-service claim is a claim for benefits before treatment, but only when the Plan requires prior authorization.
- Post-service claims are claims made after treatment.
- Disability claims are requests for benefits where the plan must make a determination of disability to decide the claim
- On-going (concurrent) treatment claims happen when your course of treatment is reduced or ended by the Plan, or your request to extend treatment is denied, and it will be treated as post-service, pre-service or urgent (as the case may be) except as indicated.

Claim denials

If your claim is denied, you will receive written notice explaining why, instructions on how to file an appeal, and other necessary information.

Appeal forms are available at the regional offices and on the Fund's website: www.uhh.org.

**Filing appeals
(other than dental, vision, and life/AD&D insurance)**

If your claim for a service or supply is denied in whole or in part, you may file an appeal. An appeal may be for any service or supply the Plan does not cover completely, such as a claim processed at non-PPO rates, a claim denial for a benefit that is not covered under the Plan, a denial of eligibility, or a denial because the care did not meet the Plan's utilization management guidelines.

All appeals must be in writing (except for appeals involving urgent care), signed, and should include the claimant's name, address, and date of birth, and your (the employee's) Social Security number. You should also provide any documents or records that support your claim. If you are appealing a denial of benefits that qualifies as a request for urgent or emergency care, you can orally request an expedited (accelerated) appeal of the denial by calling (855) 405-FUND (3863). All necessary information may be sent by telephone, facsimile or any other available reasonably effective method.

See page F-9 for rules on filing dental, vision, and life insurance appeals.

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

First level of appeal. If the claim is for a denial made by Nevada Health Solutions through the prior authorization program (*See page B-2*), the claim has two levels of appeal. Claims with two levels of appeal include medical/surgical or mental health/substance abuse claims that were denied when you asked for prior authorization; claims for which you should have gotten prior authorization but didn't; and extensions of treatment beyond limits that were already approved through prior authorization.

The first appeal of a prior authorization denial must be sent within 180 days of the date on the Nevada Health Solutions' denial letter to:

Nevada Health Solutions
Attn: Appeals Department
P.O. Box 61440
Las Vegas NV 89160

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

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

Two levels of appeals for prescription drug denials made by HospitalityRx

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 the date on HospitalityRx's denial letter to:

UNITE HERE HEALTH, Attn: HospitalityRx
P.O. Box 6020
Aurora, IL 60598-0020

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, Illinois 60504

One level of appeal for most other claims

If you disagree with all or any part of a short-term disability claim or healthcare claim denial, and you wish to appeal the decision, you must follow the steps in this section. (For steps on appealing a prior authorization denial by Nevada Health Solutions, *see page F-6*. For steps on appealing a prescription drug denial, *see page F-6*.) You must submit an appeal within 12 months of the date the short-term disability or healthcare claim was denied to:

The Appeals Subcommittee
UNITE HERE HEALTH
711 N. Commons Drive
Aurora, Illinois 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 reasonably possible.
 - Circumstances in which the claim was not processed according to the Plan's claim processing requirements.
- The Appeals Subcommittee would have overturned the original benefit denial based on its standard practices and policies.

One level of appeal for late payments or late applications for coverage

The Trustees have given the Plan Administrator sole and final authority to decide all appeals for late payments or late applications. These appeals are for:

- 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. Send your written application for appeal to:

The Plan Administrator
UNITE HERE HEALTH
711 N. Commons Drive
Aurora, Illinois 60504-4197

What are your appeal rights?

During an appeal, you have the right to review certain Plan records that apply to your appeal and to provide additional records and information to the Plan. All relevant information will be

reviewed. In certain cases, outside healthcare professionals will be consulted. All appeal denials will explain why the appeal was denied and provide other specific information, including relevant medical explanations and your right to file a lawsuit against the Plan.

When will your appeal be decided?

Urgent	Pre-Service Claims	Post-Service Claims	Disability Claims
within 72 hours	30 days	60 days	45 days

When there are two levels of appeal, the times listed in the table above are divided in half for each of the two appeal stages. (For example, Nevada Health Solutions has 30 days to review a post-service claim, and the Fund has the remaining 30 days.)

