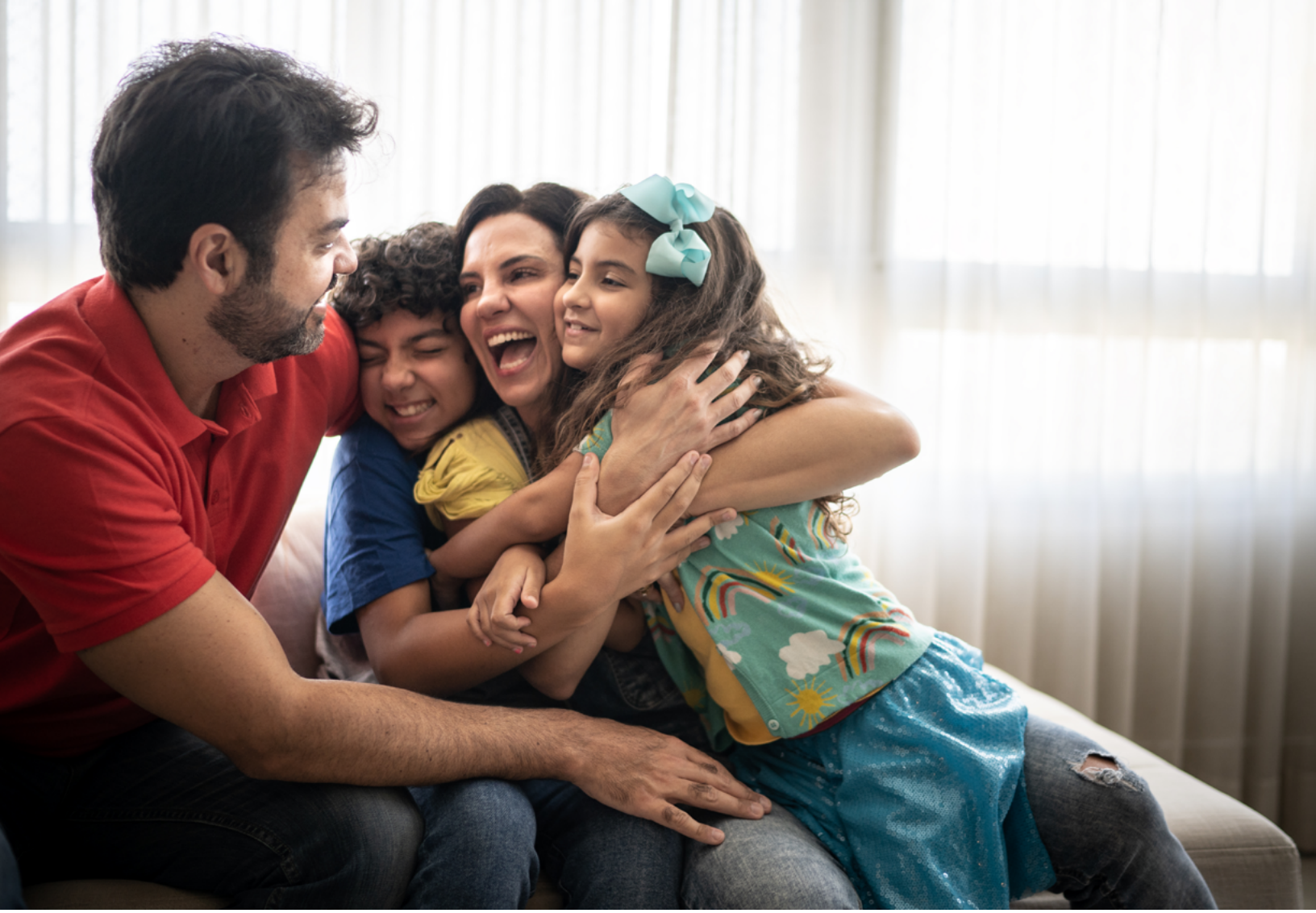

UNITE HERE HEALTH

Pittsburgh

Plan Unit 106

Summary Plan Description

Your Health and Welfare Benefits

Your plan is a grandfathered health plan

UNITE HERE HEALTH believes that your plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (Affordable Care Act). As allowed by the act, these plans can preserve certain basic health coverage that was already in place when that law went into effect on March 23, 2010.

As a grandfathered plan, your plan must comply with various benefit changes required by the Affordable Care Act (like the elimination of lifetime limits on benefits). However, please note that these plans don't have to implement all benefit changes provided for in the act.

Contact us with your questions or complaints:

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

We can answer questions like:

- Which provisions of the Affordable Care Act apply to a grandfathered health plan?
- Which provisions do not apply?
- What actions by the plan might cause it to lose grandfathered status?

You may also contact the Employee Benefit Security Administration, U.S. Department of Labor:

- **(866) 444-3272**
- www.dol.gov/ebsa/healthreform
  (This website features a table that outlines which protections do or do not apply to grandfathered plans)

UNITE HERE HEALTH

Summary Plan Description
Pittsburgh
Plan Unit 106

Effective August 1, 2023

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

This booklet contains a summary in English of your plan rights and benefits under UNITE HERE HEALTH. If you have difficulty understanding any part of this booklet, you can call UNITE HERE HEALTH at (866) 686-0003 (TTY: (855) 386-3889 or (855) FUNDTTY) for assistance.

Este folleto contiene un resumen en inglés de sus derechos y beneficios de su plan bajo UNITE HERE HEALTH. Si usted tiene problemas entendiendo cualquier parte de este folleto, usted puede llamar a UNITE HERE HEALTH al (866) 686-0003 (TTY: (855) 386-3889 o (855) FUNDTTY) para asistencia.

本手冊以英文簡要介紹 UNITE HERE HEALTH 計畫的權利及福利。如果您無法了解本手冊的任何內容，請造訪或聯絡 Chicago 地區辦事處 218 South Wabash Avenue, Suite 800, Chicago, IL 60604。您可以致電 UNITE HERE HEALTH *(866) 686-0003*(TTY（聽障專線）: (855) 386-3889 或 (855) FUNDTTY) 尋求協助。

Table of Contents

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, or a Participation Agreement (PA) between the employer and UNITE HERE HEALTH.

Your coverage is being offered under Plan Unit 106 (Pittsburgh), 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 contact the Fund at **(866) 686-0003**. The Fund can help you understand how your benefits work.

Read your SPD for important information about what your benefits are, how your benefits are paid, and what rules you may need to follow. You can find more information about a specific benefit in the applicable section. For example, you can get more information about your medical benefits in the section titled "Medical benefits." If you want to know more about your life or AD&D benefits, read the section titled "Life and AD&D benefits."

Some terms are defined for you in the section titled "Definitions" starting *on page I-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 **(866) 686-0003**.

How can I get help?

UNITE HERE HEALTH
(866) 686-0003 or **(855) 386-3889 (TTY)**
www.uhh.org

Call the Fund:

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

Download the UHH Member Portal mobile app! Get 24/7 access to your benefits and more!

To download the app, scan the QR code or search "UHH Member Portal" in your app store.

iPhone ***Android***

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 (866) 686-0003 (TTY: (855) 386-3889 or (855) FUNDTTY) for assistance.

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本手冊以英文簡要介紹 UNITE HERE HEALTH 計畫的權利及福利。如果您無法了解本手冊的任何內容，請造訪或聯絡 Chicago 地區辦事處 218 South Wabash Avenue, Suite 800, Chicago, IL 60604。您可以致電 UNITE HERE HEALTH *(866) 686-0003*(TTY（聽障專線）：(855) 386-3889 或 (855) FUNDTTY) 尋求協助。

How do I get the most from my benefits?

Learn:

- Why you should get a primary care provider.
- Why you should get preventive healthcare.
- How to reduce your costs for urgent care.
- Why you should get prior authorization for your care.
- 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.

Make sure you or your PCP calls Healthcheck360 before your first visit to a specialist. **You can save $10 if you call Healthcheck360 before you see a specialist.**

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

✓ Call Healthcheck360 to get help finding a PCP or a specialist.

Get preventive healthcare

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

See page *D-5* for more information about preventive healthcare.

Re-think emergency room care

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

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

Get prior authorization for your care

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

✓ Call HealthCheck360 at **(844) 462-7812**.

Use network providers

Reduce your costs with a network provider

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

How do I stay in the medical network?

If you need help finding a network provider, go to the part of your SPD that explains your specific healthcare benefits. The information in that part of your SPD will tell you how to stay in network. You can also go to www.uhh.org for links to your provider networks.

If you have questions about your benefits or benefit options, call the Fund at **(866) 686-0003**.

Programs to help you

The Fund may, from time to time, offer certain educational or informational programs. These programs will be available at the Fund's sole discretion and may only be offered to certain participants. The Fund will send out information about the programs as available.

Summary of benefits

Please call the Fund with questions about your benefits: **(866) 686-0003**

Medical Benefits

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

This section shows what you pay for your care (called your "cost-sharing"). You pay any deductibles or copays, your coinsurance share, any amounts over a maximum benefit, and expenses that are not covered, including any charges that are more than the allowable charge when you use a non-network provider, unless federal surprise billing protections apply, *see page I-2* for more information.

If you do not call HealthCheck360 at **(866) 866-0003** for prior authorization, your claim could be denied entirely. *See page C-2* for more information.

CLASS I

Class I Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Calendar Year Deductibles		
Calendar Year Deductibles	$100/person $200/family	$500/person
Annual Out-of-Pocket Limits for Medical Care		
For Network Medical Care *The most you pay out-of-pocket for deductibles and coinsurance for certain covered network medical expenses in a calendar year*	$1,000/person	n/a
Preventive Healthcare Services—*see page D-5 for age/frequency information*		
Well Baby Care— *for children under age 6 only*	$15 copay/visit	Not covered
Routine Gynecological Exam	$0	
Routine Mammograms		
Routine Prostate Cancer Screening		
Routine Physical Exam		
Routine Colorectal Cancer Screening		
Routine Immunizations		

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) as described *on page H-12.*

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.

Class I Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Office Visits		
Primary Care Provider (PCP) Office Visit	$10 copay/visit	50% after deductible
Specialist Visit: When your PCP provides a referral before your visit (*see page C-2*) When your PCP does not provide a referral before your visit	$10 copay/visit $20 copay/visit	
Mental Health/Substance Abuse Office Visit	$10 copay/visit	
Routine Podiatry— *up to $25 per visit, and $500 per person each calendar year*	$0	Not covered
Non-Routine Podiatry	10% after deducible	
Chiropractic Care— *Not including chiropractic x-rays; up to $25 per visit and $600 per person each calendar year*	$0	
X-Rays for Chiropractic Care— *up to $400 per person each calendar year*	10% after deductible	
Emergency and Urgent Care		
Urgent Care Center	$20 copay/visit	50% after deductible
Emergency Room Treatment— *copay waived if admitted*	$50 copay/visit, then 10%	
Professional Ambulance Services	10% after deductible	
Outpatient Services		
Laboratory Services and Radiology	$0	50%
Diagnostic Imaging— *MRI, MRA, CT Scans*	10% after deductible	50% after deductible
Outpatient Surgery		
Physical, Speech, and Occupational Therapy— *up to 30 visits per person each calendar year (combined)*		

Class I Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Habilitative Therapy for Children with Autism Spectrum Disorder — *certain limits apply (see page D-7)*	$10 copay/visit	50% after deductible
Certified Diabetes Educator	$0	Not covered
Registered Dietitian — *up to $200 per person each calendar year*		
Inpatient Services		
Inpatient Hospitalization	10% after deductible	50% after deductible
Inpatient Hospitalization for Mental Health/ Substance Abuse Treatment *including residential treatment*		
Skilled Nursing Facility — *up to 60 total days per person each calendar year; no more than 30 non-network days*		
Other Services and Supplies		
Home Healthcare Services — *up to 60 total visits per person each calendar year; no more than 30 non-network visits*	10% after deductible	50% after deductible
Hospice Care		
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment		
Durable Medical Equipment		
Travel and Lodging— *see page D-10 for information*	Plan pays 100% up to $10,000 per episode of care, including up to $200 per day for lodging and up to $50 per day for meals	
Medical Foods—*see page D-10 for information*	Plan reimburses you 100%	
All Other Covered Expenses	10% after deductible	50% after deductible

Class I Prescription Drug Benefits—What You Pay		
	Per Prescription	
Formulary Prescription Drug Benefits at Network Retail Pharmacies and Mail Order	**Retail Pharmacy** *up to a 34-day supply*	**Mail Order** *up to a 60-day supply*
Smoking Cessation Drugs and Supplies—*including prescription generic over-the-counter products, generic products, and certain brand products*	$0	
Covered Immunizations		
Generic and Some Brand Drugs	$3	
Preferred Drugs	$12	
Non-Preferred Drugs	$27	
Non-Formulary Prescription Drugs and Supplies	Not covered, unless an exception is approved	
** Current pharmacy benefit provider will actively manage and determine drugs in tier. Specialty drugs are only available through the specialty mail order pharmacy. However, if you take specialty medications as part of your HIV treatment plan, you may be able to receive an exception to use your network retail pharmacy instead.*		

Class I Dental Benefits —What the Plan Pays	
Maximum Benefit Payable Each Calendar Year	$1,000 per person *Maximum benefit does not apply to the following services for persons under age 19: dental exams, routine x-rays, routine cleanings, fluoride, or sealants*
Calendar Year Deductible	None
Description of Common Dental Care	**Maximum Benefit Payable Plan pays 100% up to:**
Periodic Oral Exam	$17
Routine Cleaning (Prophylaxis)	$51 – adults $36 – children
Routine X-Ray Services	$75 – complete set $35 – bitewings
Amalgam Restorative Services	$65 – 1 tooth surface $85 – 2 tooth surface
One Surface Metallic Inlay	$220
Crowns	$315 – resin with high noble metal $337 – porcelain fused to high noble metal
Anterior Root Canal	$188
Oral Surgery — *includes local anesthesia*	$40 – single tooth $75 – erupted tooth $113 – impacted, partially bony tooth
Complete Upper Dentures	$438
Fixed Bridgework	$320 – pontic case high noble metal $330 – pontic porcelain fused to high noble metal

