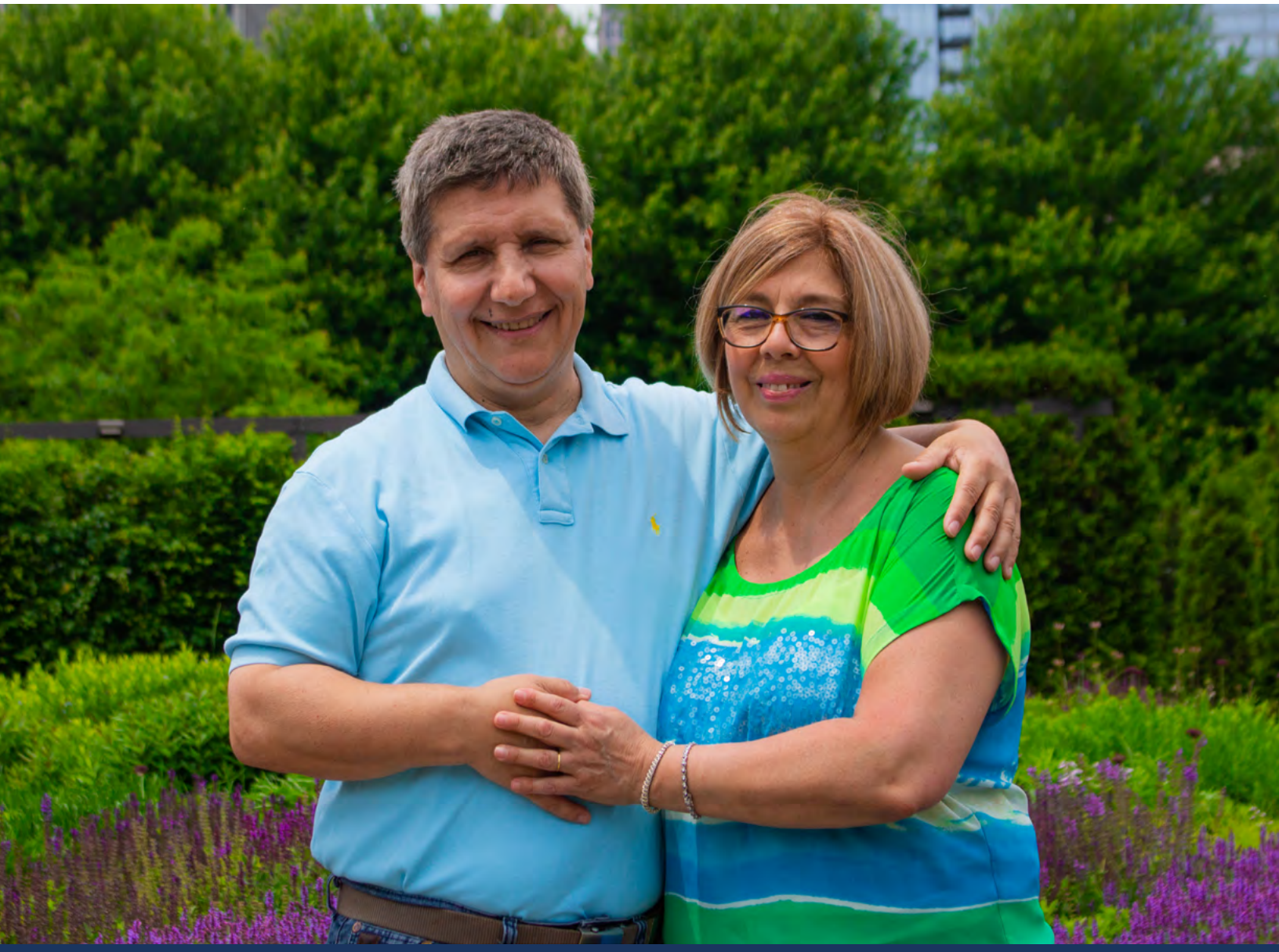
UNITE HERE HEALTH

# National Plan E

*Plan Unit 123E*



# Summary Plan Description

*Your Health and Welfare Benefits*

# UNITE HERE HEALTH

## Summary Plan Description
## National Plan E
## Plan Unit 123E

*Effective June 1, 2018*

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

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# *Using this book*

Learn:

- What UNITE HERE HEALTH is.
- What this book is and how to use it.

**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 UNITE HERE HEALTH according to a specific contract, called a Collective Bargaining Agreement (CBA), between the employer and the union.

Your coverage is being offered under the National Plan E (Plan Unit 123E), which has been adopted by the Trustees of UNITE HERE HEALTH to provide medical and other health and welfare benefits through the Fund. Other SPDs explain the benefits for other Plan Units.

## What is this book and why is it important?

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

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

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

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

## How do I use my SPD?

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

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

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

# *How can I get help?*

Learn:

- Where to call for help.

## How can I get help?

UNITE HERE HEALTH
**(833) 637-3519**

- When you have questions about your benefits.
- When you have questions about your eligibility for enrollment or benefits.
- When you have questions about your claim—including whether the claim has been received or paid.
- When you have questions about self-payments.
- To update your address.
- To report changes in your family status, such as divorce or a new child.
- To request new ID cards.
- To get forms or a new SPD.

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

*This booklet contains a summary in English of your plan rights and benefits under UNITE HERE HEALTH. If you have difficulty understanding any part of this booklet, you can call UNITE HERE HEALTH at* **(833) 637-3519** *(TTY: (855) 386-3889 or (855) FUNDTTY) for assistance.*

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

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

Learn:

- Why you should get a primary care provider.
- Why you should get preventive healthcare.
- How to 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 and coordinate your specialist care.

Your PCP also helps you keep track of when you need preventive healthcare.

✓ Call UNITE HERE HEALTH at **(833) 637-3519** to get help finding a PCP.

## Get preventive healthcare

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

✓ ***See page C-3*** and ***page H-5*** for more information about preventive healthcare.

## Use network providers

### Use a network provider

In most cases, you must use a network provider in order to get benefits. This applies to your medical benefits, your prescription drug benefits, and your dental benefits. If you use a non-network provider, you must pay 100% of the cost of the care yourself.

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

### How do I stay in the network?

- **Blue Cross Blue Shield of Illinois (BCBSIL)** provides access to a network of doctors and other healthcare professionals. To find a network provider, call **(800) 810-BLUE (2583)** or visit www.bcbsil.com.
- **Hospitality Rx** provides access to a network of retail pharmacies. To find a network pharmacy, call UNITE HERE HEALTH **(833) 637-3519** or visit www.hospitalityrx.org.
- **Cigna** provides access to a national network of dental care providers. To find a network provider, call **(800) 244-6224** or visit www.mycigna.com.

- **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 vision provider. To find a network provider, call **(800) 877-7195** or visit www.vsp.com.