Claimants in certain situations may request an expedited independent external review if:

- The claimant receives an adverse benefit determination involving urgent care and claimant has filed for an expedited internal review; or
- The claimant receives a final internal adverse benefit determination where:
 - The time frame for the completion of a standard external review (45 days) would seriously jeopardize the life or health of the claimant or would jeopardize the claimant’s ability to regain maximum function, or
 - The determination concerns an admission, availability of care, continued stay, or health care items or services for a condition for which the claimant received emergency services, but has not been discharged from a facility.

External appeals (independent review organization)

An external review is only available for appeals involving rescission or a medical judgment including medical necessity, level of care, or a determination as to whether a treatment or procedure is experimental or investigational. When an eligible person initiates an external appeal request with an Independent Review Organization (IRO), the Plan will provide the claim information, Plan exclusion and coverage criteria documentation, and clinical review criteria to the IRO. This external appeal request must be made within four months after the final internal appeal decision. External appeal requests will be assigned and rotated to one of at least three IROs in succession to avoid selection bias. The IRO will convey a final decision to the Plan within 45 days for standard reviews and within 72 hours for expedited reviews. Expedited reviews are permitted when standard review time frames would seriously jeopardize the life or health of the person.

If the IRO reverses the Plan’s adverse redetermination decision, then the Plan will provide coverage and/or payment of the claim within twenty-four hours of notification of the IRO decision. If the IRO upholds the adverse redetermination decision, the IRO will communicate the decision

to the Plan and the eligible person. If the healthcare professional files the request on behalf of the patient, then the healthcare professional would be notified as well. The Plan will provide denial letters with the specific reason for the denial and the contact information for the HHS Office of Consumer Assistance.

Filing dental, vision, and life/AD&D insurance claims and appeals

The rules for filing and appealing claim denials for dental or vision care and life/AD&D insurance are governed by the Fund’s contracts with Cigna,VSP, and Dearborn National, and so are different from the other claims and appeals rules.

Dental claims

Generally you do not need to file a claim for dental care. Cigna providers will file the claim on your behalf. No benefits are generally available if you use a non-network dentist, except in an emergency. If you do need to file a claim for dental care, you can get a claim form from Cigna by calling (800) 244-6224 or visiting www.mycigna.com. You will need to provide all information Cigna needs to process the claim. Claims can be mailed to:

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

Contact Cigna or refer to your Cigna plan booklet/certificate of coverage for more information about how to file a claim, the claim processing rules, time limits, and appeal procedures. Contact Cigna if you need a plan booklet/certificate of coverage, if you need help filing a claim or appeal, or if you have questions about the dental claim and appeal process.

Vision claims

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, you will need to file a claim if you use a provider who is not in the VSP network. If you need to file a claim for vision care, you can get a claim form from VSP by calling (800) 852-7600 or visiting www.vsp.com. You will need to provide all information VSP needs to process the claim. Fill out the claim form and send it, within 365 days of the date services or supplies were provided, 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. 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.

Life and AD&D insurance claims

Contact UNITE HERE HEALTH to file a claim for benefits:

UNITE HERE HEALTH
P.O. Box 6020
Aurora, IL 60598-0020
(855) 405-FUND (3863)

After you have contacted the Fund about an employee’s death, Dearborn National will contact you to complete the claim filing process.

- No filing deadlines apply to claims for life benefits.
- A claim for life or AD&D insurance benefits must include a certified copy of the death certificate.
- For AD&D claims, Dearborn National must receive written notice of your covered AD&D loss within 31 days of the loss, or as soon as reasonably possible. Dearborn National must receive written proof of your loss within 90 days of the loss, or as soon as reasonably possible. Generally, Dearborn will not pay for claims submitted more than one year after the proof is due. However, Dearborn may extend this claim filing deadline. Other deadlines may apply to your additional AD&D insurance benefits—your certificate of coverage provides more information.

The claim processing rules, time limits, and appeal procedures Dearborn must follow are described in the contract with Dearborn. Generally, Dearborn will respond to your claim within 90 days (but Dearborn may request a 90-day extension). You can file an appeal within 60 days of Dearborn’s decision. Dearborn will generally respond to your appeal within 60 days (but may request a 60-day extension). If you have questions about how Dearborn’s claim and appeal process works, contact Dearborn at **(800) 348-4512**.

Definitions

Learn:

- Definitions of some of the terms the Plan uses.

Call the Fund if you aren’t sure what a word or phrase means.

