



UNITE HERE HEALTH
ALASKA

Plan Unit 190



Summary Plan Description

Your Health and Welfare Benefits

UNITE HERE HEALTH

Summary Plan Description

Alaska HERE Plan Unit 190

Effective January 1, 2020

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

Dear Plan Participant:

The Fund you belong to is the UNITE HERE HEALTH Fund.

Our mission is to provide health benefits that offer high-quality, affordable healthcare to our participants at better value with better service than is otherwise available in the market. We believe our success depends on innovation and on engaging our participants.

This book is your Summary Plan Description (SPD). It explains your Health Benefits, Life Insurance and Accidental Death and Dismemberment Plan, including information about Eligibility, benefits, limitations and exclusions, claims, claim review procedures, and your legal rights. **It is your responsibility to understand your Plan of Benefits and how to use them.**

You can also call the Health Fund at 844-427-8501. We have representatives who can help you in both English and Spanish. These representatives are trained to answer your benefit questions and help you with your concerns.

It is our pleasure to serve you, and we wish you good health!

Table of Contents

Using this book	A-1
How can I get help?	A-4
How do I get the most from my benefits?	A-7
Eligibility for Coverage.....	B-1
Termination of Coverage.....	B-15
Re-establishing Eligibility	B-21
Prior Authorization	C-1
Gold Medical Benefits	D-1
Silver Medical Benefits	D-17
Bronze Medical Benefits.....	D-33
Travel Benefit Program.....	D-49
Prescription Drug Benefits.....	D-53
Coalition Health Center	D-63
Wellness and Minor Care Program	D-67
Dental Benefits	D-73
Life and AD&D Insurance Benefits	D-81
The John Wilhelm Endowed Scholarship Benefit.....	D-89
Claim Filing and Appeal Provisions	E-1
Coordination of Benefits	F-1
Repayment and Subrogation.....	F-7
Out-of-Country Emergency Claims.....	G-1
Other Important Information	H-1
General Exclusions and Limitation.....	I-1
Your Rights under ERISA	J-1
COBRA Continuation Coverage	K-1
Definitions	K-9
UNITE HERE HEALTH Board of Trustees	K-21



Using this book

Learn:

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

Using this book

Please take some time to review this book.

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

What is UNITE HERE HEALTH?

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

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

What is this book and why is it important?

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

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

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

How do I use my SPD?

This SPD is broken into sections. You can get more information about different topics by carefully reading each section. A summary of the topics is shown at the start of each section. When you have questions, you should always contact the Fund at 844-427-8501. The Fund can help you understand your benefits.

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

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

Some terms are defined for you in the section titled “Definitions” starting on *page K-10*. The SPD will also explain what some commonly used terms mean. When you have questions about what certain words or terms mean, contact the Fund (*see page A-4*).

What are my benefit options?

The benefits described in this SPD describe the terms of all of the benefit options available under the Alaska HERE Plan. However, your CBA determines which benefit options you have. For example, you may be Eligible to participate in the Bronze plan based on your CBA, but there is information in the SPD that explains the Gold and Silver Plan benefits, therefore, the parts of the SPD that explains the Gold and Silver Plan benefits do not apply to you.

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

You can change your dependent coverage choices at certain times during the year, called “enrollment periods.” *See page B-9* for more information about enrollment periods.

The dental benefits apply only to you; your dependents are not Eligible for dental benefits.

When you have questions about your benefits, contact the Fund at 844-427-8501.

Medical benefits

The Alaska Plan has a Gold Plan, Silver Plan and a Bronze Plan. Based on your CBA, you were enrolled in one of these plans, once you satisfied the initial Eligibility period. If you want to enroll your Eligible dependents in the medical benefits, you must do so during an Eligibility period. *See page B-9* for more information about how to enroll your dependents. You can check your ID card or call the Fund at **844-427-8501** to see in which plan you are enrolled. *See page B-3* for the amount you pay to add your dependents to the medical benefits.

How can I get help?

Other benefits

The Alaska HERE Plan also includes dental benefits and life insurance and accidental death and dismemberment (AD&D) insurance benefits for employees only. These benefits are not available for Eligible dependents. You can find out more about dental benefits on *Page D-74* and Life/AD&D benefits on *Page D-82*.

UNITE HERE HEALTH
844-427-8501

Call the Fund:

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

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

This booklet contains a summary in English of your plan rights and benefits under the Alaska HERE Plan of UNITE HERE HEALTH. If you have difficulty understanding any part of this booklet, you can call UNITE HERE HEALTH at 844-427-8501 for assistance. Phones are answered from 8:30 A.M. to 4:30 P.M. Alaska time.