# *Summary of benefits*

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

## MEDICAL BENEFITS

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

***MEDICAL BENEFITS—What You Pay***
***See page C-2*** *for more information about your medical benefits.*

| | Network Provider | Non-Network Provider |
|---|---|---|
| **Calendar Year Deductibles** | | |
| **Calendar Year Deductibles** | None | |
| **Annual Out-of-Pocket Limits** | | |
| **Safety Net Out-of-Pocket Limit for Network Medical Care and Prescription Drugs Combined** | $6,350/person & $12,700/family | Not applicable |
| **Office Visits** *Only care provided in a healthcare provider's office, clinic, or urgent care center is covered* | | |
| **Preventive Healthcare** (***see page H-5***) | $0 | Not covered *(except for non-hospital grade breast pumps and related supplies — limited to purchase of 1 pump per pregnancy)* |
| **Primary Care Provider (PCP) Office Visit** | $10 copay/visit | Not covered |
| **Specialist Office Visit** | $20 copay/visit | Not covered |

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

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

| *MEDICAL BENEFITS—What You Pay*<br>*See page C-2 for more information about your medical benefits.* | | |
|---|---|---|
| | **Network Provider** | **Non-Network Provider** |
| **Mental Health/Substance Abuse Office Visit** | $10 copay/visit | Not covered |
| **Urgent Care Center** | $20 copay/visit | Not covered |
| **Radiology Services** | $20 copay/visit | Not covered |
| **Laboratory Services**<br>***Only lab services provided in a healthcare provider's office, clinic, urgent care center, free-standing laboratory facility, or hospital outpatient department are covered*** | | |
| **Laboratory Services** | $20 copay/visit | Not covered |
| *PRESCRIPTION DRUG BENEFITS—What You Pay*<br>*See page C-8 for more information about your prescription benefits.* | | |
| **Formulary Preventive Healthcare Prescription Drugs and Supplies,** including immunizations *see page H-5* | $0 | Not covered |
| **Formulary Generic Drugs** | $15 | Not covered |
| **Formulary Brand Name Drugs** | $30 | Not covered |
| **Formulary Specialty and Biosimilar Drugs** | 25%, up to $50 | Not covered |
| **Prescription Drugs and Supplies NOT on the Formulary** | Not covered | Not covered |

| *DENTAL BENEFITS—What You Pay*<br>*See page C-18 for more information about your dental benefits.* | |
|---|---|
| *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 |
| **Most X-rays** | $0 |

| *DENTAL BENEFITS—What You Pay*<br>*See page C-18 for more information about your dental benefits.* | |
|---|---|
| **Regular Periodic Cleaning (adult or child prophylaxis) —**<br>*up to 2 total per person each year* | $0 |
| **Topical Application of Fluoride —**<br>*up to 2 total per person each year* | $0 |
| **Sealants** | $17 copay per tooth |
| **Periodontal Scaling and Root Planing—**<br>*up to 4 quadrants total per person every 12 months* | $60 - $110 copay per quadrant |
| **Periodontal Maintenance—**<br>*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 —**<br>*1 replacement per person every 5 years* | $370 - $470 copay, depending on type of crown |
| **Gingevectomy or Gingivoplasty**<br>(other than for restorative procedure) | $105 - $240 copay, depending on teeth per quadrant |
| **Pulp Cap** | $14 copay |
| **Root Canal** | $275 - $440 copay, depending on type of root canal |
| **Full Denture (Upper or Lower) —**<br>*1 set per person every 5 years* | $535 copay each |
| **Denture Reline or Rebase —**<br>*1 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**<br>(24 months of treatment) | $2,280 copay total ($95 copay per month) |
| **Orthodontia for Adult**<br>(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** | |

| *VISION BENEFITS —What You Pay*<br>*See page C-28 for more information about your vision benefits.* | | |
|---|---|---|
| **Description of Services**<br>*Covered once every 12 months* | **VSP Provider** | **Non-Network Provider** |
| **Exam** | $10 copay | $10 copay<br>Plan benefits limited to $45 |
| **Lenses** | $25 copay<br>Plan benefits limited to $160 for frames<br>(lenses are covered in full) | $25 copay<br>Plan benefits limited to:<br>$30 for single vision lenses<br>$50 for bifocal lenses<br>$65 for trifocal lenses<br>$100 for lenticular lenses |
| **Frames** | | $25 copay<br>Plan benefits limited to $70 |
| **Elective Contact Lenses**<br>(instead of glasses) | 100% of the exam<br>(up to $50)<br><br>$0 copay for the contacts;<br>Plan benefits limited to $160 allowance for contacts | $0<br>Plan benefits limited to $120 |
| **Medically Necessary Contact Lenses** | $25 copay | $25 copay<br>Plan benefits limited to $210 |

| *SHORT-TERM DISABILITY BENEFITS*<br>*What the Plan Pays—Employees only*<br>*See page C-32 for more information about your short-term disability benefits.* | |
|---|---|
| **Amount of Benefit** | $200/week for up to 26 weeks |
| **Day Benefits Start:** | |
| **Due to Injury** | 1st day |
| **Due to Sickness** | 8th day |

| *LIFE AND AD&D BENEFIT*<br>*What the Plan Pays—Employees only*<br>*See page C-36 for more information about your life and AD&D benefits.* | |
|---|---|
| **Life Insurance** | $10,000 |
| **Accidental Death & Dismemberment (AD&D) Insurance**<br>*Amount may vary based on type of loss (see page C-38)* | $5,000 |

# *Medical benefits*

Learn about your medical benefits:

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

## Network providers

*Benefits are only paid if you use a network provider.* **If you use a non-network provider, you pay 100% of the cost of your care.** To find a network provider, contact:

**Blue Cross and Blue Shield of Illinois (BCBSIL)—PPO Network**
toll-free: **(800) 810-BLUE (2583)**
www.bcbsil.com
*(Go to the Provider finder, and select the "Participating Provider Organization (PPO)" network)*

## What you pay

You must pay any cost share (such as copays) for your share of covered expenses. You must also pay any expenses that are not covered expenses (***see page C-3*** for information about what's not covered), including charges once a maximum benefit or limitation has been met.

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

### Copays

The copay covers your cost sharing for all of the healthcare you receive at the time of the service. For example, if you go to a specialist, the $20 copay applies to all of the medical care you get during the specialist office visit.

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

## Out-of-Pocket limit for network expenses

Your out-of-pocket cost-sharing (deductibles, coinsurance, and copays) for most covered network medical (including mental health/substance abuse) and prescription drug expenses is limited to $6,350 per person ($12,700 per family) each calendar year. Once your out-of-pocket costs for covered expenses meet these limits, the Plan will usually pay 100% for your (or your family's) network medical and prescription drug covered expenses during the rest of that calendar year.

Amounts you pay out-of-pocket for prescription drug expenses under the section of this SPD titled "Prescription drug benefits" count toward this out-of-pocket limit, too.

## 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. **Unless otherwise stated, medical care is only covered if you use a network provider.**

- **Preventive healthcare services** (*see page H-5*). You can get preventive care at a healthcare provider's office, a clinic, an urgent care facility, a hospital outpatient department, or other appropriate free-standing facility. Certain limits or rules may apply to when and how you get preventive healthcare based on your gender, age, and health status. Although medical care provided by non-network providers is generally not covered, non-hospital grade breast pumps (limited to one per pregnancy) and breast pump supplies will be covered when obtained from a non-network provider.
  - PSA tests are covered once for men at age 40, every 2 years for men age 41 through age 50, and annually for men after age 50.
  - Cervical cancer screening (pap smear) is covered once every 36 months for just the pap smear, or once every 60 months if both a pap smear and human papillomavirus screening are done together. Cervical cancer screenings are only covered for women from age 21 to age 65.
  - Screening mammography is covered once every 5 years for women age 35 but less than 40; annually for women age 40 through age 64; and every 2 years for women age 65 and older.
- **Healthcare treatment or services,** including for pregnancy, provided in a healthcare provider's office, in a clinic, or in an urgent care facility.
- **Laboratory services** provided as an outpatient in a healthcare provider's office, in a clinic, in an urgent care center, in a free-standing laboratory facility, or in the outpatient department of a hospital.
- **X-ray services** provided in a healthcare provider's office, in a clinic, or in an urgent care facility.

