UNITE HERE HEALTH

BENEFIT MODIFICATIONS

MAY 2012

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 (the SPD).

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.

Expanded Medical Benefits for Certain Dental Procedures

Effective **as of May 1, 2005, medical benefits** for dental procedures **are expanded to include facility charges when dental procedures require an institutional setting** (inpatient or outpatient services) **to safely administer dental care** otherwise **covered by the Plan's dental benefits provisions.**

Deadline for Enrolling New Dependents Expanded

Effective as of January 1, 2011, **participants** who have elected Dependent Coverage **have 60 days instead of 30 days to enroll new dependents acquired while Dependent Coverage is in force.**

Expanded Coverage for Organ Transplants

Benefits for organ transplants are **no longer limited to** a list of **specific procedures.** Effective **as of January 1, 2012, all organ transplants qualify** as covered expenses under the Plan **if they are covered by Medicare at the time the transplant is performed.** A transplant is covered by Medicare if it meets Medicare's clinical, facility, and provider requirements.

To ensure the best possible outcome, **the person** undergoing the transplant **must also use a case management program recommended by the Plan,** including case management services provided by the Plan's utilization review organization.

All other benefits and limitations regarding organ transplants continue to apply.

Medical Coverage Expanded to Certain Jaw Surgeries

Effective **as of July 1, 2012, the Plan no longer excludes Le Fort-type operations** that are primarily performed to modify the relationship between the upper and lower jaw in order **to repair birth defects of the mouth, conditions of the mid-face** (over or under development of facial features), **or damage caused by accidental injury.**

Le Fort-type operations that are solely or primarily performed **for cosmetic purposes or** that are **not medically necessary are still excluded.**

Benefits for Generic Lipitor® as of June 1, 2012

When the generic version of Lipitor®, became available in November 2011, UNITE HERE HEALTH, through its pharmacy benefit manager, Catalyst Rx, provided a temporarily way to ease the transition from brand name Lipitor® to its generic version by:

- Postponing coverage for generic Lipitor®, and
- Reducing the copayment for brand name Lipitor® from the formulary copayment level to the plan's generic drug copayment level.

Effective as of June 1, 2012, benefits are available for generic Lipitor® and benefits for brand name Lipitor® will be determined according to your Plan's generic substitution requirements. See your Summary Plan Description for details.

New Claims and Appeals Rules Provide More Information

Among other things, the Patient Protection and Affordable Care Act (ACA) changed the rules that apply to a group health plan's claims and appeal processes to: provide participants with more information about why a claim or appeal was denied, explain how to request a review by an Independent Review Organization, and provide information about additional resources that may be available to help resolve any outstanding issues.

Effective as of April 1, 2012, new claims and appeal rules require that benefit denials:

- Will be communicated in an appropriate foreign language when requested by a claimant living in a county where at least 10% of the population speaks the same foreign language; the U.S. Census Bureau determines which counties meet this requirement.
- Must contain:
  - The health care provider's name,
  - The date the service was performed,
  - The denial code and an explanation of what it means,
  - A statement that the claimant may request the diagnosis and treatment codes and an explanation of what they mean,
  - A statement explaining the availability of and the contact information for the appropriate office of health insurance consumer assistance or ombudsman.

Errata

Specialist Copays – Alternate Plan I

The Specialist copayment on pages 35 & 36 of your Summary Plan Description erroneously reads: $30; it should read $35.

Home Health Care – Base Plan

That portion of the Benefits at a Glance describing benefits for Home Health Care Services on page 13 of your Summary Plan Description erroneously limits services to a combined 60 visit maximum each calendar year; **no limit applies**.