Allowable charges

An **allowable charge** is the amount of charges for covered treatments, services, or supplies that the Plan uses to calculate the benefits it pays for a claim. The allowable charge may be less than the provider’s actual charges. This usually happens if you choose a non-network provider. You must pay any difference between the provider’s actual charges and the allowable charges. Any charges that are more than the allowable charge are not covered. The Plan will not pay benefits 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, like the BCBSIL rate. The Plan will not pay the difference between what a non-network provider actually charges, and what the Plan considers an allowable charge. You pay this difference in cost. (This is sometimes called “balance billing.”)

The allowable charge for dental benefits will be determined by Cigna. The allowable charge for vision benefits will be determined by VSP. This definition does not apply to benefits provided through Cigna or VSP.

Copay or copayment

A fixed amount (for example, \$10) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. Usually, once you have paid your **copay**, the Plan pays the rest of the covered expenses.

For example, under the Gold Plan, each time you go to your network PCP, a \$20 copay applies. Each time you go to the emergency room, a \$150 copay applies. Under the Silver Plan, each time you go to your network PCP, a \$25 copay applies. Each time you go to the emergency room, a \$200 copay applies.

Your copayments count toward your out-of-pocket limits.

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

Coinsurance

Your share of the costs of a covered expense, calculated as a percent (for example, 20%) of the

allowable charge for the service. You pay your **coinsurance** plus any deductibles or copays. For example, if the allowable charge for network durable medical equipment is \$100, your 25% coinsurance equals \$25. (Under the Silver Plan, this assumes you have met your \$1,500 deductible.)

Your coinsurance counts toward your out-of-pocket limits.

Cosmetic or reconstructive surgery

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

Mastectomies, and reconstruction following a mastectomy, will not be considered cosmetic or reconstructive surgery (*see page C-9*).

Covered expense

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

Deductible

The amount you owe for covered expenses before the Fund begins paying benefits.

For example, under the Silver Plan, the Fund will not start paying medical benefits on your behalf until you meet your \$1,500 individual **deductible**. Your 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 same rule applies if two or more members of your family satisfy the \$3,000 family deductible. Once your family deductible has been satisfied, no one else in your family has to pay deductibles for the rest of that year.

The deductible may not apply to all services, including services that have a copay. For example, under the Silver Plan, emergency room visits, network office visits, or network laboratory services will be paid by the Fund before your or your family’s deductible is met.

Amounts you pay for healthcare the Plan does not cover 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 the Plan does not pay benefits.

Your deductibles count toward your out-of-pocket limits.

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

Durable medical equipment (DME)

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

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

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

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.

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

The definition of experimental or investigational for dental benefits will be determined by Cigna, and the definition of experimental or investigational for vision benefits will be determined by VSP. This definition does not apply to benefits provided through Cigna or VSP.

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.

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 primary care provider (PCP) is defined as a provider who specializes in:

- Family medicine.
- General practice.
- Internal medicine.
- Pediatric medicine (for children).
- Obstetrics or gynecology (while you or a dependent is pregnant).

A specialist is a healthcare provider who does not practice in one of the specialties listed above.

Although an OB/GYN (or other provider specializing in obstetrics or gynecology) is not considered a PCP unless you are pregnant, the PCP copay applies to each network office visit to an OB/GYN.

You do not need prior authorization in order to access obstetrical or gynecological care from a network healthcare provider who specializes in obstetrics or gynecology. The healthcare provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For help finding participating healthcare providers who specialize in obstetrics or gynecology, contact the Fund at (855) 405-FUND (3863).

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.

Injuries and sicknesses

The Plan only pays benefits for the treatment of injuries or sicknesses that are not related to employment (non-occupational injuries or sicknesses).

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

The Plan only pays benefits for preventive healthcare for a pregnant dependent child. **Maternity charges for a pregnant dependent child that are not preventive healthcare** (*See page G-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 E-2*).

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

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

Medically necessary

Medically necessary services, supplies, 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 G-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 is 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.

The definition of medically necessary for dental benefits will be determined by Cigna. The definition of medically necessary for vision benefits will be determined by VSP. This definition does not apply to benefits provided through Cigna or VSP.

Out-of-Pocket limit for network care and treatment

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

Amounts you pay out-of-pocket for services and supplies that are not covered, such as amounts over the allowable charges, or care or treatment once you have met a maximum benefit, do not count toward your out-of-pocket limit. Non-network care or treatment does not count toward your out-of-pocket limit. 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 for the year.