## What's not covered

*See page D-2* for a list of this Plan's general exclusions and limitations. In addition to that list, the Plan will not pay benefits for, or in connection with, the following medical treatments, services, and supplies:

- Non-network providers, unless the non-network care is specifically stated as covered.
- Services or supplies not specifically listed as covered.

- Unless otherwise specifically listed as covered, any treatment, services, or supplies other than those provided in a healthcare provider's office, clinic, or urgent care facility.
- Prescription drugs and medications, other than those used where they are dispensed. Prescription drugs may be covered under the prescription drug benefit shown starting ***on page C-8***.
- Eye refractions, eyeglasses, or contact lenses. However, these expenses may be covered under the vision benefits (***see page C-28***).
- Hearing aids.
- Dental services for or in connection with routine care of the teeth and supporting oral tissues, restorative services to replace natural teeth lost as a result of injury, alveolar ridge augmentation or implant procedures to stabilize or otherwise alter natural or artificial teeth, or extractions.
- Procedures for the treatment of temporomandibular joint dysfunction, craniofacial disorders or orthognathic disorders.
- Surgery to modify jaw relationships including, but not limited to, osteoplasty and genioplasty procedures.
- Preventive healthcare services and supplies that must be purchased through the prescription drug benefits.
- Unless otherwise stated as covered, services, supplies, care, or treatment provided by or in an ambulatory surgical facility.
- Services, supplies, care, or treatment provided by or in a home health care agency, hospice, or emergency room.
- Inpatient care, including but not limited to care provided in or through a hospital, hospice, rehabilitation center, or skilled nursing facility.
- Habilitative or rehabilitative therapy, including but not limited to physical therapy, occupational therapy, or speech therapy.
- Services, supplies, care, or treatment provided in the patient's home.
- Durable medical equipment.
- Chiropractic treatment.
- Routine podiatry.
- Acupuncture.
- Private duty nursing care.

- Transportation, including transportation by ground, air, or water ambulance.
- Any of the following treatment, services, or supplies, unless provided in a healthcare provider's office, clinic, or urgent care facility, or as otherwise specifically listed as covered:
  - Surgical procedures.
  - Anesthesia and its administration.
  - Blood and blood plasma.
  - Surgical supplies and dressings.
- Oxygen and rental equipment for its administration.
- Except as specifically covered under the Plan, non-healthcare items or services, including but not limited to oral nutrition or supplements, and disposable supplies, such as bandages, antiseptics, and diapers.

# *Prescription drug benefits*

## Learn about your drug benefits:

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

The Plan has contracted with Hospitality Rx, LLC (Hospitality Rx) to administer your prescription drug benefits.

Hospitality Rx provides access to a national network of participating pharmacies that you must use in order to get benefits for prescription drugs. *Not all pharmacies are in your pharmacy network.* **Walgreens and CVS are in your network**. Wal-Mart is **not** in your network. Because this list changes from time to time, get the most current list of network pharmacies by contacting UNITE HERE HEALTH at **(833) 637-3519** or www.hospitalityrx.org.

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

| Important Phone Numbers | |
|---|---|
| **If you want to:** | **Call:** |
| Find a network pharmacy or ask questions about your benefits | UNITE HERE HEALTH<br>**(833) 637-3519** |
| Get prior authorization for prescription drugs or to ask which drugs require prior authorization | Hospitality Rx<br>**(844) 484-4726** |
| Get a free glucometer | TrueMetrix (by Trividia)<br>**(866) 788-9618** |
| | One Touch (by LifeScan)<br>*use order code 739WDRX01*<br>**(888) 883-7091**<br>www.OneTouch.orderpoints.com |
| Order from the mail-order pharmacy | WellDyneRx Home Delivery (through Hospitality Rx)<br>**(844) 813-3860** |
| Order from the specialty pharmacy | AllianceRx Walgreens Prime<br>**(877) 647-5807** |

You can also visit www.hospitalityrx.org for more information.

## What you pay

You must pay the applicable amount shown below for each fill of a prescription drug. You must also pay any expenses that are not considered covered expenses (***see page C-14*** for information about what's not covered).

| *Prescription Drugs—Network Retail or Mail Order Pharmacy Only* | *Your Cost for Each Fill or Refill* |
|---|---|
| **Formulary Preventive Healthcare Prescription Drugs and Supplies,** including immunizations ***see page H-5*** | $0 |
| **Formulary Generic Drugs** | $15 |
| **Formulary Brand Name Drugs** | $30 |
| **Formulary Specialty and Biosimilar Drugs** | 25%, up to $50 |
| **Prescription Drugs and Supplies NOT on the Formulary** | Not covered |

Drugs and supplies on the formulary are safe, effective, high-quality drugs. No benefits are paid for drugs not on the formulary unless the Fund approves the drug. Ask your healthcare provider to prescribe a drug that is on the formulary. Prescription drugs and supplies may be added to or removed from the formulary from time to time. Contact Hospitality Rx at **(844) 484-4726** if you or your healthcare provider have questions about which prescription drugs and supplies are on the formulary.

If your healthcare provider wants you to take a drug that is not on the formulary, he or she should reach out to Hospitality Rx at **(844) 484-4726** for a formulary exception. The formulary exception allows your healthcare provider to ask for approval for you to get coverage for a prescription

You must use the specialty pharmacy to get specialty and biosimilar prescription drugs. ***See page C-14*** for more information about the specialty pharmacy.

## Prescription drug out-of-pocket limit

Your cost-sharing for most network medical and prescription drug covered expenses is limited to $6,350 per person ($12,700 per family) each calendar year under the safety net out-of-pocket limit. Once your out-of-pocket costs for covered expenses meet these limits, the Plan will usually pay 100% for your (or your family's) network medical and prescription drug expenses during the rest of that calendar year. Amounts you pay out-of-pocket for medical covered expenses under the section titled "Medical benefits" count toward this out-of-pocket limit, too.

Certain prescription drug expenses don't count toward your out-of-pocket limit. This includes any amounts you must pay in addition to your copay when you or your doctor chooses a brand name drug when a generic equivalent is available (see "Generic prescription drug policy" below),

and any surcharge amounts you pay for early refills. These expenses do not count toward your out-of-pocket limit and you will continue to be responsible for these expenses even if you have met the out-of-pocket limit for the year.

You can get more information about your out-of-pocket limits on ***page C-2*** and ***page H-5***.



## Generic prescription drug policy

If you or your provider choose 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 generic prescription drug copay.

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

If you are approved for an exception to the generic prescription drug policy, you will still have to pay the applicable preferred or non-preferred copay.