Class I Vision Benefits — What You Pay *Employees only*		
Description of Services *Benefits covered once every calendar year*	**Davis Vision Network Provider**	**Non-Network Provider**
Eye Exam	$0 copay	$0 copay; $75 maximum
Retinal Imaging	$20 copay	Not covered
Lenses	$0 copay	$0 copay; $175 maximum for all materials, evaluations, and fittings combined
Frames	$0 copay for Davis collection Fashion, Designer, or Premier frames; $0 copay; $150 benefit maximum for all other frames	
Elective Contact Lenses (instead of glasses)	$0 copay for Davis collection contacts; $0 copay; $150 benefit maximum plus $60 benefit maximum for the evaluation and fitting, for all other contacts	
Medically Necessary Contact Lenses	$0 copay	

Class I Short-Term Disability Benefit — What the Plan Pays *Employees only*	
Amount of Benefit	$150/week for up to 13 weeks
Benefits Start:	
Due to Injury	1st day
Due to Sickness	8th day

Class I Life and AD&D Benefit — What the Plan Pays *Employees only*	
Life Insurance	
Employees Only	$20,000
Accidental Death and Dismemberment (AD&D) Insurance	
Employees Only *(full amount)*	$20,000

Retiree Death Benefit — What the Plan Pays *Certain retirees only*	
Life Insurance	
Retirees Only *for retirees who retired before December 1, 2019*	$1,000

CLASS II

Class II Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Calendar Year Deductibles		
Calendar Year Deductibles	$250/person	$500/person
Annual Out-of-Pocket Limits for Medical Care		
For Network Medical Care *The most you pay out-of-pocket for deductibles and coinsurance for certain covered network medical expenses in a calendar year*	$2,500/person	n/a
Preventive Healthcare Services—*see page D-5 for age/frequency information*		
Well Baby Care— *for children under age 6 only*	$15 copay/visit	Not covered
Routine Gynecological Exam	$0	
Routine Mammograms		
Routine Prostate Cancer Screening		
Routine Colorectal Cancer Screening		
Routine Immunizations		
Office Visits		
Primary Care Provider (PCP) Office Visit	$10 copay/visit	50% after deductible
Specialist Visit: When your PCP provides a referral before your visit (*see page C-2*) When your PCP does not provide a referral before your visit	$10 copay/visit $20 copay/visit	
Mental Health/Substance Abuse Office Visit	$10 copay/visit	
Routine Podiatry— *up to $25 per visit, and $500 per person each calendar year*	20%	Not covered
Non-Routine Podiatry	20% after deducible	

Class II Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Chiropractic Care— *Not including chiropractic x-rays; up to $25 per visit and $600 per person each calendar year*	20% after deductible	Not covered
X-Rays for Chiropractic Care— *up to $400 per person each calendar year*		
Emergency and Urgent Care		
Urgent Care Center	$20 copay/visit	50% after deductible
Emergency Room Treatment— *copay waived if admitted*	$50 copay/visit, then 20%	
Professional Ambulance Services	20% after deductible	
Outpatient Services		
Laboratory Services and Radiology	20%	50%
Diagnostic Imaging— *MRI, MRA, CT Scans*	20% after deductible	50% after deductible
Outpatient Surgery		
Physical, Speech, and Occupational Therapy— *up to 30 visits per person each calendar year (combined)*		
Habilitative Therapy for Children with Autism Spectrum Disorder — *certain limits apply* *(see page D-7)*	$10 copay/visit	
Certified Diabetes Educator	$0	Not covered
Registered Dietitian — *up to $200 per person each calendar year*		
Inpatient Services		
Inpatient Hospitalization	20% after deductible	50% after deductible
Inpatient Hospitalization for Mental Health/ Substance Abuse Treatment *including residential treatment*		
Skilled Nursing Facility — *up to 60 total days per person each calendar year; no more than 30 non-network days*		

Class II Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Other Services and Supplies		
Home Healthcare Services — *up to 60 total visits per person each calendar year; no more than 30 non-network visits*	20% after deductible	50% after deductible
Hospice Care		
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment		
Durable Medical Equipment		
Travel and Lodging— *see page D-10 for information*	Plan pays 100% up to $10,000 per episode of care, including up to $200 per day for lodging and up to $50 per day for meals	
Medical Foods—*see page D-10 for information*	Plan reimburses you 100%	
All Other Covered Expenses	20% after deductible	50% after deductible

Class II Prescription Drug Benefits—What You Pay		
	Per Prescription	
Formulary Prescription Drug Benefits at Network Retail Pharmacies and Mail Order	**Retail Pharmacy** *up to a 34-day supply*	**Mail Order** *up to a 60-day supply*
Smoking Cessation Drugs and Supplies— *including prescription generic over-the-counter products, generic products, and certain brand products*	$0	
Covered Immunizations		
Generic and Some Brand Drugs	$3	
Preferred Drugs	$12	
Non-Preferred Drugs	$27	
Non-Formulary Prescription Drugs and Supplies	Not covered, unless an exception is approved	
** Current pharmacy benefit provider will actively manage and determine drugs in tier. Specialty drugs are only available through the specialty mail order pharmacy. However, if you take specialty medications as part of your HIV treatment plan, you may be able to receive an exception to use your network retail pharmacy instead.*		

Class II Dental Benefits —What the Plan Pays	
Maximum Benefit Payable Each Calendar Year	$1,000 per person *Maximum benefit does not apply to the following services for persons under age 19: dental exams, routine x-rays, routine cleanings, fluoride, or sealants*
Calendar Year Deductible	None
Description of Common Dental Care	**Maximum Benefit Payable Plan pays 100% up to:**
Periodic Oral Exam	$17
Routine Cleaning (Prophylaxis)	$51 – adults $36 – children
Routine X-Ray Services	$75 – complete set $35 – bitewings
Amalgam Restorative Services	$65 – 1 tooth surface $85 – 2 tooth surface
One Surface Metallic Inlay	$220
Crowns	$315 – resin with high noble metal $337 – porcelain fused to high noble metal
Anterior Root Canal	$188
Oral Surgery — *includes local anesthesia*	$40 – single tooth $75 – erupted tooth $113 – impacted, partially bony tooth
Complete Upper Dentures	$438
Fixed Bridgework	$320 – pontic case high noble metal $330 – pontic porcelain fused to high noble metal

Class II Vision Benefits — What You Pay *Employees only*		
Description of Services *Benefits covered once every calendar year*	**Davis Vision Network Provider**	**Non-Network Provider**
Eye Exam	$0 copay	$0 copay; $75 maximum
Retinal Imaging	$20 copay	Not covered
Lenses	$0 copay	$0 copay; $175 maximum for all materials, evaluations, and fittings combined
Frames	$0 copay for Davis collection Fashion, Designer, or Premier frames; $0 copay; $150 benefit maximum for all other frames	
Elective Contact Lenses (instead of glasses)	$0 copay for Davis collection contacts; $0 copay; $150 benefit maximum plus $60 benefit maximum for the evaluation and fitting, for all other contacts	
Medically Necessary Contact Lenses	$0 copay	

Class II Life and AD&D Benefit — What the Plan Pays *Employees only*	
Life Insurance	
Employees Only	$20,000
Accidental Death and Dismemberment (AD&D) Insurance	
Employees Only *(full amount)*	$20,000

Retiree Death Benefit — What the Plan Pays *Certain retirees only*	
Life Insurance	
Retirees Only *for retirees who retired before December 1, 2019*	$1,000

CLASS III

Class III Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Calendar Year Deductibles		
Calendar Year Deductibles	$100/person $200/family	$500/person
Annual Out-of-Pocket Limits for Medical Care		
For Network Medical Care *The most you pay out-of-pocket for deductibles and coinsurance for certain covered network medical expenses in a calendar year*	$1,000/person	n/a
Preventive Healthcare Services—*see page D-5 for age/frequency information*		
Well Baby Care— *for children under age 6 only*	$15 copay/visit	Not covered
Routine Gynecological Exam	$0	
Routine Mammograms		
Routine Prostate Cancer Screening		
Routine Physical Exam		
Routine Colorectal Cancer Screening		
Routine Immunizations		
Office Visits		
Primary Care Provider (PCP) Office Visit	$10 copay/visit	50% after deductible
Specialist Visit:		
When your PCP provides a referral before your visit (*see page C-2*)	$10 copay/visit	
When your PCP does not provide a referral before your visit	$20 copay/visit	
Mental Health/Substance Abuse Office Visit	$10 copay/visit	
Routine Podiatry— *up to $25 per visit, and $500 per person each calendar year*	$0	Not covered
Non-Routine Podiatry	10% after deducible	

Class III Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Chiropractic Care— *Not including chiropractic x-rays; up to $25 per visit and $600 per person each calendar year*	$0	Not covered
X-Rays for Chiropractic Care— *up to $400 per person each calendar year*	10% after deductible	
Emergency and Urgent Care		
Urgent Care Center	$20 copay/visit	50% after deductible
Emergency Room Treatment— *copay waived if admitted*	$50 copay/visit, then 10%	
Professional Ambulance Services	10% after deductible	
Outpatient Services		
Laboratory Services and Radiology	$0	50%
Diagnostic Imaging— *MRI, MRA, CT Scans*	10% after deductible	50% after deductible
Outpatient Surgery		
Physical, Speech, and Occupational Therapy— *up to 30 visits per person each calendar year (combined)*		
Habilitative Therapy for Children with Autism Spectrum Disorder — *certain limits apply* *(see page D-7)*	$10 copay/visit	
Certified Diabetes Educator	$0	Not covered
Registered Dietitian — *up to $200 per person each calendar year*		
Inpatient Services		
Inpatient Hospitalization	10% after deductible	50% after deductible
Inpatient Hospitalization for Mental Health/ Substance Abuse Treatment *including residential treatment*		

Class III Medical Benefits—What You Pay		
	Network Provider	**Non-Network Provider**
Skilled Nursing Facility — *up to 60 total days per person each calendar year; no more than 30 non-network days*	10% after deductible	50% after deductible
Other Services and Supplies		
Home Healthcare Services — *up to 60 total visits per person each calendar year; no more than 30 non-network visits*	10% after deductible	50% after deductible
Hospice Care		
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment		
Durable Medical Equipment		
Travel and Lodging— *see page D-10 for information*	Plan pays 100% up to $10,000 per episode of care, including up to $200 per day for lodging and up to $50 per day for meals	
Medical Foods—*see page D-10 for information*	Plan reimburses you 100%	
All Other Covered Expenses	10% after deductible	50% after deductible

Class III Prescription Drug Benefits—What You Pay		
	Per Prescription	
Formulary Prescription Drug Benefits at Network Retail Pharmacies and Mail Order	**Retail Pharmacy** *up to a 34-day supply*	**Mail Order** *up to a 60-day supply*
Smoking Cessation Drugs and Supplies— *including prescription generic over-the-counter products, generic products, and certain brand products*	$0	
Covered Immunizations		
Generic and Some Brand Drugs	$3	
Preferred Drugs	$12	
Non-Preferred Drugs	$27	
Non-Formulary Prescription Drugs and Supplies	Not covered, unless an exception is approved	
** Current pharmacy benefit provider will actively manage and determine drugs in tier. Specialty drugs are only available through the specialty mail order pharmacy. However, if you take specialty medications as part of your HIV treatment plan, you may be able to receive an exception to use your network retail pharmacy instead.*		

Class III Life and AD&D Benefit — What the Plan Pays *Employees only*	
Life Insurance	
Employees Only	$20,000
Accidental Death and Dismemberment (AD&D) Insurance	
Employees Only *(full amount)*	$20,000

Retiree Death Benefit — What the Plan Pays *Certain retirees only*	
Life Insurance	
Retirees Only *for retirees who retired before December 1, 2019*	$1,000

Prior authorization program

Learn:

- About the specialist referral program.
- About getting prior authorization for your care.
- About the case management program.

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

To get prior authorization, call toll free:
HealthCheck360
(844) 462-7812

24/7 nurse line
(866) 823-9827

The prior authorization program is not medical advice. You are still responsible for making any decisions about medical matters. UNITE HERE HEALTH, your health fund ("the Fund"), is not responsible for any consequences resulting from decisions you or your provider make based on the prior authorization program or the Plan's determination of the benefits it will pay.

Specialist referral program/reduced specialist copay

You should choose a primary care provider (PCP) for yourself and for each of your dependents. You can all have the same PCP, or you can each choose different PCPs. For children, you may designate a pediatrician as your child's PCP. Remember, you save money if you use a network PCP. You have the right to designate any PCP, whether the provider participates in the network or not, who is available to accept you or your family members. You can change your PCP at any time. If you don't have a PCP, the Fund can help you find one.

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

- Family medicine.
- General practice.
- Internal medicine.
- Pediatrics (for children).
- Obstetrics/gynecology (while you are pregnant).

✓ You or your PCP should call HealthCheck360 if you need to see a specialist. However, it is up to you to make sure HealthCheck360 is contacted before you go to a specialist in order to pay the lower specialist copay. You can always contact HealthCheck360 to see if your PCP has provided the referral.

✓ You do not need a referral for: preventive care, acupuncture, chiropractic care, mental health/substance abuse treatment, routine podiatry, and physical, occupational, or speech therapy.

If you need to see a specialist, ask your PCP to contact HealthCheck360 with the referral. HealthCheck360 may send your PCP information about your healthcare services so your PCP can coordinate your care.

HealthCheck360 will send you a letter telling you when your referral to the specialist was approved, and how many visits are approved or how long the approval lasts (such as 6 months). You do not need another referral for that type of specialist until you use all of the pre-approved visits, or until after the approved period of time. If you still need specialist care, ask your PCP to contact HealthCheck360 again.

- If your PCP contacts HealthCheck360 about the network specialist visit, your copay will be $10. Any PCP can make this referral, including a non-network PCP.
- If your PCP does not contact HealthCheck360 before you see a network specialist, your copay will be $20. Your copay will NOT be reduced to $10 if your PCP calls after the specialist visit. However, if your PCP contacts HealthCheck360 before your next specialist visit, your copay for that visit will only be $10.
- If you choose a non-network specialist, you pay 50% (after deductible) of the allowable charges for the visit. HealthCheck360 can still coordinate your care, even if you choose a non-network specialist.

