MEDICAL: BLUE CROSS BLUE SHIELD PPO

The changes described in this SMM also affect your Summary of Benefits and Coverage (SBC). Remember, you can always get a copy of your SBC by visiting www.uhh.org/library or by calling **(866) 686-0003**.

New network, new rules for transplant and CAR-T services

Effective January 1, 2025, the following changes apply to all transplant-related and CAR-T therapy-related services. (CAR-T is a type of cancer immunotherapy that uses a patient's T cells to fight cancer.)

You must use the Fund-designated transplant and CAR-T network to get benefits for these services. The Fund-designated network for these very specialized types of care gives you access to the highest quality and experienced health care providers across the country.

The Plan will only pay benefits for transplant and CAR-T cell therapy (CAR-T) services (and any related services) if you use the transplant and CAR-T network, available through Optum and Cigna LifeSOURCE. ***This is not the same network as your PPO network.***

What the Plan pays for the covered transplant and CAR-T services is not changing. (For example, any office visit cost-sharing still applies to office visits.)

This change only applies if you are in the PPO medical benefit option.

To find providers in the Transplant & CAR-T Network contact **HealthCheck360** or visit **uhh.org/transplant**

UNITE HERE HEALTH

(866) 686-0003 • uhh.org

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

UNITE HERE! *Staff*

This document constitutes a Summary of Material Modifications (SMM) under the Employee Retirement Income Security Act of 1974, as amended, and summarizes recent actions taken by the Board of Trustees of UNITE HERE HEALTH. It describes benefit and administrative changes affecting the information included in your Summary Plan Description (SPD). This SMM addresses changes to all benefits in your SPD and may include changes and benefits that don't apply to you based on your or your employer's elections.

Please read this information carefully; then, keep it with your SPD for future reference. Except as described in this SMM, the information otherwise contained in your SPD continues to apply.

MEDICAL: BLUE CROSS BLUE SHIELD PPO *(continued)*

Get prior authorization for transplant and CAR-T services

You or your healthcare provider must call HealthCheck360 ***before***:

- Getting a transplant evaluation (or any transplant services) — except for cornea transplants; or
- Getting CAR-T services.

To get prior authorization, call toll free:

HealthCheck360
(844) 462-7812

Covered transplant expenses

The rules governing benefits for transplant services are generally not changing. (See "What's Covered" under the Medical benefits section of your SPD). However, there are two changes to how transplant services are covered:

- Transplants (and related services) will only be covered if you use the Fund-designated transplant network. No benefits are payable under the medical benefits for any transplant services if you don't use the transplant network.
- The exclusion for donor expenses if the donor has other coverage no longer applies.

A new exclusion is added to "What's not covered" under the Medical benefits section of your SPD:

Transplant-related and CAR-T-related services not provided through the Fund-designated transplant and CAR-T network, if use of the network is required.

Exceptions to the network rule for transplant and CAR-T services

These new rules do not apply if the Plan does not pay primary for you (the employee or dependent).

Get answers to all your questions: (866) 686-0003 • uhh.org

The UHH Member Portal mobile app gives you 24/7 access to your benefits!

Scan the QR code or search "UHH Member Portal" in your app store.

IPHONE

ANDROID

MEDICAL: BLUE CROSS BLUE SHIELD PPO *(continued)*

See the "Coordination of Benefits" section of your SPD for more information about the order the Plan pays your benefits if you have other health coverage.

These rules also don't apply to cornea transplants or emergency medical treatment, or if the Fund or its designee approves a network exception before you get the transplant-related or CAR-T-related services.

If you already started getting transplant services and had your transplant evaluation before January 1, 2025, this change will not apply to your transplant.

If your provider leaves the network

If your transplant or CAR-T provider leaves the network, the provider's contract with the transplant and CAR-T network will determine how your continuity of care works. You will be contacted with more information about how the continuity of care rules may apply to you and how to apply, if required.