Other Important contacts

MultiPlan

(888) 636-7427
www.multiplan.com

CVS Caremark

(866) 818-6911
www.caremark.com

Medical Rehabilitation Consultants

111 W. Cataldo Avenue, Suite 200
Spokane, WA 99201-3203
(800) 827-5058

CVS/ Caremark Specialty Pharmacy

(800) 237-2767
www.cvsspecialty.com



How do I get the most from my benefits?

Learn:

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

How do I get the most from my benefits?

Get a primary care provider

You and each of your dependents should have a primary care provider (also called a “PCP”). You should get to know your PCP so he or she can help you get, and stay, healthier. Your PCP can help you find potential problems as early as possible, answer questions for you, and help coordinate your care with specialists. Your PCP also helps you keep track of when you need preventive care.

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

- ✓ If you are in the Anchorage or Fairbanks area, you can go to the Coalition Health Center for primary care. *See page D-64.*
- ✓ To find a PPO Provider in the Multiplan Network:
 1. Go to “<http://www.multiplan.com>”
 2. Click on “Find a Provider” in the top right corner of the page
 3. Click on “Select a Network”
 - ▶ For providers (doctors, Hospitals, etc.) in Alaska, your PPO network is Beech Street (MultiPlan)
 - ▶ For providers (doctors, Hospitals, etc.) in Washington, Idaho and Montana, your PPO network is First Choice Network (MultiPlan)
 - ▶ For providers (doctors, Hospital, etc.) in all other states, your PPO network is PHCS (MultiPlan)
- ✓ You can call MultiPlan at (888) 636-7427 or UNITE HERE HEALTH at 844-427-8501 to get help finding a PCP.

Get preventive care

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

Get prior authorization for your care

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

- ✓ Call Medical Rehabilitation Consultants at (800) 827-5058 to get prior approval for your care.

Re-think emergency room care

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

If you use a network Hospital emergency room for routine care your PCP could provide, you pay your Coinsurance (for example 40% under the Bronze Plan) of the Allowable Charges. (*See page K-13*) for a definition of “emergency.”)

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

Call the Fund

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

- ✓ You can also call the Fund **844-427-8501** to get help finding a PCP. If you choose a PPO Provider, you will usually pay less out-of-pocket.

Use PPO Providers

Reduce your costs with a PPO provider

The Plan generally pays higher benefits if you choose a PPO provider than if you choose a Non-PPO Provider. You only have to pay the difference between the PPO provider's discounted rate (the Plan's Allowable Charge) and what the Plan pays for covered services. The PPO provider cannot charge you for the difference between the Allowable Charge and his or her actual charges (sometimes called balance billing). This means that you will usually pay less out-of-pocket if you choose a PPO provider.

How do I get the most from my benefits?

Look in the medical benefits section for an example of how using a PPO provider can save you money. The Plan will apply PPO benefits to treatment provided by a Non-PPO Healthcare Provider who specialize in emergency medicine, radiology, anesthesiology, or pathology, as well as for in-Hospital consultations with Non-PPO Providers. However, the Allowable Charge will be determined based on whether or not the provider is in the network. You must still pay the difference between the Plan's Allowable Charge and what the Non-PPO Provider charges. This rule also applies if there is no PPO provider in that specialty.

Easier claims filing with a PPO provider

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

If you choose a Non-PPO Provider, you may have to pay all of the cost of your care and then send in a claim to be paid back to you for the Plan's share of your covered care. The Non-PPO Provider may not file a claim for you. *See page E-2* for more information about filing claims.

How do I stay in the network?

When you or your dependents require health care, you may choose any physician, Hospital or other health care provider you wish. However, if you use the services of a PPO provider within the Municipality of Anchorage, the Plan pays a higher rate of Coinsurance and has a lower annual Deductible and Coinsurance limit. Regardless of the provider you choose, benefits will be subject to all other terms, conditions and limitations of the Plan. The Plan does not supervise, control or guarantee the health care services of any provider (PPO or Non-PPO).

Your PPO Providers within the Municipality of Anchorage for Hospital services, physical therapy, hand therapy, emergency medicine and pathology services are listed below. You must use these providers for these services. If you go to another provider in Anchorage for these services, the provider will be a Non-PPO Provider and you will be reimbursed based on the Non-PPO benefits.