## What's covered

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

- FDA-approved prescription drugs which can legally be purchased only with a written prescription from a healthcare provider. This includes oral and injectable contraceptives and drugs mixed to order by a pharmacist, as long as at least one part of the mixed-to-order drug is an FDA-approved prescription drug.
- The following diabetic supplies: insulin, diabetic test strips, control solution for glucometers, disposable syringes and needles, and lancets.
- Prescription and non-prescription (over-the-counter) preventive healthcare services and supplies, including immunizations (***see page H-5***).
- The following single-source vitamins: ferrous sulfate, vitamin D, cyanocobalamin, vitamin K, potassium chloride, bicarbonate, phosphate, calcium acetate, niacin, and Galzin (zinc).

### Free glucometers

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

**TrueMetrix (by Trividia)**
**(866) 788-9618**
*no order code is needed*

**OneTouch (by LifeScan)**
**(888) 883-7091**
or visit www.OneTouch.orderpoints.com
*use order code 739WDRX01*

If you don't want to use one of the Fund's free glucometers, you have to pay the full cost of the glucometer upfront. You may submit a claim under the medical benefits for the glucometer, but you may not be reimbursed for the full amount.

## Safety and cost containment programs for prescription drugs

The Fund provides extra protection through several safety and cost containment programs. These programs may change from time to time, and the prescription drugs or types of prescription drugs that are part of these programs may also change from time to time. You and your healthcare provider can always get the most current information by contacting Hospitality Rx at **(844) 484-4726** or visiting www.hospitalityrx.org.

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

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

***See page G-6*** for information about appealing a denied request for prior authorization or appealing a denial of prescription drug benefits.

### Prior authorization

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

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

### Step therapy

In many cases, effective lower-cost alternatives are available for certain prescription drugs. A step therapy program will ask you to try 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. If the generic version does not work or causes serious side effects, you may be asked to try a preferred formulary version. If this still does not work, you may be asked to try a non-preferred formulary version.

The list of prescription drugs that require step therapy changes from time to time. Contact Hospitality Rx at **(844) 484-4726** with questions about which prescription drugs require step therapy.

### Case management

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

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

## Fill and refill limits

### Quantity limits

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

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

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

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

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

Call Hospitality Rx at **(844) 484-4726** if you need an early refill of a drug.

### Exceptions to the standard quantity limits

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

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

## Mail-order pharmacy

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

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

**WellDyneRx Home Delivery**
**(844) 813-3860**
www.mywdrx.com
*(Registration is required)*

## Specialty pharmacy

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

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

**AllianceRx Walgreens Prime**
**(877) 647-5807**
**(TTY) 866-830-4366**
www.alliancerxwp.com

AllianceRx Walgreens Prime specialty pharmacy is different than Walgreens retail pharmacies.

## What's not covered

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

- Prescription drugs, vitamins, minerals, or supplies that are not included on the formulary, unless you receive an exception through the prior authorization program. You must try all of the medically appropriate drugs on the formulary before Hospitality Rx will review a request for coverage of a non-formulary drug.
- Prescription drugs that have not been approved by the FDA. However, the Fund may cover prescription drugs not approved by the FDA in certain situations. You or your healthcare provider may ask for an exception through the prior authorization program.
- Specialty prescription drugs, other than those used to treat HIV/AIDS, if you do not use the specialty pharmacy.
- Experimental or investigational drugs.
- Fertility drugs.
- Prescriptions or refills in amounts over the quantity limits (***see page C-12***).
- Non-sedating antihistamines or histamine receptor blockers.

- Over-the-counter proton pump inhibitors.
- Vitamins, dietary supplements, or dietary aids, except those specifically listed as a covered expense.
- New-to-market prescription drugs until the Fund or its representative has reviewed and approved the prescription drug.
- High-cost "me too" drugs, unless the Fund or its representative approves an exception through the prior authorization program. "Me-too" drugs usually have only very small differences in how they work, but are considered "new" drugs with no generic equivalent. Often, the manufacturer charges high prices for these drugs even though there are other drugs available that work just as well for a lower cost.
- Drugs that require review under a safety or cost containment program (such as a drug that requires prior authorization, or a drug subject to the step therapy program) if that safety or cost containment program is not followed, or does not approve the drug.
- Drugs, medications, or supplies that are not for an FDA-approved indication, that are not covered under the Plan's or Plan's designee's claims processing guidelines or any other internal rule, including but not limited to any national guidelines used by the medical community.
- Glucometers, other than those the Fund gives to you for free. You may be able to get a glucometer through the medical benefits if you do not want to use one of the free ones, but you will usually have to pay part or all of the cost.
- Rogaine and other drugs to prevent hair loss.
- Drugs or medications used, consumed or administered at the place where it is dispensed, other than immunizations. (These drugs may be covered under your medical benefits.)
- Diagnostics or biologicals.
- Drugs used for cosmetic reasons.
- Weight control drugs, unless for the treatment of morbid obesity under the direct supervision of a healthcare provider, and authorized in writing by the Plan.
- Human growth hormone, except to treat emaciation due to AIDS.
- Drugs or other covered supplies not purchased from a network pharmacy.
- Medical foods.

# *Dental benefits*

Learn about your dental benefits:

- What you pay for your covered dental care.
- How to use your dental benefits.
- Getting a primary care dentists.
- What types of dental care are covered.
- What types of dental care are not covered.

# *Dental benefits*

C

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 |
| **Most X-rays** | $0 |
| **Regular Periodic Cleaning (adult or child prophylaxis) —** *up to 2 total per person each year* | $0 |
| **Topical Application of Fluoride —** *up to 2 total per person each year* | $0 |
| **Sealants** | $17 copay per 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 |

| Dental Benefits—Dental Health Maintenance Organization | |
|---|---|
| **Onlays (metallic)** | $370 - $440 copay, depending on type of onlay |
| **Crowns —** *1 replacement per person every 5 years* | $370 - $470 copay, depending on type of crown |
| **Gingevectomy or Gingivoplasty** (other than for restorative procedure) | $105 - $240 copay, depending on teeth per quadrant |
| **Pulp Cap** | $14 copay |
| **Root Canal** | $275 - $440 copay, depending on type of root canal |
| **Full Denture (Upper or Lower) —** *1 set per person every 5 years* | $535 copay each |
| **Denture Reline or Rebase —** *1 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** | |

## Using your benefits

✓ **Your dental benefits don't take effect until you select a dentist.** Call Cigna at **(800) 244-6224** (1-800-CIGNA24) to select a dentist.

✓ You must see a primary dentist in the Cigna Dental Care HMO. If you don't, your dental bills will not be paid.

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

- You must pick a primary dentist (***see page C-20***) 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. 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 periadicular 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 periadicular surgery.