Clarification to your prior authorization list

You must get prior authorization for physical, occupational, and speech therapy after the first 12 visits for each type of therapy *each calendar year*. This means that you must get prior authorization for any additional physical therapy visits after your first 12 physical therapy visits during a calendar year. This rule applies separately to occupational therapy visits and to speech therapy visits (e.g., after 12 visits of each type of therapy each calendar year, you must get prior authorization for any additional visits).

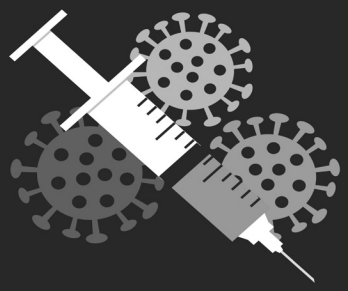
This change only applies if you are in the PPO medical benefit option.

Get answers to all your questions: (866) 686-0003 • uhh.org

Protect yourself!

Talk to your primary care doctor about which vaccines are right for you!

Vaccines help protect you from getting and spreading serious diseases that could result in poor health, missed work, medical bills, and not being able to care for your family. ***Want more info?*** *Visit www.cdc.gov*



GENERAL

Court-ordered treatment clarification

Under the general exclusions and limitations section of your Summary Plan Description, the exclusion for court-ordered or court-provided treatment is amended effective November 1, 2024 to read:

Court-ordered or court-provided treatment, unless the treatment would be covered under the Plan in the absence of the court order or requirement.

GENERAL: KAISER HMO

Updates to the Kaiser HMO grievance, claims, and appeals procedures

The claim and appeal rules for the Kaiser HMO medical and prescription drug benefits have been updated. The following language replaces the Kaiser HMO medical and prescription drug benefits section titled "Grievance, claims and appeals" in your Summary Plan Description.

This change only applies if you are in the HMO medical benefit option.

Grievance, claims, and appeals

This is a summary of your rights as of the date this was printed. ***Please note, Kaiser may change its procedures, which supersede this summary.***

Kaiser providers should always file a claim for you. However, you may have to file a claim for non-Kaiser providers. You should include bills, receipts, medical records, or any other related information.

GENERAL: KAISER HMO *(continued)*

Kaiser may ask for additional information; if you do not provide it, Kaiser will make the final decision with the information it has. You may review, without charge, a copy of all relevant information Kaiser has about your grievance, claim, or appeal.

If, after Kaiser pays your claim, you receive a non-Kaiser provider bill for charges other than your cost-sharing, please call Kaiser.

Another person, such as a friend, relative, or attorney, may file your claim, appeal, or grievance for you (you must inform Kaiser in writing who will represent you). You may file grievances, claims, and appeals or your minor children.

Filing Claims and Grievances

Claims are for services you have already received, such as non-plan or out-of-area urgent or emergency services, ambulance services, post-stabilization care, or services that were not authorized by Kaiser. File these with Kaiser as soon as possible.

Grievances are for any expression of dissatisfaction, including prior authorization denials, requests for non-formulary drugs, services your doctor determines are not medically necessary, services that are not covered, or continued coverage of ongoing courses of treatment. File within 180 days following the incident or action.

Contact **Kaiser** or visit any member services office for more information about your rights or for help.

www.kp.org

(800) 464-4000
(TTY: 711)

Get answers to all your questions: (866) 686-0003 • uhh.org

Good health starts with knowing your benefits!

- Your most up-to-date benefits information is always available online. Visit **www.uhh.org/library** to view your SPD, SBC, and other SMMs. These documents help you understand what your benefits are and how to use them. They also tell you the plan's rules and regulations.
- Your Benefits at a Glance, an overview of your benefits in an easy-to-read format, is also online. Go to **www.uhh.org** and select your plan.