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

Plan Document

The rules and regulations governing the Plan of benefits provided to eligible employees and dependents participating in the Hospitality Plan.

Preventive healthcare

Under the medical and prescription drug benefits, the Plan covers preventive healthcare 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.
- PSA tests (prostate-specific antigen tests) for males between ages 40 and 69.

You may need a prescription in order to get preventive healthcare under the prescription drug benefits.

The Plan may cover certain preventive healthcare more liberally (for example, more frequently or

Definitions

at earlier/later ages) than required. For example, mammograms may be covered for women under age 40 who are at high risk for developing breast cancer.

Contact the Fund with questions about what types of preventive care is covered, and to find out if any age, risk, or frequency limitations apply. You can also go to: <https://www.healthcare.gov/preventive-care-benefits> for a summary.

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

Other important information

Learn:

- ▶ Important information about UNITE HERE HEALTH and your benefits.

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?

The Plan provides the medical benefits, the prescription drug benefits, and short-term disability benefits on a self-funded basis. Self-funded means that none of these benefits are funded by insurance contracts. Benefits and associated administrative expenses are paid directly from UNITE HERE HEALTH.

The Plan provides dental benefits, vision benefits, and life and accidental death & dismemberment (AD&D) benefits through fully insured contracts. Dental benefits are funded and guaranteed under a group contract with Cigna Health and Life Insurance Company (Cigna). Vision benefits are funded and guaranteed under a group contract with Vision Service Plan (VSP). The life and AD&D benefits are funded and guaranteed under a group contract underwritten by Dearborn National.

The Plan also contracts with other organizations to help administer certain benefits. Prescription drug benefits are administered by HospitalityRx, a wholly owned subsidiary of UNITE HERE HEALTH. Prior authorization and other utilization review services, and case management for the Plan’s medical benefits are provided by Nevada Health Solutions, a wholly owned subsidiary of UNITE HERE HEALTH.

Remedies for fraud

If you or a dependent submit information that you know is false or if you purposely do not submit or 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.

Interpretation of Plan provisions

For claims subject to independent external review (see page F-8), the IRO has the authority to make decisions about benefits, and decide all questions about claims, submitted for independent external review.

For dental benefits provided through the Cigna contact, Cigna has the authority to make decisions about benefits, and decide all questions about dental claims.

For vision benefits provided through the VSP contact, VSP has the authority to make decisions about benefits, and decide all questions about vision claims.

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 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 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, 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 intend to continue the Plan within the limits of the funds available to them. However, they reserve the right, in their sole discretion, to amend or terminate the Plan, in its entirety or in part, without prior notice. An insurance contract under which benefits are paid is not necessarily the same as the Plan. Therefore, termination of an insurance contract does not necessarily terminate the Plan.

If the Plan is terminated, benefits for claims incurred before the termination date will be paid based on available assets. Full benefits may not be available if the Plan owes more than the assets available. If there is money left over, the Trustees may use it in a method consistent with the

purposes for which the Plan was created or they may transfer it to another fund providing similar benefits.

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 Plan 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 Plan. You should select a provider or treatment based on all appropriate factors, only one of which is coverage under the Plan.

Providers are not agents or employees of UNITE HERE HEALTH, and the Plan 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

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

Employer and employee organizations

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

Plan administrator and agent for service of legal process

The Plan Administrator and the agent for service of legal process is the Chief Executive Officer (CEO) of the UNITE HERE HEALTH. Service of legal process may also be made upon a Plan 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.

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 contact information

Blue Cross and Blue Shield of Illinois
300 East Randolph Street
Chicago, IL 60601-5099
[\(312\) 653-6000](#)

Cigna Health and Life Insurance Company (Cigna)
900 Cottage Grove Road
Bloomfield, CT 06002
[\(800\) 244-6224](#)

ConsejoSano
2230 California St. N.W. Suite 4DW
Washington, D.C. 20008
[\(855\) 785-7885](#)

Dearborn National
1020 31st Street
Downers Grove, IL 60515-5591
[\(800\) 348-4512](#)

Doctor on Demand
121 Spear Street (Rincon 2), Suite 420
San Francisco, CA 94105
[\(800\) 997-6196](#)