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

# *Vision benefits*

Learn:

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

# *Vision benefits*

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 PLUS BENEFITS—*What You Pay* | | |
|---|---|---|
| **Description of Services**<br>***Covered once every 12 months*** | **VSP Provider** | **Non-Network Provider** |
| **Exam** | $10 copay | $10 copay<br>Plan benefits limited to $45 |
| **Lenses** | $25 copay<br>Plan benefits limited to $160 allowance for frames<br>(lenses are covered in full) | $25 copay<br>Plan benefits limited to:<br>$30 for single vision lenses<br>$50 for bifocal lenses<br>$65 for trifocal lenses<br>$100 for lenticular lenses |
| **Frames** | | $25 copay<br>Plan benefits limited to $70 |
| **Elective Contact Lenses**<br>(instead of glasses) | 100% of the exam<br>(up to $50)<br><br>$0 copay for the contacts;<br>Plan benefits limited to $160 allowance for contacts | $0<br>Plan benefits limited to $120 |
| **Medically Necessary Contact Lenses** | $25 copay | $25 copay<br>Plan benefits limited to $210 |

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

## Network and non-network vision providers

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

To locate a network provider near you, contact:

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

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

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

## What you pay

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

### Upgrade options and other discounts through network providers

Although the Plan will not pay for any upgrades or options, if you use a network provider, you can get certain upgrades or options for a set fee. Common lens options include but are not limited to anti-reflective coatings, progressive lenses, polycarbonate lenses for adults, and photochromic lenses. Standard scratch resistant coatings and, for children under age 26, polycarbonate lenses, are available with no copay to you.

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

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

## What the Plan pays

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

## What's covered

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

You can also get low vision services if a network provider believes you need additional treatment. VSP must pre-approve any low vision services. Generally, the Plan pays up to $1,000 every 2 years for all of your low vision services (tests and supplemental aids combined), regardless of whether you use a network or a non-network provider. You pay nothing for low vision tests, up to 2 tests per year, and 25% for supplemental aids. However, if you use a non-network provider, VSP will only pay up to $125 for low-vision supplemental testing. 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 new 12-month benefit period.
- Frames/lenses in addition to contact lenses during the same benefit period.
- Any other service or supply excluded under the VSP contract.

# *Short-Term disability benefit*

Learn:

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

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



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

No benefits are available for any period of continuous disability beginning:

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

You are considered disabled if you are prevented by injury or sickness from engaging in your own occupation. You must submit a completed application for benefits and a doctor's statement establishing total disability before benefits can begin. Contact the Fund for the required forms, or visit www.uhh.org.

## What the Plan pays

The Plan pays a weekly benefit of $200 for as long as you are disabled—up to 26 weeks during any 1 period of disability. The Plan provides a daily benefit of 1/7 of your weekly rate for periods of disability less than 7 days.

Benefits begin on:

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

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

## Multiple periods of disability

Periods of disability due to the same cause will be treated as 1 period of disability unless you have returned to work for at least 2 weeks.

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

## What's not covered

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

In addition, no short-term disability benefits are payable if you are not under the regular care of a healthcare provider.

# *Life and AD&D insurance benefits*

Learn:

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

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

| Event | Amount of Benefit | Who Receives |
|---|---|---|
| **Life Insurance** | $10,000 | Your beneficiary |
| **AD&D Insurance**<br>*amount may vary based on type of loss (**see page C-38**)* | $5,000 | You<br>(or your beneficiary if you die) |

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

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

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

## Life insurance benefit

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

### Continuation if you become totally disabled

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

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

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

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

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



### Converting to individual life insurance coverage

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

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

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

## Accidental death & dismemberment insurance benefit

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

| Your AD&D Benefit for a loss (death or dismemberment) within 365 days of an accident | | |
|---|---|---|
| **Event** | **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 | $2,500 | 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 benefits do not cover losses caused by:

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

See your certificate for complete details.

## Additional accidental death & dismemberment insurance benefits

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

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

## Naming a beneficiary

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

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

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

## Additional services

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

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

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

# *General exclusions and limitations*

Learn:

- The types of care not covered by the Plan.

# General exclusions and limitations

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

- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a healthcare provider.
- Any injury, sickness, or dental or vision treatment which arises out of or in the course of any occupation or employment, or for which you have gotten or are entitled to get benefits under a workers' compensation or occupational disease law, whether or not you have applied or been approved for such benefits.
- Any treatment, services, or supplies:
  - For which no charge is made.
  - For which you, your spouse or your child is not required to pay.
  - Which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish, or municipal hospital when there is no legal requirement to pay for such treatment, services, or supplies.
- Any charge which is more than the Plan's allowable charge (***see page H-2***).
- Treatment, services, or supplies not recommended or approved by your healthcare provider, or not medically necessary in treating the injury or sickness as defined by UNITE HERE HEALTH (***see page H-4***).
- Experimental treatment (***see page H-3***), or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH.
- Preventive care, unless specifically considered preventive healthcare (***see page H-5***), or as otherwise stated as covered. If you don't meet the criteria for preventive healthcare the Plan otherwise covers, it might not be covered under the Plan.
- Any expense or charge for failure to appear for an appointment as scheduled, or charge for completion of claim forms, or finance charges.
- Any treatment, services, or supplies provided by an individual who is related by blood or marriage to you, your spouse, or your child, or who normally lives in your home.
- Any treatment, services, or supplies purchased or provided outside of the United States (or its Territories), unless for a medical emergency. The decision of the Trustees in determining whether an emergency existed will be final.
- Any 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.

- Any treatment, services or supplies for or in connection with the pregnancy of a dependent child except for preventive healthcare services. For example, ultrasounds, treatment associated with a high-risk pregnancy, non-preventive care, and delivery charges are not covered with respect to the pregnancy of a dependent child.
- Hospital charges for personal comfort items, including but not limited to telephone, television, cosmetics, guest trays, magazines, and bed or cots for family members or other guests.
- Supplies or equipment for personal hygiene, comfort, or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, tanning bed, or water bed.
- Home construction for any reason.
- Sex transformation for any reason.
- Treatment for or in connection with infertility, other than for diagnostic services, including but not limited to in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and fertility drugs and medications of any kind.
- Any dental treatment of teeth or their supporting structures, or services or supplies associated with such treatment, unless specifically listed as a covered expense under the Plan.
- Weight loss programs or treatment, except to treat morbid obesity if the program is under the direct supervision of a healthcare provider, or as specifically stated as covered (for example, diabetes education, nutrition counseling, or preventive healthcare services).
- Any smoking cessation treatment, drug, or device to help you stop smoking or using tobacco, other than preventive healthcare services.
- 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 (***see page C-28***).
- Eyeglasses, contact lenses, or hearing aids, unless specifically listed as covered.
- 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 elective procedure (other than sterilization or abortion, or as otherwise specifically stated as covered) that is not for the correction or cure of a bodily injury or sickness.

- Procedures to reverse a voluntary sterilization.
- 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.
- Education or training, unless specifically stated as covered.
- 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.
- Christian Science.
- A service or item that is not covered under the Plan's claims processing guidelines or any other internal rule, guideline, protocol or similar criterion that the Plan relies upon.
- Any expense greater than any maximum benefit, or any expense incurred before eligibility for coverage begins or after eligibility terminates, unless specifically provided for under this Plan.
- Charges or claims incurred as a result, in whole or in part, of fraud, false information, or misrepresentation.

# *Coordination of medical benefits*

Learn:

- How benefits are paid if you are covered under other plan(s).

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

No coordination of benefits applies to prescription drug benefits, to the dental benefits, or to the vision benefits.