GENERAL: KAISER HMO *(continued)*

Initial Filing		
Grievances	**Claims for non-Kaiser provider emergency services, post-stabilization care, out-of-area urgent care, or emergency ambulance services**	**All other services**
• Call member services: **(800) 464-4000 (TTY: 711)** • Visit www.kp.org **OR** • ***Non urgent grievances:*** Mail or take your grievance to any member services office* • ***Urgent grievances:*** Visit any member services office, or: Mail to: Kaiser Foundation Health Plan Expedited Review Unit P.O. Box 1809 Pleasanton, CA 94566 Call the Expedited Review Unit: **(888) 987-7247 (TTY: 711)** Fax the Expedited Review Unit: **(888) 987-2252**	• Visit www.kp.org **OR** • Mail your claim to: Kaiser Foundation Health Plan Claims Administration—SCAL P.O. Box 7004 Downey, CA 90242-7004	• Mail or take your claim to any member services office* • Call member services: **(800) 464-4000 (TTY: 711)** • Visit www.kp.org
** Visit www.kp.org for a directory*		

For grievances for nonformulary prescription drugs, Kaiser will notify you of the decision within 72 hours (24 hours for an urgent request).

For urgent grievances, you will receive oral notice as soon as your clinical condition requires, but within 72 hours. Contact Kaiser for information about when a grievance is urgent.

Unless you filed an urgent grievance or a grievance for nonformulary prescription drugs, Kaiser will give you its written decision within 30 days after receipt of your initial filing, but may request 15 more days for circumstances beyond its control. Kaiser will make a decision within these extra 15 days.

GENERAL: KAISER HMO *(continued)*

Filing Appeals

You may appeal a grievance or a claim denied in full or in part within 180 days of receiving Kaiser's denial. Kaiser will send the final decision within 30 days after receiving your appeal.

Filing an Appeal		
Appealing grievances	**Claims for non-Kaiser provider emergency services, post-stabilization care, out-of-area urgent care, or emergency ambulance services**	**Appealing all other services**
• Mail or take your appeal to any member services office* • Call member services: **(800) 464-4000 (TTY: 711)** • Visit www.kp.org	• Mail your appeal to: Kaiser Foundation Health Plan Special Services Unit P.O. Box 23280 Oakland, CA 94623 • Call member services: **(800) 464-4000 (TTY: 711)** • Visit www.kp.org	• Mail or take your appeal to any member services office* • Call member services: **(800) 464-4000 (TTY: 711)** • Visit www.kp.org
** Visit www.kp.org for a directory.*		

Independent review organization (IRO) reviews for nonformulary prescription drugs

You may request an IRO review of a denied nonformulary drug within 180 days of receiving the denial.

- Call **(888) 987-7247 (TTY: 711)** or fax: **(888) 987-2252**
- Visit any member services office (visit www.kp.org for a directory)
- Complete a grievance form at www.kp.org
- Mail a written request to:
  Kaiser Foundation Health Plan Inc.
  Expedited Review Unit
  P.O. Box 1809
  Pleasanton, CA 94566

GENERAL: KAISER HMO *(continued)*

You will receive a decision within 72 hours for non-urgent reviews (24 hours for urgent reviews). If the IRO does not decide in your favor, you may request independent medical review or submit a complaint to the California Department of Managed Healthcare.

Independent medical review

Independent medical review is available if you believe that Kaiser improperly denied, modified, or delayed services or payment of services, and one of the following requirements is met:

- The denial was based on a finding that the services are not medically necessary.
- The requested treatment was denied as experimental or investigational.
- A provider recommended medically necessary services.
- You got emergency services, emergency ambulance services, or urgent care services from a provider who determined the services were medically necessary.
- You were seen by a Plan provider for the diagnosis or treatment of your medical condition.

Also, if you file a grievance and you later need help with it because your grievance is an emergency, it hasn't been resolved to your satisfaction, or it's unresolved after 30 days, you may call the California Department of Managed Health Care toll free at **(888) HMO-2219** and a TDD line **(877) 688-9891** for the hearing and speech impaired for assistance.

Additional appeal rights

You may have additional rights beyond your Kaiser internal and external appeals. Contact Kaiser for more information.

If you need help with a grievance involving an emergency or a grievance unresolved after 30 days, contact the California Department of Managed Health Care.

Kaiser

(800) 464-4000
(TTY: 711)

www.kp.org

California Dept. of Managed Health Care

(888) HMO-2219
TDD: (877) 688-9891

www.dmhc.ca.gov