Although an OB/GYN (or other provider specializing in obstetrics or gynecology) is only considered a PCP if you are pregnant, the $10 PCP copay applies to each network office visit to an OB/GYN. HealthCheck360 can help coordinate your care between the OB/GYN and your PCP.

You do not need prior authorization from HealthCheck360 in order to access obstetrical or gynecological care from a network healthcare provider who specializes in obstetrics or gynecology. The healthcare provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For help finding participating healthcare providers who specialize in obstetrics or gynecology, contact HealthCheck360 at **(844) 462-7812**.

Get prior authorization for certain services and supplies

✓ If you use a network provider for an inpatient stay, the inpatient facility must get prior authorization for you.

You or your healthcare provider must get prior authorization before you get any of the types of care listed below. If you don't get prior authorization before you receive these types of care, your claim may be denied. Making sure you get prior authorization first helps you avoid surprise medical bills. **If you get treatment, services, or supplies that are not approved, not covered, or are not medically necessary, you pay 100% of your care.**

HealthCheck360
(844) 462-7812

✓ Prior authorization does not guarantee eligibility for benefits. The payment of Plan benefits are subject to all Plan rules, including but not limited to eligibility, cost sharing, and exclusions.

When to call for prior authorization

✓ The prior authorization list may change from time to time. Contact the Fund at **(866) 686-0003** for the most up-to-date information.

You or your healthcare provider should get prior authorization before any of the following:

- Any inpatient admission, regardless of the type of facility or care, including but not limited to skilled nursing facility care, hospice care, acute rehabilitation care, long-term acute facility care, residential treatment, maternity admissions following 48 hours for a vaginal delivery and 96 hours following a Cesarean delivery, and elective Cesarean section (C-section) admissions under 38 weeks
- Non-emergency air ambulance transportation
- Bariatric surgery (including but not limited to gastric bypass and banding procedures)
- Blepharoplasty
- Chemotherapy
- Clinical trials
- Diagnostic imaging services as follows:
  - CT, CTA, and CAT scans (computed tomography scintiscan or computerized axial tomography scintiscan)

  - MRA and MRI (magnetic resonance angiography or magnetic resonance imaging)
  - PET scan (positron emission tomography scintiscan)
- Dialysis – notification only
- Durable medical equipment over $500 (including breast pumps costing over $500)
- Electroconvulsive therapy (ECT)
- Gender reassignment surgical services and certain hormone therapy
- Genetic testing
- Gynecomastia surgery
- Habilitative therapy for children with autism spectrum disorder
- Hospice services
- Hyperbaric oxygen therapy treatment
- Hysterectomy
- Select injectable, infused, ingested, or inhaled medications administered by your provider in an outpatient setting
- Joint replacements, including but not limited to hip and knee replacements
- Laminectomy
- Le Fort osteotomy
- Lipectomy and panniculectomy
- Mammoplasty (breast reduction)
- Medical foods for inborn errors of metabolism
- Orthognathic surgery
- Orthotics or prosthetics (including podiatric orthotics) over $500
- Partial hospitalization and intensive outpatient programs
- Physical, occupational, and speech therapy after the first 12 visits
- Radiation therapy
- Reconstructive surgery
- Sinus surgery (including but not limited to rhinoplasty, and/or septoplasty, and submucous resection)

- Skilled services provided in a home setting, including home healthcare, home therapy (PT, OT, ST) and home infusion
- Sleep studies
- Temporomandibular joint surgery
- Transcranial magnetic stimulation (TMS)
- Transplant services
- Travel and lodging
- Varicose vein procedures (including vein sclerotherapy)

For emergency admissions, be sure to call no later than the first business day following the admission. No prior authorization is required for emergency medical treatment, including observation or admissions following an emergency visit.

If you are hospitalized because you are having a baby, you do not need to call HealthCheck360 for prior authorization unless your stay will be longer than 48 hours following a vaginal childbirth, or 96 hours following a Cesarean section. This protection under the Newborns' and Mothers' Health Protection Act (NMHPA) also means your benefits are not restricted during the 48-hour period (or 96-hour period, as applicable). However, NMHPA doesn't prohibit your (or your newborn's) attending provider from discharging you or your newborn earlier than 48 hours (or 96 hours as applicable), after consulting with you first.

See *"Rules for Prior Authorization" on page H-6* for information about when the applicable entity must respond to your request for prior authorization and information about how to appeal a prior authorization denial.

Nurse Line

Healthcheck360 nurse line
(866) 823-9827

HealthCheck360 offers a free 24/7 nurse line to answer questions about your or your family's health. The HealthCheck360 nurse line is open 24 hours a day, 7 days a week, and 365 days a year. The nurse can help answer questions like:

- Should I see my PCP or go to the emergency room?
- What are the side effects of my medications?
- Will my new medication interact with other medications?

Case management program

You and your dependents may be eligible for the case management program under certain circumstances, including if you have a complex or chronic medical condition or if your condition has a high expected cost. You may be contacted to participate in case management, but you or your healthcare provider can also request case management services. HealthCheck360 provides case management services.

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

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

In some cases, case management may be required. For example, you may be required to use the case management program in order to get benefits for transplants or travel and lodging costs. If you do not use the case management program when required, Plan benefits may not be payable. Unless specified as mandatory, it is your choice whether or not to join the case management program, and whether or not to follow the program's recommendations.

Medical benefits

Learn:

- How to use your medical benefits.
- How the network out-of-pocket limits protect you from large out-of-pocket expenses.
- What types of medical healthcare the Plan covers.
- What types of medical healthcare are not covered.

See the applicable Summary of Benefits starting *on page B-1* for a summary of what you pay for your medical healthcare.

Network providers

UNITE HERE HEALTH has contracted with Blue Cross and Blue Shield of Illinois (BCBSIL) so you and your covered dependents can receive medical and surgical services from area hospitals and providers participating in the network.

✓ *See page A-7* for more information about how staying in the network can help you save money.

Benefits are paid based on whether you use a network provider or a non-network provider. Treatment by a non-network provider is generally reimbursed at a lower level. To find a network provider, contact:

Blue Cross and Blue Shield of Illinois

(800) 810-BLUE (2583) toll free

www.bcbsil.com

When a non-network provider may be considered a network provider

In the special circumstances listed below, the Plan will pay for non-network services at the network cost share, and the network cost-sharing will apply towards your out-of-pocket limit.

In some cases, you may have to pay the difference between the allowable charge and the provider's actual charge (called balance billing). In other cases, the provider cannot balance bill you. The below list will state whether the provider can balance bill you.

A non-network provider may be considered a network provider when:

- *Emergency medical treatment*
  You get emergency medical treatment from a non-network provider. The non-network provider cannot balance bill you for your emergency medical treatment. (*See page I-4* for the definition of "emergency medical treatment.")
- *You use a network hospital or network ambulatory surgical center*
  You get services and supplies from non-network providers in connection with a visit to a network hospital (including the outpatient department) or a network ambulatory surgical center. The non-network provider cannot balance bill you. However, this does not apply if you give informed consent to your healthcare professional agreeing to give up your protections from balance billing (you do not have to give consent if you don't want to).

- *Non-network providers who provide inpatient consultations or specialize in anesthesiology, emergency medicine, pathology, or radiology*
  You use non-network providers who provide inpatient consultations or who specialize in anesthesiology, emergency medicine, pathology, or radiology. You pay the network cost-sharing. Unless the rules above about emergency medical treatment or visits to a network hospital or network ambulatory surgical center apply, the provider may also balance bill you.

- *Ambulance services*
  You use a non-network ambulance service (ground, air, water). Non-network air ambulance providers cannot balance bill you. Non-network ground and water ambulance providers can balance bill you.

- *The provider directory is wrong*
  You rely on the Plan's provider directory, or the Fund or Blue Cross Blue Shield of Illinois tells you a provider is in the network when the provider really is not in your network. Contact the Fund if you think this rule applies to your claim. The provider may balance bill you.

  Make sure you always ask if the provider is in your network.

- *Your provider leaves the network*
  You are getting a course of treatment with a provider who leaves the network and you are a "continuing care patient" as defined by federal law because:

  - You are pregnant and getting care for your pregnancy.
  - You are getting treatment for a serious and complex condition requiring specialized medical care.
  - You are getting inpatient care.
  - You have scheduled a non-elective surgery (including post-operative care).
  - You are terminally ill (expected to live for 6 months or less).

  The Fund may continue to pay network benefits for covered services you get from that provider for up to 90 days (or until your continuing care ends, if earlier). In this case, the non-network provider cannot balance bill you.

  If your provider leaves the network, you will get a notice and a continuity of care application. If you think you qualify as a continuing care patient, and you want to continue treatment with your provider, you should return the application to the Fund. Your provider will have to document that you meet the definition of a continuing care patient (as listed above).

  The notice will include the deadline to apply for continuity of care and information on how to submit your application.

If you feel your claim was not paid correctly under these rules, you may submit an appeal. *See page H-7* for information about appealing claims, including your right to external review.

What you pay

You must pay your cost-share (such as deductibles, copays and coinsurance) for your share of covered expenses. You must also pay any expenses that are not considered covered expenses (*see "What's not covered" on page D-11* for information about what's not covered), including charges once a maximum benefit or limitation has been met.

See your applicable Summary of Benefits starting on *page B-1* for more information about your cost-sharing.

Deductibles

- **Classes I & III**
  - Calendar year deductibles of $100 per person and $200 per family apply each calendar year to your covered expenses provided by *network providers* before this Plan pays benefits. Once your family deductible has been satisfied, no one else in your family has to pay deductibles for the rest of that year.
  - A calendar year deductible of $500 per person applies each calendar year to your covered expenses provided by *non-network providers* before this Plan pays benefits. (There is no family deductible for non-network providers.)
- **Class II**
  - A calendar year deductible of $250 per person applies each calendar year to your covered expenses provided by *non-network providers* before this Plan pays benefits. Once your family deductible has been satisfied, no one else in your family has to pay deductibles for the rest of that year.

Amounts you pay for prescription drugs, vision care, or dental care will not apply toward the deductibles. In addition, the deductibles do not apply to certain medical benefits. See the applicable Summary of Benefits for which services require the deductible and which services are covered before you satisfy the deductible.

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

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

Copays

You pay copays for certain types of care *(see page B-2).* Your copay is your only cost-sharing for all of the healthcare you receive during a network office visit or urgent care center visit.

For example: You only pay one office visit copay for all healthcare you receive during the office visit, even if you received other services at the same time.

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

Out-of-Pocket limit for network expenses

Your out-of-pocket coinsurance and deductibles for most covered network medical care (including mental health/substance abuse) is limited to $1,000 per person each calendar year for Classes I & III, and $2,500 per person for Class II. Once your out-of-pocket costs for covered expenses meet these limits, the Plan will usually pay 100% for your (or your family's) network medical covered expenses during the rest of that calendar year.

However, the following costs you pay out-of-pocket do not apply to your out-of-pocket limits, and the Plan won't pay 100% for these charges even if you have met the out-of-pocket limit:

- Copayments.
- Amounts you pay out-of-pocket for prescription drug expenses under the section titled "Prescription drug benefits."
- The 50% coinsurance you pay for certain covered services.
- Care or treatment you receive after meeting the Plan's maximum benefit.
- Amounts you pay for services and supplies that are not covered.
- Amounts over the allowable charge.
- Non-network care or treatment, except for situations in which the non-network provider is considered a network provider (*see page D-2*).

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

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.

- The following **preventive healthcare services** when a network provider is used:
  - Routine well-baby exams for children up to age 6.

  - Immunizations, when performed according to the guidelines established by the American Academy of Pediatrics of the American Academy of Family Practitioners.
  - Cervical cancer screening (pap smears and human papillomavirus screening) are covered once each calendar year for women, regardless of age.
  - Routine mammogram screenings are covered once each calendar year for women age 35 and older, and are covered once each calendar year for women under age 35 who are at high risk for breast cancer.
  - PSA tests for men are covered once every 12 months for men age 40 through 69.
  - Routine colorectal cancer screenings, subject to the guidelines established by the United States Preventive Services Task Force for preventive colorectal cancer screenings.
  - ***For Classes I & III employees and dependents only:*** one routine physical exam, once each calendar year, including a doctor's office visit, blood test, EKG, and chest x-ray.
- Professional services of a **healthcare provider**.
- General or private duty nursing services performed by a Registered Graduate Nurse (RN) or Licensed Practical Nurse (LPN), and other specialized services performed by a Certified Registered Nurse Anesthetist (CRNA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), and Certified Nurse Midwife (CNM).
- Administration of **injectable medications**, including immunizations provided by a healthcare provider.
- Treatment of **mental health/substance abuse disorders**, including inpatient and residential care, outpatient care, partial hospitalization, intensive outpatient programs, and ambulatory detoxification.
- **Acupuncture services**.
- The following **podiatric care:**
  - **Routine podiatric care**, subject to the maximum benefits shown on the Summary of Benefits.
  - **Surgical services** of a podiatrist.

  Non-network services are not covered.
- **Chiropractic care**, including chiropractic x-rays, when provided by a network provider, subject to the following limits:
  - Up to $25 per visit;
  - Up to $600 per person each calendar year (excluding for x-rays); and

- Up to $400 per person each calendar year for x-rays for chiropractic care.

Non-network services are not covered.

- Covered services provided in an **urgent care center**.
- Hospital **emergency room** services.
- Transportation by a **professional ambulance service** to an area medical facility that is able to provide the required treatment.