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

This Plan coordinates benefits with the following types of plans:

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

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

## Which plan pays first

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

### Order of payment

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

- Plans that do not contain COB provisions always pay before those that do.
- Plans that have COB and cover a person as an employee always pay before plans that cover the person as a dependent.
- Plans that have COB and that covers a person (or dependent of such person) who is laid off, retired, or enrolled in continuation coverage offered in accordance with federal or state law will be secondary to active coverage, including self-paid coverage.

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

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

## COB and prior authorization

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

# Special rules for Medicare

## I am an active employee

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

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

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

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

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

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

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

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

## I have COBRA coverage or retiree coverage

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

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

## How to get help with Medicare

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

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

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

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

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

# *Subrogation*

Learn:

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

# The Plan's right to recover payments

## When injury is caused by someone else

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

Typical examples include injuries sustained:

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

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

## Statement of facts and repayment agreement

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

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

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

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

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

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

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

# *Eligibility for coverage*

Learn:

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

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

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

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

## Who is eligible for coverage

### Employees

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

- You work for an employer who is required by a CBA to contribute to UNITE HERE HEALTH on your behalf.
- The contributions required by the CBA are received by UNITE HERE HEALTH.
- You pay any co-premiums required by your CBA or by UNITE HERE HEALTH for your dependents' share of coverage.
- You meet the Plan's eligibility rules.

Under certain circumstances you (the employee) can refuse coverage by signing the waiver of coverage portion of your election form. Special rules govern how and when coverage becomes effective after a waiver is revoked. Contact the Fund at **(833) 637-3519** for more information about waiving 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.

Coverage for your dependents is not free. You must make any required co-premiums for the cost of your dependents' coverage. You must pay the amount you owe directly to the Fund.

You can add dependents after your coverage starts. See "Dependent coverage" starting ***on page F-6*** for more information.

## Who your dependents are

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

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

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

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

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

# Enrollment requirements

## Employees

You must enroll within the time frames established by the Fund, and provide the Fund with any required information, in order to enroll. This may include providing a signed enrollment form.

You cannot elect medical, dental, vision, short-term disability, or life and AD&D insurance separately. If you enroll in medical coverage, you will be enrolled in all types of coverage.

## Dependents

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

In order to enroll your dependents, you must provide any requested information about them to UNITE HERE HEALTH within the time frames established by the Fund.

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

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

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

## When your coverage begins (initial eligibility)

Your coverage begins at 12:01 a.m. on the first day of the coverage period corresponding to the first work period for which contributions are required on your behalf, and for which you pay any applicable co-premiums, as long as you work during that month.

For purposes of establishing initial eligibility:

- **Work period** means the calendar month for which your employer must make contributions to UNITE HERE HEALTH on your behalf, and during which you meet the required eligibility requirement each month.
- **Lag period** means the calendar month between the end of a work period and the beginning of the corresponding coverage period.
- **Coverage period** means the calendar month for which coverage is in force as determined by the corresponding work period.

| Example: Establishing Initial Eligibility | | |
|---|---|---|
| **Work period** | **Lag period** | **Coverage period** |
| April | May | June |

Suppose you work the required hours, and your employer makes the required contributions, for April. Your coverage begins June 1.

## Continuing eligibility

Once you establish eligibility, you maintain eligibility when you continue to meet the work requirements specified in your CBA during the corresponding work periods.

For purposes of continuing eligibility:

- **Work period** means a calendar month for which your employer must make a contribution to UNITE HERE HEALTH on your behalf, including any co-premium you are required to contribute under the terms of your CBA, and during which you meet the eligibility requirement.
- **Lag period** means the calendar month between the end of a work period and the beginning of the corresponding coverage period.
- **Coverage period** means the calendar month during which coverage is in force as determined by the corresponding work periods.

| Example: Continuing Eligibility | | |
|---|---|---|
| **Work Month** | **Lag Period** | **Coverage Period** |
| May | June | July |
| June | July | August |

Suppose you work the required hours, and your employer makes the required contributions, for May. Your coverage continues during July. An employer contribution for June will continue your coverage during August, and so forth.

## Self-payments

### Self-payments during remodeling or restoration

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

### Self-payments during a strike

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

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

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

## Dependent coverage

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

You must enroll any dependents in order for them to be covered. Once your dependents are enrolled, their coverage will continue as long as you remain eligible and make any required co-premiums for the cost of their coverage directly to UNITE HERE HEALTH. Payments for

dependent coverage are due the 15th day of the month prior to the coverage month for which the co-premium buys coverage. For example, the dependent co-premium for the May coverage month is due April 15.

You can enroll your dependents during your initial enrollment period. You must submit the required enrollment materials and payments for the cost of your dependents' coverage. UNITE HERE HEALTH will tell you the date this information is due.

You can choose to have your dependents' coverage begin when your coverage begins by making your first payment for dependent coverage equal to 2 monthly payments. If your first payment for dependent coverage is equal to 1 monthly payment, your dependents' coverage will begin 2 months after your coverage begins.

Call UNITE HERE HEALTH for more information about immediate coverage, and dependent co-premiums requirements.

| Example: When dependent coverage starts | | |
|---|---|---|
| **Your Coverage Starts** | **First Payment for Dependent Coverage** | **Dependent Coverage Starts** |
| June 1 | Equal to 2 monthly payments | June 1 |
| *or* | | |
| June 1 | Equal to 1 monthly payment | August 1 |

## 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 F-8***) to enroll dependents.
- If you only chose coverage for yourself and one dependent when you became initially eligible, you have to wait until the next open enrollment or special enrollment period (***see page F-8***) to enroll more dependents.
- If you elected coverage for yourself and your family when you became initially eligible, you can add a dependent at any time. The dependent's coverage will start as explained below:
  - If you get married or 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 F-8***) will determine when the child becomes covered.
  - You can enroll a dependent who meets the Fund's definition of a dependent 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 dependent, coverage for the dependent will start on the first day of the month following the date you tell the Fund about the dependent.

# Enrollment periods

## Open enrollment periods

Open enrollment periods take place as designated by the Plan. They provide you with the opportunity to elect coverage for yourself if you did not enroll when you were first eligible to do so. Open enrollment periods also allow you to add or drop dependents. You must submit the required enrollment material and arrange to pay any required co-premiums.

## Special enrollment periods

In a few special circumstances, you do not need to wait for the open enrollment period to enroll yourself, or to add or drop dependents. You qualify for a special enrollment period by contacting the Fund 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 benefits.
- When you or a dependent becomes eligible for state financial assistance under a Medicaid or Child Health Insurance Program to help pay for the cost of UNITE HERE HEALTH's dependent coverage.

If you submit the required enrollment material as specified above, and make the required payments, coverage for your dependents will begin on the 1st day of the 2nd month following the month in which you start making your dependent co-premiums.

However, if you make an initial payment equal to 2 months of required payments plus any additional payments required until the month during which your first required payment is made, coverage for your dependents can begin as shown below:

- If you get married or the other coverage terminates, you and/or your dependents will be covered on the first day of the month following that date.
- If your child is born, you adopt a child, or a child is placed with you for adoption, or a dependent comes to the United States to take up residence with you, your dependents' coverage begins on that date.

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. ***See page F-8*** for an exception if you are already making co-premiums for coverage for your entire family.