HospitalityRx
P.O. Box 6020
Aurora, IL 60598-0020
[\(855\) 405-FUND](#)

Nevada Health Solutions
P.O. Box 61440
Las Vegas NV 89160
[\(855\) 487-0353](#)

VSP
3333 Quality Drive
Rancho Cordova, CA 95670
[\(800\) 852-7600](#)

Walgreens Specialty Pharmacy
60173-6801
[\(877\) 647-5807](#)

WellDyneRx
7472 Tucson Way, Suite 100A
Centennial, CO 80112
[\(844\) 813-3860](#)

UNITE HERE HEALTH Board of Trustees

Union Trustees

Chairman of the Board

D. Taylor

President

UNITE HERE
1630 S. Commerce Street
Las Vegas, NV 89102

Geoconda Arguello-Kline

Secretary/Treasurer

Culinary Union Local 226
1630 S. Commerce Street
Las Vegas, NV 89102

William Biggerstaff

UNITE HERE International Ex-
ecutive Vice President/Financial
Secretary-Treasurer

UNITE HERE Local 450
7238 West Roosevelt Road
Forest Park IL 60130

Donna DeCaprio

Financial Secretary Treasurer

UNITE HERE Local 54
1014 Atlantic Avenue
Atlantic City, NJ 08401

Jim DuPont

Director, Food Service Division

UNITE HERE
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

Bill Granfield

President

UNITE HERE Local 100
275 Seventh Avenue, 10th Floor
New York, NY 10001

Terry Greenwald

Secretary-Treasurer

Bartenders Local 165
4825 W. Nevso Drive
Las Vegas, NV 89103

Connie Holt

Connecticut Director

UNITE HERE Local 217
425 College Street
New Haven, CT 06511

Karen Kent

President

UNITE HERE Local 1
218 S. Wabash Avenue, 7th floor
Chicago, IL 60604

Rev. Clete Kiley

UNITE HERE International
Union

218 S. Wabash Avenue, 7th Floor
Chicago, IL 60604

Brian Lang

President

UNITE HERE Local 26
33 Harrison Avenue, 4th floor
Boston, MA 02111

C. Robert McDevitt

President

UNITE HERE Local 54
1014 Atlantic Avenue
Atlantic City, NJ 08401

Leonard O’Neill

Secretary-Treasurer

UNITE HERE Local 483
702C Forest Avenue
Pacific Grove, CA 93950

Henry Tamarin

UNITE HERE Local 1

218 S. Wabash Avenue, 7th floor
Chicago, IL 60604

Tom Walsh

President

UNITE HERE Local 11
464 S. Lucas Avenue, Suite 201
Los Angeles, CA 90017

Employer Trustees

Secretary of the Board

Arnold F. Karr

President

Karr & Associates
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

Paul Ades

Senior Vice President Labor
Relations

Hilton Worldwide
7930 Jones Branch Drive
McLean, VA 22102

James Anderson

c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

Richard Betty

c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

James L. Claus

Executive Vice President

Tishman Hotel Corporation
100 Park Avenue, 18th Floor
New York, NY 10017

Richard Ellis

Vice President/Labor Relations
ARAMARK
1101 Market Street, 6th Floor
Philadelphia, PA 19107

George Greene

Vice President Labor Relations

Starwood Hotels and Resorts
715 W. Park Avenue, Unit 354
Oakhurst, NJ 07755

Cynthia Kiser Murphey

President & Chief Operating
Officer

New York-New York
3790 Las Vegas Blvd. South
Las Vegas, NV 89109

Robert Kovacs

VP Total Rewards North America

Compass Group
2400 Yorkmont Road
Charlotte, NC 28217

Russ Melaragni

Vice President of Associate &
Labor Relations

Hyatt Hotels & Resorts
71 S. Wacker Drive
Chicago, IL 60606

Frank Muscolina

Vice President Corporate Labor
Relations

Caesars Palace
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

William Noonan

Senior Vice President -
Administration

Boyd Gaming
3883 Howard Hughes Parkway
9th Floor
Las Vegas, NV 89118

James Stamas

Dean Emeritus

Boston University School of
Hospitality
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

Harold Taegel

Senior Director Labor Relations

Sodexo
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

George Wright

c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504

UNITE HERE HEALTH

P.O. Box 6020

Aurora, IL 60598-0020

(630) 236-5100