  If you have no control over the ambulance getting called, for example when the ambulance is called by a healthcare provider, employer, law enforcement, school, etc., the ambulance will be considered medically necessary. Contact the Fund if you had no control over an ambulance being called.
- **Radiology services**, including x-rays, ultrasounds, and fetal monitoring.
- **Laboratory services**.
- **Diagnostic imaging**, including MRIs, MRAs, CAT/CT scans, CTA scans, cardiac CT scans, PET scans, cardiac catheterizations, echocardiograms, nuclear medicine, and nuclear cardiac imaging.
- **Radium** or radioactive isotope therapy**.**
- **Ambulatory surgical facility services**, including general supplies, anesthesia, drugs, and operating and recovery rooms. If you have multiple surgeries, covered expenses are limited to charges for the primary surgery.
- **Sterilization procedures**.
- **Surgical supplies, surgical dressings, casts, splints, and trusses**.
- **Orthotics and prosthetics.**
- **Physical, speech and occupational therapy services,** when provided by a licensed therapist, up to 30 total visits combined per person each calendar year.
- **Habilitative therapy** for children with autism spectrum disorder. *You, or your provider, must get prior authorization for habilitative therapy before the Plan pays benefits.* Plan benefits are limited to 30 hours per person each week, and a total of 36 months. "Habilitative therapy" includes applied behavioral analysis (ABA) therapy and similar types of treatment. It does not include physical, speech, or occupational therapy.

  - Your child must be at least 2 years old, but no more than 8 years old.
  - Your child must have a diagnosis of autism spectrum disorder, and have a prorated mental age of at least 11 months.

- The provider supervising the habilitative therapy must be certified by the Behavioral Analyst Certification Board (BACB) as a Board Certified Behavior Analyst or Board Certified Behavior Analyst Doctorate.
- The person providing the habilitative therapy must be certified by the BACB as a Board Certified Assistant Behavioral Analyst or Registered Behavioral Technician.
- The Plan will only pay benefits for services supplemental to any therapy for which your child is eligible through his or her school or school district. No benefits will be paid for therapy provided through the school or school district.
- The habilitative therapy and treatment plan must get prior authorization from the Fund before treatment begins. The treatment notes and treatment plan must be reviewed by the Fund at least twice a year, and must show that:
  - Your child is demonstrating improvement.
  - You are trained to, and do, participate in the habilitative therapy.
  - You follow the treatment plan.

- Network professional services of a **licensed Certified Diabetes Educator** for the care, monitoring, or treatment of diabetes. Non-network services are not covered.
- Network professional services of a **licensed Registered Dietitian**, up to $200 per person each calendar year. Non-network services are not covered.
- **Repair of sound natural teeth** and their supporting structures, if the covered expenses are the result of an injury. Treatment must be received while you are covered under the Fund. You may have additional dental coverage under your dental benefits—see the section titled "Dental benefits."
- **Hospital charges** for room and board, and other inpatient or outpatient services. Hospital charges include intensive care unit accommodations, and routine nursery charges for a covered newborn child.
- Treatment of **pregnancy** and pregnancy-related conditions, including childbirth, miscarriage, or abortion, for employees and covered dependent spouses. No benefits are payable for pregnancy or pregnancy-related conditions for a dependent child.
- **Mastectomies**, including all stages of surgery to rebuild the removed breast (reconstruction), surgery and reconstruction of the other breast so breasts look even, breast implants and prostheses, and treatment of physical health problems from a mastectomy, including swollen lymph glands (lymphedema).
- **Medical services for organ transplants** if the following rules are all met:
  - The transplant must be covered by Medicare, including meeting Medicare's clinical, facility, and provider requirements.

- You must use any case management program recommended by the Fund or its representative.
- You must get prior authorization for the transplant.
- Donor expenses for your transplant are only covered if the donor has no other coverage.
- Transplant coverage does not include your expenses if you are giving the organ instead of getting the organ.

- **Anesthesia** and its administration.
- **Facility charges**, including anesthesia and other ancillary services, and charges for the administration of anesthesia by an anesthesiologist, for dental procedures requiring an institutional setting to safely administer the care, including for treatment if you are suffering from medical or behavioral conditions, such as autism or Alzheimer's, that severely limit your ability to cooperate with the necessary care. This covered expense only applies to the extent the treatment would otherwise be covered under a dental benefit. Benefits for other types of dental care may be covered under the dental benefit (*see page D-23*).
- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- Treatment of **tumors, cysts, or lesions** not considered a dental procedure.
- Oral surgery for the **removal of bony impacted teeth.**
- **Skilled nursing facility** inpatient treatment, up to a calendar year maximum of 60 days, including no more than 30 non-network days, per person, as long as you are under the care of a doctor, and are confined as a regular bed patient.
- **Blood and blood plasma** and their administration.
- **Oxygen,** including administration of oxygen.
- **Home healthcare services**, up to a calendar year maximum of 60 visits, including no more than 30 non-network visits, per person. Home health care services include home intravenous therapy, medical supplies, prescription drugs and medications, nursing services by a registered graduate nurse or licensed practical nurse, services by a licensed therapist for physical, occupational, and speech therapy. General housekeeping services or custodial care is not covered.
- **Hospice** services and supplies if you are terminally ill, as follows:
  - Hospice room and board, while the person is an inpatient.
  - Other hospice services furnished by a hospice or hospice team comprised of a doctor and a registered nurse and may include one or more of the following: licensed social

worker, a clergyman/counselor, volunteers, a clinical psychologist, a physical therapist, or an occupational therapist.

- Counseling services provided by members of a hospice team.
- Home health aid services.

- **Durable medical equipment**, and supplies, for all non-disposable devices or items prescribed by a healthcare provider, such as wheelchairs, hospital-type beds, respirators and associated support systems, infusion pumps, home dialysis equipment, monitoring devices, home traction units, and other similar medical equipment or devices.
  - Rental fees are covered if the DME can only be rented, and the purchase price is covered if the DME can only be bought.
  - However, if DME can be either rented or bought, and if the rental fees for the course of treatment are likely to be more than the equipment's purchase price, benefits may be limited to the equipment's purchase price.
  - If DME is bought, costs for repair or maintenance are also covered.
- **Medical foods** if you have an inborn error of metabolism (IEM). *You must get prior authorization for your medical food costs before the Plan will reimburse you.* The Plan will reimburse 100% of your costs for medical foods. To be reimbursed, the medical food must be: (1) ordered by and used under the supervision of a healthcare provider; (2) the primary source of your nutrition; and (3) labeled and used for dietary management of your IEM.
- Reimbursement for **travel, lodging, and meal costs** to get covered medical treatment that is not available from a network provider within 100 miles of your home. The following rules apply:
  - Except in limited situations, the Plan generally requires you get prior authorization of these expenses in order to receive reimbursement. Be sure to contact the Fund before you obtain services to get more information.
  - Expenses that are not primarily for and essential to medical care are not covered.
  - The travel, lodging, and meal costs of one other person traveling with you (same day as you) will also be covered.
  - Travel expenses are reimbursable for airfare or rail travel at the coach rate, taxi or ground transportation, or mileage reimbursement at the current mileage rate issued by the IRS for the most direct route between your residence and the facility. Tolls and parking expenses are also considered eligible travel expenses.
  - Expenses that are not directly related to travel and lodging are not covered. This includes but is not limited to: alcohol, tobacco, laundry, dry cleaning, telephone, charges exceeding coach class rates, travel or personal trip insurance, child care, house sitting or kennels, reimbursement for any lost wages, charges in connection with a

family support person not incurred during your stay at the facility, car maintenance, clothes, entertainment, flowers, cards, stationery, household utilities, cell phone chargers, maid services, security deposits, toiletries, fines or traffic tickets.

- Reimbursement is limited to $10,000 per episode of care for you and your traveling companion combined. This includes up to $200 each day for lodging and up to $50 per day for meal costs for you and your traveling companion combined.
- You must provide the Plan with receipts and any information necessary to process your claim.
- You must participate in any case management programs required by the Fund.
- You cannot get reimbursed for expenses related to your participation in a clinical trial or for services outside of the United States.
- The Fund may prearrange or prepay certain travel or lodging costs instead of requiring you to pay yourself and then file for reimbursement.

If your reimbursement exceeds certain IRS limits, it is considered "imputed income" (benefits that aren't part of your wages but are taxed as income) and the Fund will send you a tax form. More details about the benefit are available upon request.

- If you have a diagnosis of gender dysphoria, the following **gender reassignment services** and related charges (e.g., laboratory work, x-rays, office visits, etc.) are covered when prior authorization is obtained:
  - Surgical procedures, including medically necessary corrective surgeries, to change your gender one time (for example, if the Plan covers procedures changing your gender from male to female, the Plan will not then pay to change your gender back to male).
  - Hormone therapy for gender reassignment if the hormone therapy can only be administered by a healthcare professional. (*See page D-16* for information about coverage for hormone therapy under the prescription drug benefits.)

What's not covered

The following list will generally not apply to emergency medical treatment. However, the Fund will still not cover any treatment that would otherwise be excluded, regardless of the circumstances (for example, the Fund does not cover any treatment that is not medically necessary).

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

- Prescription drugs and medications, other than those used where they are dispensed.

Prescription drugs may be covered under the prescription drug benefit starting *on page D-14*.

- Services or supplies provided by a non-network providers if the services or supplies are not covered when provided by a non-network provider.
- Podiatric services furnished or prescribed by a non-network provider.
- Alveolar ridge augmentation or implant procedures, whether of natural or artificial materials, to stabilize or otherwise alter natural or artificial teeth.
- Dental extractions or dental services for, or in connection with, routine care of the teeth and supporting oral tissues, or restorative services to replace natural teeth lost as a result of injury.
- Treatment of temporomandibular joint (TMJ) disorders, craniofacial disorders or orthognathic disorders, unless UNITE HERE HEALTH or its representative provides prior authorization.
- Surgery to modify jaw relationships including, but not limited to, osteoplasty and genioplasty procedures. However, Le Fort-type operations are covered when primarily to repair birth defects of the mouth, conditions of the mid-face (over or under development of facial features), or damage caused by injury.
- Private duty nursing care.
- Birth control devices.
- Eye refractions and eyeglasses. However, certain eye care may be covered for Class I and II employees under the vision benefits (*see page D-31*).
- 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:

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

Hospitality Rx (a subsidiary of UNITE HERE HEALTH) provides pharmacy benefit management services. Hospitality Rx contracts with several organizations to provide specialized administrative services. Benefits are only paid if you buy your prescription drugs at a pharmacy that participates in the network, like Walgreens. Not all retail pharmacies are in your pharmacy network. Sam's Club and Wal-Mart are **not** in your network.

Be sure to visit www.hospitalityrx.org to find a network pharmacy.

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:**	**At:**
Find a network pharmacy or ask questions about your benefits	Hospitality Rx	**(844) 813-3860** www.hospitalityrx.org
Get prior authorization for prescription drugs or to ask which drugs require prior authorization	Hospitality Rx	**(844) 813-3860** www.hospitalityrx.org
Get a free glucometer	FreeStyle *(by Abbott)*	**866) 224-8892** www.ChooseFreeStyle.com *use order code RAFITLWP*
	OneTouch *(by LifeScan)*	**(800) 668-7148** www.OneTouch.orderpoints.com *use order code 573EXP333*
Order from the mail-order pharmacy	WellDyneRx Home Delivery *(through Hospitality Rx)*	**(844) 813-3860** wellview.welldyne.com
Order from the specialty pharmacy	WellDyne Specialty Pharmacy	**(800) 373-1879** www.welldynespecialty.com

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 D-20* for information about what's not covered).

Prescription Drug Benefits (all Classes) —What You Pay		
	Per Prescription	
Formulary Prescription Drug Benefits at Network Retail Pharmacies and Mail Order	**Retail Pharmacy** *up to a 34-day supply*	**Mail Order** *up to a 60-day supply*
Smoking Cessation Drugs and Supplies— *including prescription generic over-the-counter products, generic products, and certain brand products*	$0	
Covered Immunizations		
Generic and Some Brand Drugs	$3	
Preferred Drugs	$12	
Non-Preferred Drugs	$27	
Non-Formulary Prescription Drugs and Supplies	Not covered, unless an exception is approved	
** Current pharmacy benefit provider will actively manage and determine drugs in tier. Specialty drugs are only available through the specialty mail order pharmacy. However, if you take specialty medications as part of your HIV treatment plan, you may be able to receive an exception to use your network retail pharmacy instead.*		

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

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

What's covered

A medication or supply must be listed on the "focus" formulary in order to be covered (unless you get a formulary exception from the Plan). The Plan pays benefits only for the following formulary expenses:

- FDA-approved medications and supplies 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 lancet devices.
- Routine immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control, when provided by a network pharmacy. You must have a prescription for the immunizations in order for the Fund to pay for these services.
- Tobacco cessation drugs and supplies, as long as you have a prescription. This includes certain over-the-counter tobacco cessation drugs and supplies, generic buproprion, and Chantix.
- Vitamins.
- Hormone therapy as long as the hormones are FDA approved and only available by prescription. Prior authorization is required for certain hormone therapy.

Free glucometers

You can get a free glucometer once every 12 months through this free glucometer program.

Free manufacturer glucometer
The manufacturers will provide one free glucometer every 36 months:

OneTouch (by LifeScan)	**FreeStyle (by Abbott)**
www.OneTouch.orderpoints.com **(800) 668-7148** *Order code 573EXP333*	www.ChooseFreeStyle.com **(866) 224-8892** *Order code RAFITLWP*
Take your voucher and glucometer prescription to a network pharmacy	Your meter will be sent to the address you provide during the ordering process

Manufacturer program details like glucometer model, order code, and other details may change from time to time. Visit www.hospitalityrx.org for the most current information.

Free glucometer by calling Hospitality Rx
If you need a glucometer sooner than the manufacturer allows, call Hospitality Rx at **(844) 484-4726** or visit www.hospitalityrx.org to get prior authorization for a new glucometer (the 12-month limit still applies).

- You need a prescription for the glucometer from your healthcare provider.
- You need to go to a network pharmacy to get your free glucometer (be sure to check out at the pharmacy counter).

If you don't want a free glucometer, you pay the full cost of the glucometer yourself. You may submit a claim under the medical benefits for the glucometer, but all medical benefit rules apply and you may not be paid back for the full amount - any applicable cost-sharing for durable medical equipment applies (see the applicable Summary of benefits starting *on page B-1*).

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) 813-3860**, 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 or more 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.

If a prescription drug is subject to a safety or cost containment program, you must follow the program in order to get benefits for the drug.

See page H-9 for information about appealing a request for prior authorization or appealing a denial of prescription drug benefits.