# *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 F-5***. However, your coverage ends if one of the events described below happens. If your coverage terminates, you may be eligible to make self-payments to continue your coverage (called COBRA continuation coverage). ***See page F-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 **(833) 637-3519**.

## When employee coverage ends

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

- The date the Plan is terminated.
- The last day of the coverage period for which you were last credited with the minimum work requirements requiring your employer to make contributions on your behalf during the corresponding work period.
- The last day of the coverage period for which you last made any applicable co-premium for your share of the cost of coverage.
- The last day of the coverage period for which you last made a timely self-payment, if allowed to do so.

## When dependent coverage ends

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

- The date the Plan is terminated.
- Your (the employee's) coverage ends.
- The dependent enters any branch of the uniformed services.
- The last day of the coverage period for which you last made any applicable co-premium for your share of the cost of coverage.
- The last day of the month in which your dependent no longer meets the Plan's definition of a dependent (***see page F-3***).

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

## The effect of severely delinquent employer contributions

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

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

## Special termination rules

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

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

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

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

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

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

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

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

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

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

## Certificate of creditable coverage

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

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

# *Reestablishing eligibility*

Learn:

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

## Portability

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

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

## Family and Medical Leave Act (FMLA)

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

If you are making co-premiums for your coverage when your FMLA leave starts, you can continue your coverage during your leave by making any required co-premiums to your employer. If you stop making co-premiums, your coverage under the Plan will end. However, your coverage will start again on the first day of the month for which your employer must make a contribution on your behalf after you return to work, provided you begin making co-premiums as soon as you return to work. Your dependents' coverage will begin as described in the section titled "Dependent coverage"—see ***page F-6*** for more information.

## The effect of uniformed service

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

- You provide your employer with advance notice of your absence, whenever possible.
- Your cumulative length of absence for "eligible service" is not more than 5 years.
- You report or submit an application for re-employment within the following time limits:

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

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

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

Your dependents' coverage will begin as described in the section titled "Dependent coverage"—see ***page F-6*** for more information.

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

## Reestablishing eligibility lost for other reasons

### Reestablishing eligibility for employees

If you lose eligibility, and your loss of eligibility is less than 12 consecutive months, you can reestablish your eligibility by satisfying the Plan's continuing eligibility rules (***see page F-5***). If your loss of eligibility lasts for 12 or more months you must again satisfy the Plan's initial eligibility rules.

### Reestablishing eligibility for dependents

For losses of eligibility for reasons other than termination of employment, provided you start making dependent co-premiums again immediately upon your return to covered employment, your dependents' coverage will start as described on ***page F-6***.

# *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 F-3***).
- Your coverage under Medicare. (Medicare coverage means you are eligible to receive coverage under Medicare; you have applied or enrolled for that coverage, if an application is necessary; and your Medicare coverage is effective.)
- Your employer withdraws from UNITE HERE HEALTH.

## What coverage can be continued?

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

## How long can coverage be continued?

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

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

  However, you may be able to continue coverage for yourself and your dependents for up to an additional 11 months, for a total of 29 months. The Social Security Administration must determine that you or a covered dependent are disabled according to the terms of the Social Security Act of 1965 (as amended) any time during the first 60 days of continuation coverage.
- Up to 36 months from the date coverage would have originally ended for all other qualifying events (***see page F-20***), as long as those qualifying events would have resulted in a loss of coverage despite the occurrence of any previous qualifying event.

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

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

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

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

## Notifying UNITE HERE HEALTH when qualifying events occur

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



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

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

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

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

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

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

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

- 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: 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 the Fund at **(833) 637-3519**.

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

# *Claim filing and appeal provisions*

Learn how you file claims and appeal a denied claim:

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

## Filing a benefit claim

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

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

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

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

Claims for life insurance claims must include a certified copy of the death certificate. All claims for benefits must be made as shown in this section. If you need help filing a claim, call UNITE HERE HEALTH at **(833) 637-3519**.

**Prescription drug claims**

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

**Hospitality Rx**
**UNITE HERE HEALTH**
711 N. Commons Drive
Aurora, IL 60504

**Dental claims**

Generally you do not need to file a claim for dental care. Benefits are generally not available if you use a non-network dentist, except in an emergency. If you need to file a claim for dental care, mail the claim to:

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

**Vision claims**
If you use a VSP provider, the provider should file the claim for you. If you use a non-network provider, you usually have to pay the provider's charges when you get the vision care or supplies. You then must file a claim form with VSP to get paid back for your vision care:

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

**Life insurance claims**
Call the Fund at **(833) 637-3519** for help filing life and AD&D claims. After the Fund helps you initiate the claim, Dearborn National will contact you (or your beneficiary) to complete the claim filing process. A claim for life insurance benefits must include a copy of the certified death certificate.

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

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

**All other benefit claims, including healthcare claims under the medical benefit**
All short-term disability claims and claims for healthcare services or supplies should be mailed to UNITE HERE HEALTH. All claims, including healthcare claims, prescription drug claims, and dental and vision claims denied because you are not eligible should also be mailed to:

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

## Deadlines for filing a benefit claim

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

| Deadline for filing a claim | |
|---|---|
| **Type of claim** | **Deadline to file** |
| Life insurance | Within a reasonable amount of time |
| AD&D insurance | • Written notice must be received within 31 days of loss (or as soon as possible).<br>• Written proof of loss must be received within 90 days of loss (or as soon as possible). Other deadlines may apply to your additional AD&D insurance benefits—your insurance certificate provides more information. |
| Dental claims | 1 year following the date the claim was incurred |
| Vision claims | 365 days following the date the claim was incurred |
| All other claims (including healthcare and prescription drug claims) | 18 months following the date the claim was incurred |

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

## Individuals who may file a benefit claim

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

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

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

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

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

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

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

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

## Determination of claims

**Post-service healthcare claims not involving concurrent care decisions**
You will be notified of the decision within a reasonable period of time appropriate to your medical circumstances, but no later than 30 days after getting your claim. In general, benefits for medical/surgical services will be paid to the provider of those services.

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

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

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

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

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

**Life insurance claims**
In general, you will be notified of the decision on your claim for life insurance claims no later than 90 days after your claim is received.

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

## Rules for prior authorization of benefits

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

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

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

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

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

### Special rules for decisions involving urgent concurrent care

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

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

### If a request for prior authorization is denied

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

### Appealing a benefit prior authorization denial

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

## If a benefit claim is denied

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

### Life insurance claims

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

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

### Appealing claim denials (other than life insurance claims)

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

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

## Two levels of appeal for dental claims

The claim processing rules, time limits, and appeal procedures Cigna must follow are described in the Cigna contract. Generally, if a claim is denied, you must request a review within 365 days of your receipt of the denial. Cigna will respond to your appeal within 30 days, but may take an additional 15 days. If you appeal the first-level appeal, you can file a second-level appeal within 365 days of your receipt of Cigna's decision on your first-level appeal. Cigna will generally respond to your second-level appeal within 30 days, but may take an additional 15 days. You may be able to file an appeal with an independent review organization—see your Cigna booklet for more information about filing claims and appeals. If you need help filing a claim or appeal, or have questions about how Cigna's claim and appeal process works, contact Cigna:

**Cigna**
P.O. Box 188037
Chattanooga, TN 37422-8037
**(800) 244-6224**
www.mycigna.com

## Two levels of appeal for vision care claims

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:

**VSP**
3333 Quality Drive
Rancho Cordova, CA 95670
**(800) 877-7195**
www.vsp.com

## Two levels of appeals for prescription drug claim denials

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

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

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

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

## One level of appeal for most other claims

If you disagree with all or any part of any other healthcare claim and you wish to appeal the decision, you must follow the steps in this section.