Generic prescription drug policy

Generics have the same active ingredient as the brand name drugs, but you pay less for them. Ask your doctor to help you save money by prescribing generic drugs when possible.

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 at retail, and the Fund's cost for the generic equivalent is $30, you must pay the $50 difference. You will also have to pay the 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 at **(844) 813-3860**. This rule will also not apply if you get an exception through a safety or cost containment program. 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 copay.

Prior authorization

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

Step therapy

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

For example, if you need an ARB (angiotensin receptor blocker) 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 brand name version.

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

Case management

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

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

Quantity limits

The amount of a prescription the Plan will fill at one time is limited to the lesser of:

- The amount prescribed by your healthcare professional.
- If you use a retail pharmacy, up to a 34-day supply.
- If you use the non-specialty mail-order pharmacy, up to a 60-day supply.
- The amount allowed under any safety or cost containment program. For example, most prescriptions filled through the specialty mail-order pharmacy will be limited to less than a 34-day or 60-day supply.

If your prescription is for a drug only available in 90-day quantities, or is a birth control drug that uses a steady hormone release over time (such as NuvaRing*), you can get the full 90-day amount. You will still have to pay the applicable copay based on the drug's tier (generic, brand, or specialty).

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.

Early refills

You generally cannot refill a prescription earlier than allowed under any applicable guidelines, safety or cost containment programs, or other Plan rules. 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. If your early refill is approved, you can get up to a 60-day supply for the applicable retail drug copay.
- Your drug is lost or stolen.
- You run out of a drug too soon because you misunderstood the instructions or accidentally used too much. You will be able to get one such early refill per lifetime for that drug.

You may be required to use the case management program in order to get an early refill.

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

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
wellview.welldyne.com

Specialty pharmacy

You must use the specialty pharmacy to purchase all specialty prescription drugs. 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. However, if you take specialty medications as part of your HIV treatment plan, you may be able to receive an exception to use your network retail pharmacy instead. The specialty drug copays will apply, even if you get an exception. You can get a copy of the form you must fill out to request this exemption by calling HospitalityRx at **(844) 484-4726**.

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.

WellDyne Specialty Pharmacy
(800) 373-1879
www.welldynespecialty.com

What's not covered

See page E-2 for a list of this Plan's general exclusions and limitations. For example, experimental and investigative treatments, including drugs, are not covered. In addition to that list, the following types of prescription drug treatments, services, and supplies are not covered under the prescription drug benefit:

- Prescription drugs that have not been approved by the FDA. However, the Fund or its designee may cover prescription drugs not approved by the FDA in certain situations. You or your healthcare professional may ask for an exception through the prior authorization program.

- Drugs or supplies that are not listed on the formulary, unless the Fund or its designee gives prior approval for the drug or supply. You must try all medically appropriate formulary alternatives before you can get a formulary exception.
- Drugs or medications used, consumed or administered at the place where dispensed, other than immunizations. (These drugs may be covered under your medical benefits.)
- Prescriptions or refills in amounts over the quantity limits *(see page D-19)*.
- Vitamins, dietary supplements, or dietary aids, except those specifically included on the formulary.
- Drugs used for cosmetic reasons, including Rogaine and other drugs to prevent hair loss.
- Human growth hormone, except to treat emaciation due to AIDS.
- Drugs or covered supplies not purchased from a network pharmacy.
- Non-sedating antihistamines.
- Birth control devices.
- Fertility drugs.
- Glucometers, other than those the Fund gives you for free. You may be able to get a glucometer through the medical benefits if you do not want one of the free ones, but you will usually have to pay part or all of the cost.
- Weight control drugs, unless for the treatment of morbid obesity under the direct supervision of a healthcare provider, and authorized in writing by the Fund or its designee.
- 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.
- New-to-market prescription drugs until the Fund or its designee has reviewed and approved the prescription drug.
- Specialty prescription drugs if you do not use the specialty pharmacy. This exclusion does not apply to HIV/AIDS drugs if you are approved to use a network retail pharmacy for these drugs.
- Over-the-counter drugs not specifically list on the formulary.
- High-cost "me too" drugs, unless the Fund or its designee approves the drug for purchase. "Me-too" drugs usually have only very small differences in how they work, but are considered "new" drugs with no generic equivalent. Often, the manufacturer charges high prices for these drugs even though there are other drugs available that work just as well for a lower cost. You can find out if a "me too" drug is covered by contacting Hospitality Rx.

- Diagnostics (drugs used to help in the process of diagnosing certain medical conditions).
- Drugs, medications, or supplies that are not covered under the Fund's or Fund's designee's claims processing guidelines or any other internal rule, including, but not limited to any national guidelines used by the medical community.
- Medical foods (medical foods may be covered under the medical benefit—*see page D-10*).

Dental benefits

Learn:

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

Dental benefits are payable for Class I and II employees and dependents only. No dental benefits are payable for Class III employees or dependents.

Classes I & II Dental Benefits —What the Plan Pays	
Maximum Benefit Payable Each Calendar Year	$1,000 per person *Maximum benefit does not apply to the following services for person under age 19: dental exams, routine x-rays, routine cleanings, fluoride, or sealants*
Calendar Year Deductible	None
Description of Common Dental Care	**Maximum Benefit Payable Plan pays 100% up to:**
Periodic Oral Exam	$17
Routine Cleaning (Prophylaxis)	$51 – adults $36 – children
Routine X-Ray Services	$75 – complete set $35 – bitewings
Amalgam Restorative Services	$65 – 1 tooth surface $85 – 2 tooth surface
One Surface Metallic Inlay	$220
Crowns	$315 – resin with high noble metal $337 – porcelain fused to high noble metal
Anterior Root Canal	$188
Oral Surgery — *includes local anesthesia*	$40 – single tooth $75 – erupted tooth $113 – impacted, partially bony tooth
Complete Upper Dentures	$438
Fixed Bridgework	$320 – pontic case high noble metal $330 – pontic porcelain fused to high noble metal

The above table summarizes the maximum benefit payable for the most common types of dental procedures. Call the Fund to get a complete listing of the maximum benefits by dental procedure.

You can use any licensed dentist you want to get your dental care. You don't have to worry about finding a network dentist—there is no network. Instead, the Plan pays 100% of your covered dental expenses, subject to the maximum benefit for each procedure, regardless of which dentist you use.

What the Plan pays

The Plan pays 100% up of covered expenses provided by a dentist, up to the scheduled maximum benefit. The Plan pays up to $1,000 per person each calendar year. However, this annual maximum does not apply to the following types of dental care for persons under age 19: dental exams, routine x-rays, routine cleanings, fluoride, or sealants.

If multiple procedures are performed at the same site, Plan benefits are limited to the most inclusive service, plus pro-rated amounts for other, associated services.

The Plan will prorate covered services provided by quadrant as follows:

- Benefits for treatment involving 1 or 2 teeth in a quadrant will be limited to 1/3 of the quadrant allowance.
- Benefits for treatment involving three or four teeth in a quadrant will be limited to 1/2 of the quadrant allowance.
- Benefits for treatment involving five or more teeth in a quadrant will equal 100% of the quadrant allowance.

A covered dental expense is considered incurred on the date that:

- The final impression is taken for dentures and partials.
- The involved teeth are prepared for fixed bridgework, crown, inlays, and onlays.
- The pulp chamber is opened for root canal therapy.
- Any other service is rendered.

A temporary dental service is considered part of the final service, not a separate service.

What you pay

A maximum benefit applies to each covered expense. You pay any billed charges that are more than what the Plan pays for that covered expense. You also have to pay for any dental care that isn't covered, including dental care you get more often than is covered, or dental care once you reach your maximum benefit for dental care during a year.

What's covered

There may be limits on how often certain services and supplies are covered. If the amount of time in any limitation has not passed since the service or supply was last provided, you may have to pay the entire cost. You can always contact the Fund to find out the last time you got benefits for a certain service or supply.

- **Diagnostic and preventive services and procedures**, including but not limited to exams and cleanings.
  - Routine cleanings (prophylaxis). These types of cleanings are limited to 2 each year if you are age 19 or older. (No frequency limit applies to routine cleanings for people under age 19.)
  - X-rays. Full-mouth or panoramic x-rays for persons age 19 and older are limited to 1 set every 36 consecutive months. (No frequency limit applies to x-rays for people under age 19.)
  - Topical application of fluoride for persons under age 19 only.
  - Sealants for children under age 16.
- **Emergency palliative care** to temporarily relieve pain and discomfort.
- **Diagnostic x-rays** to diagnose a specific condition.
- **Restorative services**, including but not limited to inlays, onlays, crowns, and labial veneers.
- **Endodontic services and procedures** to treat teeth with diseased or damaged nerves.
- **Periodontic services** to treat diseases of the gums and supporting structures of the teeth.
  - Root planing and scaling is covered once every 18 months per quadrant.
  - Periodontal surgery of any type is considered a covered service once every 36 months per quadrant. Periodontal surgeries subject to this limit include but are not limited to gingivectomies, gingivoplasties, gingival curettage, gingival flap procedures, mucogingival surgeries, osseous surgeries, osseous grafts, pedicle grafts, free tissue grafts, etc.
  - Full mouth debridement to remove extensive plaque and tartar is limited to once in a 24-month period.
- **Prosthodontics**, and repairs to prosthodontics (such as relining and rebasing).
  - Denture relining must be performed more than 6 months after you get the denture.
  - Relines are limited to once every 12 consecutive months.
- **Oral surgery**, extractions, and other surgical procedures.

What's not covered

See page E-1 for a list of this Plan's general exclusions and limitations. In addition to that list, the following types of dental care are not covered under the dental benefit:

- Treatment in progress before coverage begins, but only to the extent charges for such treatment are incurred before coverage begins.
- Replacement of a lost or stolen dental appliance, duplicate dentures, or charges for the replacement of an existing bridge or partial denture which is or can be made satisfactory.
- Replacement of a prosthesis (other than a crown necessitated for restorative purposes only) installed while you were covered by the Plan and being replaced within five years after the initial installation, unless:
  - Replacement is made necessary by the initial placement of an opposing full prosthesis or the extraction of natural teeth,
  - The prosthesis is a temporary prosthesis and is being replaced by a permanent prosthesis, or
  - The prosthesis, while in your mouth, is damaged beyond repair by an injury occurring while covered by the Plan.
- Labial veneers if the tooth or teeth can be reasonably restored with composite materials.
- Procedures used to change vertical dimension.
- Cast inlays or non-abutment crowns, unless the tooth cannot be restored with amalgam or composite materials.
- Treatment of temporomandibular joint dysfunction (TMJ), cranio-facial pain disorders, or orthognathic surgery; however, charges for night guards are covered.
- Dental implants and all attachments to implants, including posts, crowns, retainers, and other devices.
- Setting fractures or dislocations, or treatment of malignancies, cysts, or neoplasms over 1.25 cm., unless a benefit is listed in the Plan's schedule of dental benefits.
- Placement of bone grafts or extra-oral substances in the treatment of periodontal disease.
- Orthodontic services and supplies.
- Fixed prostheses on:
  - Periodontically compromised teeth with significant bone loss, unless certified by a independent periodontist that the recommended treatment is appropriate and the prognosis for the affected tooth or teeth is good, or

  - Endodontically compromised teeth, unless it is certified by an independent endodontist that needed therapy is complete and that prognosis for the affected tooth or teeth is good.

- Fissure sealants for covered persons age 16 or older.
- Topical fluoride for anyone age 19 or older.
- Congenital or developmental malformations unless for dental care otherwise covered.
- Services that are primarily cosmetic in nature.
- Conditions caused by atomic explosion.
- Customization of dental prostheses, including but not limited to personalized, elaborate, or precision attachment dentures, bridges, or specialized techniques.
- Drugs of any kind.
- Services for which benefits may be payable under the medical benefits (*see page D-5*).
- Services or supplies which will not have a satisfactory result, or that are not necessary for your dental health.

Predetermination of dental benefits

You or your dentist may contact UNITE HERE HEALTH before treatment starts for any non-emergency services your dentist expects to cost more than $250. Your dentist can get treatment pre-determination by sending examination and treatment records to UNITE HERE HEALTH along with an itemized estimate of the cost of the recommended treatment. UNITE HERE HEALTH will let you and your dentist know how much the Plan will pay for the suggested treatment. Through predetermination, you will know before treatment starts how much of the bill you will be required to pay.

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

Alternate course of treatment

If your dentist submits a pre-treatment plan, and UNITE HERE HEALTH determines that an alternate method of treatment would be at least as effective, but less costly, the Plan may pay benefits based on the alternate method, as long as the alternate treatment is both:

- Commonly used in the treatment of the existing condition, as determined by UNITE HERE HEALTH or its designee.

- Recognized by the dental profession to be appropriate in accordance with accepted nationwide standards of dental practice.

Benefits after coverage ends

If coverage ends while dental treatment is in progress, benefits will be extended for the services shown below until the end of the month following the month coverage ends.

Coverage will only be extended for the following services:

- Amalgam restorations, if a temporary medicated filling has been placed before coverage ends.
- Minor adjustments to prosthetic devices placed before coverage ends.
- A crown, fixed bridgework, or inlay if the tooth had final preparation and the impressions were taken before coverage ends.
- A denture, if the final impressions were taken before coverage ends.
- Endodontic treatment, including root canal work, if the tooth was opened before coverage ends.

Vision benefits

Learn:

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

Vision benefits are payable for Class I and II employees only. No vision benefits are payable for any dependent, or for Class III employees.

UNITE HERE HEALTH has contracted with Davis Vision to administer your vision benefits.

CLASSES I & II VISION BENEFITS—What You Pay *Employees Only*		
Description of Services *Benefits covered once every calendar year*	**Davis Vision Network Provider**	**Non-Network Provider**
Eye Exam	$0 copay	$0 copay; $75 maximum
Retinal Imaging	$20 copay	Not covered
Lenses	$0 copay	$0 copay; $175 maximum for all materials, evaluations, and fittings combined
Frames	$0 copay for Davis collection Fashion, Designer, or Premier frames; $0 copay; $150 benefit maximum for all other frames	
Elective Contact Lenses (instead of glasses)	$0 copay for Davis collection contacts; $0 copay; $150 benefit maximum, plus $60 benefit maximum for the evaluation and fitting, for all other contacts	
Medically Necessary Contact Lenses	$0 copay	

Network and non-network vision providers

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

To find a network provider near you, contact:
Davis Vision
toll free: **(800) 999-5431**
www.davisvision.com
(Register for detailed information)

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 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. Some options may be available at no cost; others may have a set fee. Your costs depend on which upgrade(s) you pick.