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

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

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

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

## Appeals involving urgent care claims

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

- **(630) 699-4372** for urgent healthcare appeals.
- **(844) 484-4726** for urgent prescription drug appeals.

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

## Appeals under the sole authority of the plan administrator

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

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

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

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

## Review of appeals

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

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

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

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

## Notice of the decision on your appeal

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

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

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

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

## Independent external review procedures

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

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

- You must have been eligible for benefits at the time you incurred the medical expense.
- Your claim must relate to an issue that involved medical judgment or rescission of coverage.
- You must have exhausted your internal appeal rights, unless you are deemed to have exhausted all levels of the internal appeals process.

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

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

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

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

### Internal Appeal Exception

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

If you believe the Plan violated its own internal procedures, you may ask the Plan for a written explanation of the violation. The Plan will provide you with an answer within ten (10) days. To use this exception, you must request external review or commence a legal action no later than 180 days after receipt of the initial adverse determination.

If the court or external reviewer rejects your request for immediate review, the Plan will notify you (within 10 days) of your right to pursue internal appeal. The applicable time limit for you to now file your internal appeal will begin to run when you receive that notice from the Plan.

## Non-assignment of claims

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

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

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

## Commencement of legal action

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

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

# *Definitions*

## Learn:

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

***The definitions in this section do not apply to any benefits provided through the dental or the vision benefits. Call the Fund at (833) 637-3519 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 this Plan uses to calculate the benefits it pays for a claim. If you choose a non-network provider, the provider may charge more than the **allowable charge**. You must pay this difference between the actual charges and the **allowable charges**. 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. Except when a different allowable charge is required by federal law for non-network emergency medical treatment, the Plan calculates benefits (if any) for non-network providers based on established discounted rates, such as Medicare rates, or the contracted network rates. This Plan will not pay the difference between what a non-network provider actually charges, and what is considered an **allowable charge**. You pay this difference in cost. (This is sometimes called "balance billing.")

## Copay or copayment

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

Your medical and prescription drug **copays** apply to your out-of pocket limits (***see page C-2*** and ***see page C-9***).

You can get more information about your medical and prescription drug copays, or any applicable 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 you fill a prescription for a covered specialty drug through the specialty pharmacy, you pay 25% of the cost of the drug (up to $50). The Fund pays the rest of the allowable charge.

Your prescription drug **coinsurance** counts toward your prescription drug out-of-pocket limits.

## Covered expense

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

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

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

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

## Healthcare provider

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

A **primary care provider** (PCP) is defined as a provider who has completed the necessary training and education to practice in the following fields:

- 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 has received training and education in a particular medical specialty. A specialist is a provider who does not practice in one of the primary care fields described above.

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 li-

cense. 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 clinic) that provides treatment, services, or supplies.

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

## Injuries and sicknesses

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

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

The Plan only pays benefits for preventive healthcare for a pregnant dependent child. *Maternity charges for a pregnant dependent child that are not preventive healthcare (**see page H-5**) 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 F-3***).

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

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

## Medically necessary

**Medically necessary** services, supplies, and treatment are:

- Consistent with and effective for the injury or sickness being treated;
- Considered good medical practice according to standards recognized by the organized medical community in the United States; and
- Not experimental or investigational (***see page H-3***), nor unproven as determined by appropriate governmental agencies, the organized medical community in the United States, or standards or procedures adopted from time-to-time by the Trustees.

The Board of Trustees has the sole authority to determine whether care and treatment is **medically necessary**, and whether care and treatment is experimental or investigational. In all cases, the

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

## Out-of-Pocket limit for network care and treatment

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

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

You can get more information about your **out-of-pocket limits** *on page C-2* and *on page C-9*.

## Plan Document

The rules and regulations governing the Plan of benefits provided to eligible employees and dependents participating in Plan Unit 123E (National Plan E).

## Preventive healthcare

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

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

Certain **preventive healthcare** may be covered more liberally (for example, more frequently or

at earlier/later ages) than required. The Plan also considers routine PSA screening tests (prostate-specific antigen tests) to be preventive healthcare.

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

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

# *Other important information*

## Who pays for your benefits?

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

## What benefits are provided through insurance companies?

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

- Medical benefits.
- Prescription drug benefits. These benefits are administered by Hospitality Rx, LLC, a wholly owned subsidiary of UNITE HERE HEALTH.
- Short-term disability benefits.

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

- Life and AD&D insurance benefits through Dearborn National.
- Dental benefits through Cigna.
- Vision benefits through Vision Service Plan, Inc. (VSP).

## Interpretation of Plan provisions

For claims subject to independent external review (***see page G-11***), the IRO has the authority to make decisions about benefits, and decide all questions about claims, submitted for independent external review.

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

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

- Make the final decisions about applications for or entitlement to Plan benefits, including:
  - The exclusive discretion to increase, decrease, or otherwise change Plan provisions for the efficient administration of the Plan or to further the purposes of UNITE HERE HEALTH,

  - The right to obtain or provide information needed to coordinate benefit payments with other plans,
  - The right to obtain second medical or dental opinions or to have an autopsy performed when not forbidden by law;
- Interpret all Plan provisions and associated administrative rules and procedures;
- Authorize all payments under the Plan or recover any amounts in excess of the total amounts required by the Plan.

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

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

## Amendment or termination of the Plan

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

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

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

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

## Free choice of provider

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

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

## Workers' compensation

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

## Type of Plan

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

## Employer and employee organizations

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

## Plan administrator and agent for service of legal process

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

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

## Employer identification number

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

## Plan number

The Plan number is 501.

## Plan year

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

## Remedies for fraud

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

## Limited retroactive terminations of coverage allowed

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

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

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

# *Your rights under ERISA*

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

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

## Receive information about your Plan and benefits

ERISA provides that all Plan participants shall be entitled to:

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

## Continue group health Plan coverage

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

## Prudent actions by Plan fiduciaries

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

## Enforce your rights

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

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

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

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

## Assistance with your questions

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

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

# Important phone numbers and addresses

**Blue Cross and Blue Shield of Illinois**
300 East Randolph Street
Chicago, IL 60601-5099
**(800) 810-2583**
www.bcbsil.com

**Cigna Health and Life Insurance Company (Cigna)**
900 Cottage Grove Road
Bloomfield, CT 06002
**(800) 244-6224**
www.cigna.com

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

**Hospitality Rx**
P.O. Box 6020
Aurora, IL 60598-0020
**(844) 484-4726**
www.hospitalityrx.org

**UNITE HERE HEALTH**
711 North Commons Drive
Aurora, IL 60504
**(833) 637-3519**
www.uhh.org

**Vision Service Plan (VSP)**
3333 Quality Drive
Rancho Cordova, CA 95670
**(800) 852-7600**
www.vsp.com

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