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

Get your questions about upgrades and options answered by contacting Davis Vision, or by asking your network provider.

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

Benefits are available every calendar year. For example, if you have an exam and get glasses on January 15, 2024, the next time the Plan would cover your exam and lenses would be January 1, 2025.

- Exams (including dilation when professionally indicated).
- Retinal imaging provided by a network provider.
- Plastic lenses, including single vision, bifocal lenses, trifocal lenses, or lenticular lenses.
- Frames.
- Standard contact lenses (disposable or planned replacement), including evaluation & fitting, instead of glasses.
    - Disposable and planned replacement contacts will be supplied in quantities determined by Davis Vision.
- Medically necessary contacts, with prior authorization from Davis Vision.

- Low vision services provided by a network provider, with prior authorization from Davis Vision:
  - One low-vision evaluation is covered every five calendar years, with a maximum of $300.
  - Four follow-up care visits are covered in a five-calendar-year period, with a maximum of $100 per visit.
  - Up to $600 for low-vision aids every five calendar years, subject to a lifetime maximum of $1,200.

What's not covered

The section titled "General exclusions and limitations" explains what the Plan won't cover. In addition to that list, the following vision treatments, services, and supplies are not covered under the vision benefits:

- Retinal imaging provided by a non-network provider.
- Non-prescription lenses.
- Any type of lenses, frames, services, supplies, or options that are not covered under the Davis Vision contract.
- Two pairs of glasses instead of bifocals.
- Contacts and eyeglasses during the same calendar year.
- Low vision services or supplies that are not pre-approved, or that are more than the maximum benefits or frequency limits specified in the contract with Davis Vision.
- Medical treatment of eye disease or injury.
- Replacement of lost or broken contacts, lenses, or frames, except as available under Davis Vision's warranty.

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 Class I employees only. No short-term disability benefits are payable for dependents or for Class II or III employees.

CLASS I SHORT-TERM DISABILITY BENEFIT — What the Plan Pays *Employees Only*	
Amount of Benefit	$150/week for up to 13 weeks
Benefits Start:	
Due to Injury	1st day
Due to Sickness	8th day

Short-term disability (STD) benefits provide 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 13 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 performing the duties of 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 the applicable weekly benefit for as long as you are disabled—up to 13 weeks during any 1 period of disability. If disability benefits are paid for less than a full week, a daily rate equal to 1/7th of the weekly benefit will be paid for the partial week. 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 sections *(see page E-2)*. In addition, no short-term disability benefits are provided if you are not under the regular care of a healthcare professional.

Life and AD&D benefits

Learn:

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

Life and AD&D Benefit (all Classes) — What the Plan Pays *Employees only*	
Life Insurance	
Employees Only	$20,000
Accidental Death and Dismemberment (AD&D) Insurance	
Employees Only *(full amount)*	$20,000

Life insurance and AD&D insurance benefits are provided under an insured group insurance policy issued to UNITE HERE HEALTH by Dearborn Life Insurance Company, branded as Blue Cross and Blue Shield of Illinois (BCBSIL). The terms and conditions of your 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 free of charge by contacting UNITE HERE HEALTH.

Retiree death benefit

*for retirees who retired **before** December 1, 2019*

The amount of the retiree death benefit is $1,000 and is solely provided by UNITE HERE HEALTH, not Dearborn National. This section does not apply to the retiree death benefit. To qualify for retiree death benefits, you must:

- Be at least 62 when you retire.
- Have at least 30 years of credited service when you retire.
- Begin receiving pension benefits under the National Retirement Fund, formerly known as the H.E.R.E.I.U. Pension Plan, upon retirement.
- Not be entitled to life insurance benefits as an active UNITE HERE HEALTH Plan participant when you die.

Call the Fund when you have questions about retiree death benefits or for help filing a claim.

Retiree benefits provided through the Fund are not vested or accrued benefits. This means the retiree benefits are not guaranteed to continue indefinitely. The Trustees have full and exclusive authority to change or terminate the benefits and the eligibility requirements at any time.

Life insurance benefit

Your life insurance benefit is $20,000 and will be paid to your beneficiary(ies) if you die while you are eligible for coverage or within the 31-day period immediately following the date coverage ends.

Continuation if you become totally disabled

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

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

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

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

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

Converting to individual life insurance coverage

If your insurance coverage ends and you don't qualify for the disability continuation just described, you may be able to convert your group life coverage to an individual policy of whole life insurance by submitting a completed application and the required premium to BCBSIL within 31 days after the date your coverage under the Plan ends. Even if you decide to elect COBRA for your health benefits, the 31-day deadline for life insurance applies to you.

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. If you think you might want to convert your group life insurance to an individual policy you pay for yourself, go to www.uhh.org/conversion to get the "Application to Convert Group Life Insurance" form. You can

also get the form by calling Member Services. For more information about conversion coverage, contact BCBSIL:

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

Terminal illness benefit

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

Accidental death & dismemberment insurance benefit

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

Your AD&D Benefit for a loss (death or dismemberment) within 365 days of an accident		
Event	**Benefit**	**Who Receives**
Death	$20,000	Your beneficiary
Loss of both hands or feet		You
Loss of sight in both eyes		
Loss of one hand and one foot		
Loss of one hand and sight in one eye		
Loss of one hand or one foot	$10,000	
Loss of the sight in one eye		
Loss of index finger and thumb on same hand	$5,000	

AD&D exclusions

AD&D benefits do not cover losses resulting from or 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.
- 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 BCBSIL 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 first surviving relative in the following order: your spouse; your children in equal shares; your parents in equal shares; your brothers and sisters in equal shares; or your estate. However, BCBSIL may pay benefits up to any applicable limit, to anyone who pays expenses for your burial. The remainder will be paid in the order described above.

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

Additional services

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

Travel Resources Services

Your life insurance benefits include medical emergency and travel emergency assistance programs when you're traveling 100 or more miles from home.

- **Medical Emergency Assistance** helps you and your dependents get care and support during a medical emergency. Examples of services currently offered include:
  - Medical referrals.
  - Medical monitoring.
  - Medical evacuation.
  - Foreign hospital admission assistance.
  - Prescription assistance.

- **Travel Emergency Assistance** helps you and your dependents get assistance if you have an emergency while traveling. Examples of services currently offered include:
  - Travel for a companion to join you if you're hospitalized alone.
  - Emergency minor childcare if you are injured.
  - Transportation for a companion if you need to be transported for medical care.
  - Transportation for your body if you die.
  - Other services, including return of your vehicle, legal and interpreter referrals, emergency cash and bail coordination, and pre-trip planning information.

Assist America
(800) 872-1414 (tollfree in the U.S.)
(609) 986-1234 (outside the U.S.)
medservices@assistamerica.com
Reference number: 01-AA-TRS-12201
You can also get the mobile app.

All services must be arranged by Assist America and limits may apply.

Beneficiary Resource Services

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

Morneau Shepell
(800) 769-9187
www.beneficiaryresource.com
(username: beneficiary)

John Wilhelm Scholarship

Learn:

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

John Wilhelm Scholarship

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

Who is eligible

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

You must meet the following requirements:

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

How to apply

- You may apply for the scholarship through the UNLV financial aid and scholarship office by completing the Free Application for Federal Student Aid (FAFSA) and any other required materials. Contact UNLV for help getting or completing the required application materials, or for information on application deadlines.
- You must apply for the scholarship each year, even if you have received it in the past. You may re-apply each year, even if you did not receive it in prior years.

Scholarship decisions

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

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

Other important information

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

Appeal rights

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

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

See page H-9 for more information about the subcommittee's review of your appeal, and when you will be notified of the Appeal Subcommittee's decision.

General exclusions and limitations

Learn:

- The types of care not covered by the Plan.

General exclusions and limitations

Each specific benefit section has a list of the types of treatment, services, and supplies that are not covered. In addition to those lists, the following types of treatment, services and supplies are also excluded for all medical care, prescription drugs, vision care, and the short-term disability benefits.

The following list will generally not apply to emergency medical treatment. However, the Fund will still not cover any treatment that would otherwise be excluded, regardless of the circumstances (for example, the Fund does not cover any treatment that is not medically necessary).

No benefits will be paid under the Plan for charges incurred for or resulting from any of the following:

- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a healthcare provider.
- Any injury, 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 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 I-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 I-6).*
- Experimental treatment *(see page I-4)*, or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH.
- Any expense or charge for failure to appear for an appointment as scheduled, or charge for completion of claim forms, or finance charges.
- Any treatment, services, or supplies provided by an individual who is related by blood or marriage to you, your spouse, or your child, or who normally lives in your home.
- Any dental treatment of teeth or their supporting structures, or services or supplies associated with such treatment, unless specifically stated as covered.

- Any treatment, services, or supplies purchased or provided outside of the United States (or its Territories), unless for a medical emergency. The decision of the Trustees in determining whether an emergency existed will be final.
- Any charges incurred for treatment, services, or supplies as a result of a declared or undeclared war or any act thereof; or any loss, expense or charge incurred while a person is on active duty or in training in the Armed Forces, National Guard, or Reserves of any state or any country.
- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault.
- Any expense greater than the Plan's maximum benefits, or any expense incurred before eligibility for coverage begins or after eligibility terminates, unless specifically provided for under the Plan.
- Any charges incurred for education or training, unless specifically included as covered services.
- Cosmetic services.
- Any expense or charge by a rest home, old age home, or a nursing home.
- Routine physical examinations (unless specifically stated as covered), or medical certificates required for employment.
- Except as specifically stated as covered under the prescription drug benefits, any smoking cessation treatment, drug, or device to help you stop smoking or using tobacco.
- Birth control devices, fertility medication, or drugs or vitamins prescribed for dietary purposes.
- Any treatment, services, or supplies for or in connection with the pregnancy or pregnancy-related condition of a dependent child.
- Any charges denied for any treatment, services, or supplies requiring prior authorization, when this mandatory program is not used as required.
- Any elective procedure (other than sterilization or abortion, or as otherwise specifically stated as covered) that is not for the correction or cure of a bodily injury or sickness.
- Procedures to reverse a voluntary sterilization.
- Treatment for or in connection with infertility, other than for diagnostic services.
- Hospital charges for personal comfort items, including but not limited to telephones, televisions, cosmetics, guest trays, magazines, and bed or cots for family members or other guests.

- 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 beds.
- Home construction for any reason.
- Any charges incurred while you are confined in a hospital, nursing home, or other facility or institution (or a part of such facility) which are primarily for education, training, or custodial care.
- Weight loss programs or treatment, except to treat morbid obesity if the program is under the direct supervision of a healthcare provider, or as specifically stated as covered (for example, diabetes education, or nutrition counseling).
- Any smoking cessation treatment, drug, or device to help you stop smoking or using tobacco, other than preventive healthcare services or as otherwise stated as covered.
- Eye refractions or eyeglass, 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 the section starting *on page D-31*).
- Hearing aids, hearing exams, or the fitting of hearing aids.
- Orthoptics, vision training, subnormal vision aids, or tonography (a test measuring pressure in the eye, unless otherwise specifically covered under the Plan.
- Psychological testing for the purpose of evaluating covered dependent children for school-related problems.
- Charges for shoe inserts and similar devices.
- Growth hormones, unless otherwise specifically covered under the Plan.
- Services provided by a social worker, unless otherwise specifically covered under the Plan.
- A service or item that is not covered under the Plan's claims processing guidelines or any other internal rule, guideline, protocol or similar criterion that the Plan relies upon.
- Charges of claims incurred as a result, in whole or in part, of fraud, false information, or misrepresentation.

Coordination of benefits

Learn:

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

These coordination of benefit provisions only apply to the medical benefits and the dental benefits. No coordination applies to prescription drug benefits, vision benefits, short-term disability benefits, or life and AD&D benefits.

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

This Plan coordinates benefits with the following types of plans:

- Group, blanket, or franchise insurance coverage.
- Group Blue Cross or Blue Shield coverage.
- Any other group coverage, including labor-management trusteed plans, employee organization benefit plans, or employer organization benefit plans.
- Any coverage under governmental programs or provided by any statute, except Medicaid.
- Any automobile insurance policies (including but not limited to "no fault" coverage containing personal injury protection (PIP)).

This Plan will not coordinate benefits with health maintenance organizations (HMOs) or reimburse an HMO for services provided. The Plan 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 Plan is primary, it will pay its full benefits. However, if the Plan is secondary, the benefits it would have paid will be used to supplement the benefits provided under the other plan, up to 100% of allowable expenses. Contact the Fund for more information about how the Plan determines allowable expenses when it is secondary.

Order of payment

The general rules that determine which plan pays first are summarized below. Contact the Fund if you have any questions.

- Plans that do not contain COB provisions always pay before those that do.
- Plans that have COB and cover a person as an employee always pay before plans that cover the person as a dependent.
- Plans that have COB and 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. In the event the dependent child's coverage under the spouse's plan began on the same date as either or both parents' plans, the order of benefits shall be determined by applying the birthday rule to the dependent child's parent(s) and spouse.

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, prior authorization, and referrals

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 have, or my dependent has, end-stage renal disease (ESRD)

Regardless of whether you have active, retiree, or COBRA coverage, the Plan pays primary for the first 30 months you (or your dependent) are eligible for Medicare because of ESRD 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.

When the Plan coordinates with itself

If you are covered under this Plan as both an employee and a dependent (for example, if you are an employee and your spouse's or your parent's dependent), or your dependents are also covered as the dependent of another employee (for example, if you and your spouse both cover your children), this Plan coordinates most of your coinsurance and copays with itself, reducing what you pay out-of-pocket.

However, this Plan will not coordinate any of the following items:

- Benefit maximums (for example, visit limits or dollar maximums).
- Deductibles.
- Coinsurance and copays for non-emergency treatment at a network or out-of-network emergency room.
- Coinsurance and copays for out-of-network providers (except for in-hospital consultations or providers like anesthesiologists, pathologists, radiologists, or emergency room providers that the Plan pays as a network provider).

Subrogation

Learn:

- Your responsibilities and the Plan's rights if your 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 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 bills, even though benefits for the same expenses may be paid by the Plan. By accepting benefits paid by the Plan, you agree to repay the Plan if you recover anything from a third party.

Statement of facts and repayment agreement

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

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

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

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

Settling your claim

Before you settle your claim with a third party, you or your attorney should contact UNITE HERE HEALTH to obtain the total amount of 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 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.
- When your dependents become eligible.

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 any 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

The Plan provides three levels of health care benefits depending on your employment classification and the level of employer contribution required by your Collective Bargaining Agreement:

- Class I Benefits (Regular Employees)
- Class II Benefits (Extra Employees—wait staff and bartenders)
- Class III Benefits (employees not qualifying as Regular or Extra Employees)

Employees

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

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

If you are required to make any payment toward the cost of providing coverage for your family, you must arrange with your employer to make those payments by payroll deduction. If your employer does not permit payroll deductions, you must submit any payment owed to UNITE HERE HEALTH. Payments are due by the 15th day of the month prior to the coverage month for which you are making a self payment.

UNITE HERE HEALTH
P.O. Box 6557
Aurora, IL 60598-0557

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 cannot start before your coverage starts. You cannot decline coverage for yourself and sign up your dependents.

If you don't sign up your dependent, or don't make any required payments for your share of dependent coverage, the Plan will not pay benefits for that person.

Who your dependents are

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

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

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

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

- 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 or your employer must provide the Fund with any required information before benefits will be paid on your behalf. You must provide the required information by the end of your initial enrollment period. UNITE HERE HEALTH will tell you when this information is due. You choose the level of coverage that is right for you.

Dependents

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

In order to enroll your dependents, you must provide any requested information about them to UNITE HERE HEALTH during your initial enrollment period. UNITE HERE HEALTH will tell you when this information is due. If you choose to just cover yourself (no dependent coverage), or if you do not provide the required enrollment materials by the due date, you have to wait to enroll your dependents until the next open enrollment or special enrollment period (*see page D-10* for more information).

See page G-7 for information about when coverage for your dependents starts.

You must 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 your marriage certificate.
- A commemoration of marriage from a generally recognized denomination of organized religion.
- A certified copy of the birth certificate.
- A baptismal certificate.
- Hospital birth records.
- Written proof of adoption or legal guardianship.
- Court decrees requiring you to provide medical benefits for a dependent child.

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

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

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

Eligibility

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. The terms of your employer's CBA determines when your employer must make contributions for your work, and when you establish initial eligibility.

For purposes of establishing initial eligibility:

- **Work period** means the 2-calendar-month period during which you meet the eligibility requirements described in your CBA, including any payments you are required to make for your share of your coverage:
  - **If your employer's CBA requires flat-rate monthly contributions:** Your employer must make a contribution to UNITE HERE HEALTH on your behalf.
  - **If your employer's CBA requires hourly contributions:** Your employer must make a contribution to UNITE HERE HEALTH on your behalf ***and***:
    - You are credited with at least 1 hour of work in each of the 2 months;
    - You are credited during the 2 month period with at least:
      1. For Class I and Class III employees: 160 hours of work
      2. For Class II employees: 64 hours of work for wait-staff and 32 hours of work for bartenders
- **Lag period** means the 2-calendar-month period between the end of a work period and the beginning of the corresponding coverage period.
- **Coverage period** means the calendar month you get coverage for benefits (based on the related work period).

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

Suppose employer contributions are required for the months of July and August. Your coverage begins on November 1 and continues through the entire month of November.

Continuing eligibility

Once you establish eligibility, you continue to be eligible as long as your employer is required to make contributions on your behalf as explained in your CBA.

For purposes of continuing eligibility:

- **Work period** means a calendar month during which you meet the eligibility requirements described in your CBA, including any payments you are required to make for your share of your coverage:
  - **If your employer's CBA requires flat-rate monthly contributions:** Your work period is any month during which your employer must make a contribution to UNITE HERE HEALTH on your behalf.
  - **If your employer's CBA requires hourly contributions:** Your work period is any month during which your employer must make a contribution to UNITE HERE HEALTH on your behalf and you are credited with at least:
    - For Class I and Class III employees: 80 hours of work
    - For Class II employees: 32 hours of work for wait-staff and 16 hours of work for bartenders
- **Lag period** means the 2-calendar-month period between the end of a work period and the beginning of the corresponding coverage period.
- **Coverage period** means the calendar month you get coverage for benefits (based on the related work period).

Example—Continuing Eligibility		
Work Period	Lag Period	Coverage Period
September	October and November	December
October	November and December	January

Example—Continuing Eligibility		
November	December and January	February

Suppose you became covered November 1 because your employer was required to make contributions on your behalf for the July and August work period. If a contribution is required on your behalf for September, your coverage continues during December. A contribution for October continues your coverage for January, November will continue your coverage for February, and so on.

Dependent coverage

✓ If you are a Class I employee, your CBA determines whether or not you must contribute towards the cost of your dependents' coverage.

✓ If you are a Class II or Class III employee, you must contribute towards the cost of your dependents' coverage.

Your dependents' coverage cannot start before your coverage starts. Your dependents will remain covered as long as you remain eligible, as long as you make any required payments for your share of your dependents' coverage, and they continue to meet the definition of a dependent. Dependent coverage cannot continue after your coverage ends (except in certain limited circumstances, *see page G-21*). Remember, you must enroll your dependents before the Plan will pay benefits (*see page G-4*).

If your employer pays the entire cost of your dependents' coverage

Your dependents' coverage begins on the date you become eligible for coverage as long as you enroll your dependents when you become eligible. If you get a new dependent, you can enroll the dependent at the next open enrollment or special enrollment period (*see page G-10*).

However, you may be able to enroll a previously unenrolled dependent outside open or special enrollment periods if your CBA provides for automatic dependent coverage. Contact the Fund at **(866) 686-0003** for more information about how to enroll a dependent, and when your dependents' coverage starts.

If you pay part or all of the cost of your dependents' coverage

- Your dependents' coverage will start on the date your coverage starts as long as you make an initial payment to the Fund equal to 3 monthly payments.

- If you don't make this initial 3-month payment:
  - **If you are a Class I employee:** Your dependents' coverage will begin on the 1st day of the third month following the month of your first payroll deduction. (For example, if your payroll deductions start in July, your dependents' coverage will start October 1.)
  - **If you are a Class II or Class III employee:** Your dependents' coverage will begin on the 1st day of the 3rd month following the month in which you make your 1st monthly payment to the Fund, as long as you make the payment by the 15th of the month before the month for which coverage is to begin. (For example, if you make your first payment to the Fund on July 10th, your dependents' coverage will start October 1.)

If you don't enroll your dependents when you first become eligible, you will have to wait until the next open or special enrollment period to add dependents (*see page G-10*).

However, if you pay a composite rate for your share of your dependents' coverage (meaning you pay the same amount no matter how many dependents you have), you may be able to enroll a previously unenrolled dependent outside open or special enrollment periods. Contact the Fund at **(866) 686-0003** for more information about how to enroll a dependent, and when your dependents' coverage starts.

Disability credit hours to continue eligibility

Class II employees are not entitled to disability credit hours.

If you are a Class I or III employee, you can continue eligibility while you are totally disabled if you meet all of the following:

- You have established initial eligibility.
- You have become totally disabled for at least 15 days because of injury or sickness, including pregnancy.
- You were actively working during the month you became totally disabled.
- You were credited with at least 80 hours of work during the work period immediately preceding the one in which total disability begins.
- You provide acceptable proof of your total disability to the Fund.

If you meet these requirements, you will be credited with up to 80 disability credit hours for each work period you are totally disabled. If your employer's CBA requires a flat-rate contribution, you get disability credit hours in an amount necessary to maintain eligibility for each work period you are totally disabled.

Hours you actually work during the work period in which your total disability begins and the work period during which your total disability ends will be subtracted from the amount of disability credit hours you could otherwise get.

You can continue you coverage with disability credit hours for up to 12 consecutive work periods (12 months).

You are considered disabled if you are prevented by injury or sickness from engaging in the normal activities of your job. The required claim forms are available at www.uhh.org.

Self-payments

Self-Payments for continuing eligibility

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

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

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

The work period for which you are making a self-payment must immediately follow a work period for which you were credited with at least the minimum work requirement to maintain eligibility, for which your employer is required to make a contribution on your behalf, or for which you make a COBRA self-payment.

- If your employer's CBA requires flat-rate contributions, the amount of self-payment is the same as the flat-rate contribution the employer must pay under the terms of the CBA.
- If your employer's CBA requires contributions on an hourly basis, the amount of the self-payment is:
  - **For Class I and III employees:** Your employer's hourly rate times the difference between 80 hours and your actual hours credited for that work period.
  - **For Class II employees:** The difference between 40 hours and your actual hours credited for that work period.

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

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

Self-payments can be made by calling the Fund at **(866) 686-0003**. You can also mail your self-payment. Contact the Fund for more details.

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 your work place reopens. However, you may only make self-payments for up to 18 months from the date your work place closed.

However, if the facility is not reopened, if you are not recalled, or if you decline recall, no further self-payments will be accepted to continue your coverage. Your coverage will terminate on the last day of the month for which a payment was last accepted. However, you may be eligible for COBRA coverage (*see page G-22*).

Self-payments during a strike

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

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

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

Enrollment periods

Open enrollment periods

Open enrollment periods give you the chance to elect coverage for your dependents if you do not have dependent coverage, or want to add additional dependents. If you want to enroll dependents, you must provide the required enrollment materials and arrange to make any required payments. Your open enrollment materials will describe the deadlines for enrollment and when coverage will start.

Special enrollment periods

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

- Termination of other health coverage you (or your dependent) had when you previously became eligible for coverage (or your dependent first became eligible for coverage). If your (or your dependent's) other coverage was COBRA, you have a special enrollment right only if you (or your dependent) have exhausted the COBRA maximum continuation period.
- Your marriage.
- The birth of a child.
- The adoption or placement for adoption of a child under age 26.
- A dependent previously living in a foreign country comes to the United States and takes up residence with you.
- The loss of your or a dependent's eligibility for Medicaid or Child Health Insurance Program (CHIP) benefits.
- When you or a dependent becomes eligible for financial assistance under Medicaid or CHIP to help pay for the cost of UNITE HERE HEALTH's dependent coverage.

As long as you enroll within 60 days and make the number of monthly payments required, coverage for your dependents will start:

- the 1st day of the month following your marriage or termination of other coverage.
- the date of event for all other special enrollment events.

For help understanding when dependent coverage will start if your payment doesn't include the extra payments to start coverage right away, call the Fund at **(866) 686-0003**.

If you don't take advantage of a special enrollment period, you must wait until the next open enrollment period or special enrollment period to enroll your dependents.

Termination of coverage

Learn:

- When your coverage and your dependents' coverage ends.

Your and your dependents' coverage continues as long as you maintain your eligibility as described *on page G-6* and you make any required payments for your share of your dependents' coverage. However, your coverage ends if one of the events described below happens. If your coverage terminates, you may be eligible to make payments to continue your coverage (called COBRA continuation coverage). *See page G-22*.

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 **(866) 686-0003**.

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 corresponding to the work period for which your employer was required to make a contribution on your behalf, and, if applicable, you were credited with the minimum number of hours required to maintain eligibility during the corresponding work period.
- The last day of the coverage period for which you last made a timely self-payment, if allowed to do so.

See page G-15 for special rules that apply if your employer's CBA expires.

When dependent coverage ends

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

- The date the Plan is terminated.
- Your (the employee's) coverage ends.
- The dependent enters any branch of the uniformed services.
- The last day of the last coverage period for which you made a timely payment for dependent coverage.
- The last day of the month in which your dependent no longer meets the Plan's definition of a dependent.

You may also ask the Fund to stop covering your dependent (or dependents). Contact the Fund at **(866) 686-0003** for more information about how to stop covering a dependent, or how to re-enroll a dependent if you change your mind.

The effect of severely delinquent employer contributions

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

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

Special termination rules

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

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

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

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

Then: Your coverage ends on the last day of the coverage period corresponding to the last work period for which contributions were received.

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

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

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

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

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

Certificate of creditable coverage

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

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

Reestablishing eligibility

Learn:

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

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 UNITE HERE HEALTH stating that your eligibility should be provided under the portability rules. Your eligibility under the new Plan Unit will be based on that Plan Unit's rules to determine eligibility for the employees of new contributing employers (immediate eligibility).
- If written notice is not provided within 60 days after you begin working for your new employer, your eligibility under the new Plan Unit will be based on that Plan Unit's rules to determine eligibility for the employees of current contributing employers.

Family and Medical Leave Act

The Fund complies with federal law governing leaves of absence under the Family and Medical Leave Act (FMLA), including continuing your and your dependents' coverage during your leave and reinstating your coverage following your leave. Your employer may still be required to make contributions on your behalf, and you may still be required to make any applicable payments for your or your dependents' coverage. Contact your employer with questions about FMLA leaves of absence.

The effect of uniformed service

The Fund complies with federal law governing military leaves of absence under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Provided your return to work is in accordance with federal law and you make any applicable payments for your or your dependents' coverage, your and your dependents' coverage will be reinstated immediately upon your return to covered employment (no waiting period will apply).

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 G-6).*
If your loss of eligibility lasts for 12 months or more you must again satisfy the Plan's initial eligibility rules *(see page G-5)*.

Reestablishing eligibility for dependents

If you remain eligible but dependent coverage terminates because you stop making the required payments, you will not be able to re-enroll your dependents until the next special enrollment period or next open enrollment period *(see page G-10)*, whichever happens first.

If dependent coverage terminates because you lose eligibility for reasons other than termination of employment, your dependents' coverage will be reestablished on the first day of the third month immediately following the month in which you once again begin making payments for dependent coverage, as long as you begin making payments immediately upon your return to covered employment.

COBRA continuation coverage

Learn:

- How you can make payments to continue your coverage.

The right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. **This part of your SPD explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.**

For more information about your rights and obligations under the Plan and under federal law, you should read this SPD or contact the Fund.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage, except that you cannot continue life and accidental death and dismemberment insurance or short-term disability benefits. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct; or
- Your employer withdraws from UNITE HERE HEALTH.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse's employer withdraws from UNITE HERE HEALTH;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee's employer withdraws from UNITE HERE HEALTH;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

UNITE HERE HEALTH uses its own records to determine when participants' coverage under the Plan ends.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

UNITE HERE HEALTH
Attn: COBRA Department
P. O. Box 6557
Aurora, IL 60589-0557

You should use the Fund'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 at **(866) 686-0003**.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, 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 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.

COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

You must complete a COBRA continuation coverage election form and submit it within 60 days from the later 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.

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 can be made by check or money order (or other method acceptable to UNITE HERE HEALTH), payable to UNITE HERE HEALTH, and mailed to:

UNITE HERE HEALTH
Attn: COBRA Department
P. O. Box 809328
Chicago, IL 60680-9328

Generally, COBRA continuation coverage is a temporary continuation of coverage that lasts for up to 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To qualify for this special extended COBRA Coverage, the individual must send (or bring) to the Fund Office the Social Security disability determination before the initial 18 months of continuation coverage expires. After the Plan receives a copy of the disability determination, you will be notified of any increase in cost required to continue the COBRA Coverage for the extended period (the period between 18 and 29 months). Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event.

This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

When will COBRA continuation coverage end?

COBRA continuation coverage will end when you have reached the maximum period of time for which coverage can be continued. However, continuation coverage will end sooner if any of the following occur:

- 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.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through self-pay (if you have that option), or the Health Insurance Marketplace, in Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.HealthCare.gov.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out-of-pocket than you would under COBRA because the new coverage may impose a new deductible.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa (addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:

UNITE HERE HEALTH
Attn: COBRA Department
P. O. Box 6557
Aurora, IL 60589-0557
(866) 686-0003

Claim filing and appeal provisions

Learn:

- What you need to do to file a claim.
- The deadline to file a claim.
- When you will get a decision on your claim.
- How to appeal if your claim is denied.
- When you will get a decision on your appeal.
- 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 or member ID number.
- A description of the injury, sickness, symptoms, or other condition upon which your claim is based.

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

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

Claims for life or AD&D benefits may require a certified copy of the death certificate. All claims for benefits must be made as shown below. If you need help filing a claim, contact the Fund at **(866) 686-0003**.

Medical/surgical and mental health/substance abuse claims
Network providers will generally file the claim for you with the local Blue Cross Blue Shield plan where you were treated.

When you should file a claim directly with the Fund:

However, in some case you may need to file a claim directly with the Fund:

- If your non-network provider will not file a claim for you or if you paid out-of-pocket for services and need reimbursement.
- Claims for reimbursement for medical foods and travel and lodging expenses.

In these cases, be sure to include a completed claim form and itemized receipts, as well as any other necessary information. You can get the claim form on www.uhh.org. If you need help filing a claim, contact the Fund at **(866) 686-0003**.

UNITE HERE HEALTH
Attention: Claims Manager
P.O. Box 6020
Aurora, IL 60598-0020
Fax: (630) 236-4394
claims@uhh.org

The Fund is always careful with your personal information, but email is not always private or secure. Please keep this in mind before emailing the Fund.

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 network pharmacy, you should send it to:

WellDyneRx Claim Reimbursement
P.O. Box 90369
Lakeland, FL 33804

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

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

All other claims
All dental claims, life or AD&D claims, short-term disability claims, or any claims denied because you are not eligible, should be mailed to:

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

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

Deadlines for filing a benefit claim

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

Deadline for filing a claim	
Type of claim	**Deadline to file**
Vision claims	365 days following the date the claim was incurred
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). • 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.
All other claims— Including dental, short-term disability benefits, and healthcare benefits, including medical/surgical claims, mental health/substance abuse claims, 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 on your behalf 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. Call UNITE HERE HEALTH to obtain a form and submit it to:

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

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

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

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

Your authorized representative may act on your behalf 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 one time 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 clinical records on day 20 of your stay show that you only need to stay a total of 25 days, the approval for your skilled nursing facility stay may be changed from 30 days to 25 days. The final 5 days of your original 30-day stay will not be covered, and are considered a denial of your claim.

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

Your request that your approved course of treatment 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 the medical circumstances. You will be notified of the decision (whether denial or not) no later than 24 hours after receipt of your claim, provided you submit the claim at least 24 hours prior to the expiration of the initial treatment period.

Short-term disability claim
In general, you will be notified of the decision on your claim for short-term disability benefits no later than 45 days after your claim is received. This 45-day period may be extended for up to an additional 30 days if special circumstances require additional time. The Fund will notify you in writing if it requires more processing time before the end of the first 45-day period.

UNITE HERE HEALTH may extend this additional 30-day period of time for up to an additional 30 days for the same reason if it notifies you prior to the expiration of the initial 30-day extension period, of the circumstances requiring the extension of time and date by which UNITE HERE HEALTH expects to render a decision.

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

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

Rules for prior authorization of benefits

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

However, this 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 and AD&D claims

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

BCBSIL
Attn: Claim Department Appeals Specialist
P.O. Box 7070
Downers Grove, IL 60515-5591

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

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

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

Two levels of appeal for medical prior authorization denials

First level of appeal
All appeals for medical/surgical claims denied under the prior authorization program (prior authorization denials, denials based on retrospective review, or extensions of treatment beyond limits previously approved) must be sent within 12 months of your receipt of the claim denial to:

HealthCheck360
Appeals
800 Main Street
Dubuque, IA 52001

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

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
P.O. Box 6020
Aurora, IL 60598-0020

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

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

John Wilhelm Scholarship benefits: one level of appeal

If you or your dependent(s) do not get the scholarship benefit because you do not meet the Fund eligibility requirement as described *on page D-48*, you may appeal the denial within 60 days of receiving the denial notice to:

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

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

One level of appeal for continuity of care denials

If your application for continuity of care for a network provider leaving the network (*see page D-3*) is denied, you must appeal the denial within 180 days of your receipt of the denial to:

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

All other claims: one level of appeal

If you disagree with all or any part of a short-term disability, dental, or vision claim denial, or post-service healthcare claim denial, and you wish to appeal the decision, you must follow the steps in this section. You must submit an appeal within 12 months of your receipt of the claim denial to:

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

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

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

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 medical appeals.
- **(844) 813-3860** for urgent prescription drug appeals.

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

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, including payments for dependent coverage, 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 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 H-4* for details).

In addition, UNITE HERE HEALTH must 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 must 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 Plan's external review procedures (where applicable), how to appeal for external review, and the time limits applicable to such procedures.

Independent external review procedures

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

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

- You must have been eligible for benefits at the time you incurred the medical expense.
- Your claim denial must involve a claim subject to the following federal no surprises billing protections:
  - Non-network emergency medical treatment;
  - Non-network air ambulance services;

  - Services and supplies provided by a non-network provider in connection with a visit at a network hospital (including outpatient department) or a network ambulatory surgical center.

- The denial must not relate to your failure to meet the Plan's eligibility requirements (eligibility claims are not subject to external review).
- You must have exhausted your internal appeal rights.
- You must submit all the necessary information and forms.

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

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

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

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

Internal appeal exception

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

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

Non-assignment of claims

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

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

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

Commencement of legal action

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

If you finish all internal appeals and decide to file a lawsuit against the Plan, that lawsuit must be commenced no more than 12 months after the date of the appeal denial letter. If you fail to commence your lawsuit within this 12-month time frame, you will permanently and irrevocably lose 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 the Plan uses.

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

Allowable charges

An **allowable charge** is the amount of charges for covered treatments, services, or supplies that the Plan uses to calculate the benefits it pays for a claim. If you choose a non-network provider, the provider may charge more than the **allowable charge**. You must pay this difference between the actual charges and the **allowable charges**. Any charges that are more than the **allowable charge** are not covered. 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 where a different allowable charge is required by federal law for non-network emergency medical treatment or for claims subject to the federal surprise billing protections, the Plan calculates benefits for non-network providers based on an independent metric, such as Medicare rates, or the contracted network rates. This Plan will not pay the difference between what a non-network provider actually charges, and what is considered an allowable charge. You pay this difference in cost (this is sometimes called "balance billing").

Copay or copayment

A fixed amount (for example, $10) 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**, the Plan pays the rest of the covered expenses.

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

Your medical copays do not apply toward your out-of-pocket limit (*see page D-5*).

Coinsurance

Your share of the costs of a covered expense, calculated as a percent (for example, 20%) of the allowable charge for the service. For example, if the allowable charge for durable medical equipment is $1,000, your 20% **coinsurance** equals $200. The Fund pays the rest of the allowable charge.

Generally, your medical coinsurance applies toward your out-of-pocket limits (*see page D-5 and page D-16*).

Cosmetic services

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

Mastectomies, and reconstruction following a mastectomy, will not be considered a **cosmetic service** *(see page D-8)*.

Medically necessary gender reassignment services are not cosmetic services (*on page D-11*).

Covered expense

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

Deductible

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

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

Durable medical equipment (DME)

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

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

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

Emergency medical treatment

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

Emergency medical treatment includes services provided in the emergency department of a hospital or an independent freestanding emergency department. It also includes pre-stabilization services if you are admitted to the hospital from an emergency room, and post-stabilization services connected to the emergency medical treatment, such as outpatient observation or an inpatient or outpatient stay. However, emergency medical treatment will not include covered expenses after you give informed consent agreeing to give up your protections against balance billing as allowed under federal law.

Whether your treatment meets the definition of **emergency medical treatment** will be determined based on this definition rather than solely on your final diagnosis.

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.

Healthcare provider

A doctor or healthcare professional is any of the following:

- A person licensed to practice medicine and surgery as a Doctor of Medicine or Osteopathy;
- A person licensed as a dentist, podiatrist, chiropractor or optometrist and who is practicing within the scope of his or her profession.

- With respect to mental health and substance abuse treatment, any person who is licensed to practice any of the branches of medicine and surgery by the state in which the person practices, as long as he or she is practicing within the scope of his or her license.
- A dentist if he or she is licensed to practice dentistry or perform oral surgery in the state in which he or she is practicing, as long as he or she practices within the scope of that license.
- Additional types of providers specifically listed as covered—for example a certified diabetes educator providing diabetes education.

A primary care provider (PCP) is defined as a doctor 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 doctor 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 license. Another type of healthcare provider may be considered a dentist if the **healthcare provider** is performing a covered dental service and otherwise meets the definition of "**healthcare provider.**"

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

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

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

However, with respect to mastectomies and associated reconstructive treatment, allowable charges for such treatment is considered **medically necessary** for covered expenses incurred based on the treatment recommended by the patient's healthcare provider, as required under federal law. For ambulance benefits and medical necessity requirements *see page D-7*.

However, 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. 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, the Plan limits your cost-sharing for covered network medical services during a calendar year. This limit is called your out-of-pocket limit. Once your out-of-pocket costs for covered medical expenses meet the out-of-pocket limit, this Plan will usually pay 100% for your (or your family's) covered medical expenses during the rest of that year.

The following amounts do not count toward your out-of-pocket limit and will not be paid at 100%, even if you have met your out-of-pocket limit for the year:

- Copayments.
- Amounts you pay out of pocket for prescription drug expenses under the section titled "Prescription drug benefits."
- The 50% coinsurance you pay for certain covered services.

- Care or treatment you receive after meeting the Plan's maximum benefit.
- Amounts you pay for services and supplies that are not covered.
- Amounts over the allowable charge.
- Non-network care or treatment, except for situations in which the non-network provider is considered a network provider (*see page D-2*).

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

Plan Document

The rules and regulations governing the Plan of benefits provided to eligible employees and dependents participating in Plan Unit 106 (Pittsburgh).

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; however the Plan may contract with other organizations to help administer certain benefits. 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. HealthCheck360 provides prior authorization and other utilization review services, case management, and chronic condition management.
- Prescription drug benefits. These benefits are administered by Hospitality Rx, LLC, a wholly-owned subsidiary of UNITE HERE HEALTH.
- Vision benefits are administered by Davis Vision.
- Short-term disability benefits.
- Dental benefits.
- John Wilhelm Scholarship benefits.

The Plan provides the life and accidental death & dismemberment (AD&D) benefits on a fully insured basis. These benefits are funded and guaranteed under a group policy underwritten by Dearborn National (branded as BCBSIL).

Interpretation of Plan provisions

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

For claims subject to the independent dispute resolution process under the federal surprise billing protections, the independent dispute resolution entity has the sole authority to determine the allowable charges for purposes of provider payment. However, the independent dispute resolution entity has no authority over any other aspect of the Fund's administration, including but not limited to the determination of what benefit ts are payable and what expenses are covered.

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.

Restriction of venue

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

Amendment or termination of the Plan

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

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

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

Employer and employee organizations

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

Plan administrator and agent for service of legal process

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

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

Employer identification number

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

Plan number

The Plan Number is 501.

Plan year

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

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.

Benefits not vested

Retiree benefits provided through the Fund are not vested or accrued benefits. This means the retiree benefits are not guaranteed to continue indefinitely. The Trustees have full and exclusive authority to change or terminate the benefits and the eligibility requirements at any time.

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 relations 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 Blue Shield of Illinois
P.O. Box 805107
Chicago, IL 60680-4112
(800) 810-2583
www.bcbsil.com

Blue Cross Blue Shield of Illinois (Dearborn)
701 E. 22nd St, Suite 300
Lombard, IL 60148
(800) 367-6401
www.bcbsil.com/ancillary

Davis Vision
P.O. Box 1525
Latham, NY 121110
(800) 999-5431
www.davisvision.com

HealthCheck360
800 Main Street
Dubuque, IA 52001
(844) 462-7812
www.healthcheck360.com

Hospitality Rx
P.O. Box 6020
Aurora, IL 60598-0020
(844) 813-3860
www.hospitalityrx.org

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711 North Commons Drive
Aurora, IL 60504-4197
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www.uhh.org

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