- Alaska Regional Hospital
- Chugach Physical Therapy
- Alaska Hand Rehabilitation
- Ascension Physical Therapy
- Denali Emergency Medicine Associates
- Pathology Associates

How do I get the most from my benefits?

A

The Fund is able to obtain substantial discounts at these facilities, in order to reduce overall health costs for you while maintaining high standards of care.

If you have questions about your benefits, or if you need help finding a PPO provider, call the Fund at 844-427-8501.

Getting Care Outside of the Municipality of Anchorage

If you go to a Hospital or other facility outside of the Municipality of Anchorage, you will pay the Deductible and Coinsurance percentage. Your out-of-pocket costs for a Non-PPO facility/Hospital may be higher, however, because the Plan may not pay as much as it would for a PPO Hospital or facility. This means the Hospital or facility may bill you for what the plan did not pay.

(See sample claim on page D-8)



Eligibility for coverage

Learn:

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

Eligibility for coverage

B

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

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

Who is Eligible for coverage

Employees

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

- You work for an Employer who is required by a CBA to contribute to UNITE HERE HEALTH on your behalf.
- The contributions required by that CBA are received by UNITE HERE HEALTH.
- You meet the Plan's Eligibility rules. *See page B-5* for more information about the Eligibility rules.

Dependents

If you have dependents when you become Eligible for coverage, you can sign up (enroll) your dependents for coverage during your initial enrollment period. Your dependents' coverage will start when yours does (not before).

You can add dependents after your coverage starts, but only at certain times. *See page B-9* for more information about enrollment events.

You must sign up any dependent you want covered and make any required contributions for the cost of dependent coverage. Your contributions are in addition to any cost sharing you pay for your specific healthcare services and supplies. Contact the Fund when you need more information about the amount of your contributions for your dependent's coverage. Contact the Fund for more information about when your dependents' coverage starts.

Cost of dependent coverage

Number of dependents	Monthly Contributions
1	\$35
2 or more	\$50

If you don't sign up your dependent(s), or don't make the required contributions for your dependent(s), the Plan will not pay benefits for that person.

Who your dependents are

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

- Your legally married spouse.
 - Your children who are under age 26, including:
 - Natural children.
 - Step-children.
 - Adopted children or children placed with you for adoption, if you are legally responsible for supporting the children until the adoption is finalized.
 - Children for whom you are the legal guardian or for whom you have sole custody under a state domestic relations law.
 - Children entitled to coverage under a Qualified Medical Child Support Order (QMCSO).
- ✓ Federal law requires UNITE HERE HEALTH to honor Qualified Medical Child Support Orders (QMCSO). 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 (QMCSO). To obtain a copy of these procedures at no cost or for more information, contact the Fund.

Eligibility for coverage

B

Your child may be covered after age 26 if he or she can't support himself or herself because of a mental or physical handicap. The handicap must have started before the child turned 19, and the child must have been covered under the Plan on the day before his or her 19th birthday. For more information, *see page B-17*. (Special rules apply to children with a mental or physical handicap who were covered under the Employer's plan when a new Employer begins participation in the Alaska HERE Plan. Contact the Fund with questions.)

Enrollment requirements

Employees

You are automatically enrolled. The Fund may request that you provide information and documentation the Fund requires for its records even if your Employer pays the entire cost of your coverage.

Dependents

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

In order to enroll your dependents, you must provide information about them when you enroll. You must provide the requested information during your initial enrollment period. UNITE HERE HEALTH will tell you when this information is due. If you do not provide the requested information by the due date, you may have to wait to enroll your dependents until the next open enrollment or special enrollment period (*see page B-9* for more information).

See page B-8 for information about when coverage starts for your dependent(s).

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

- A certified copy of the marriage certificate.
- A commemoration of marriage from a generally recognized denomination of organized religion.
- A certified copy of the birth certificate.

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

Only one parent's name must be on the documents you provide to the Fund as proof to show that a child is your dependent. However, if your name is not the parent's name listed on the proof of document, you must be able to show your relationship to the child (for instance, the child's listed parent is your spouse). For example, if your child's birth certificate names your spouse as the child's parent, but not you, you must also provide proof that you are married to your spouse in order to prove your relationship to the child.

You must provide any required dependent proof documents by the date you must provide your enrollment information (*See page B-9* for information about special enrollment rights). Remember, you must provide any required proof documentation before claims will be paid on behalf of your dependent.

When your coverage begins (initial Eligibility)

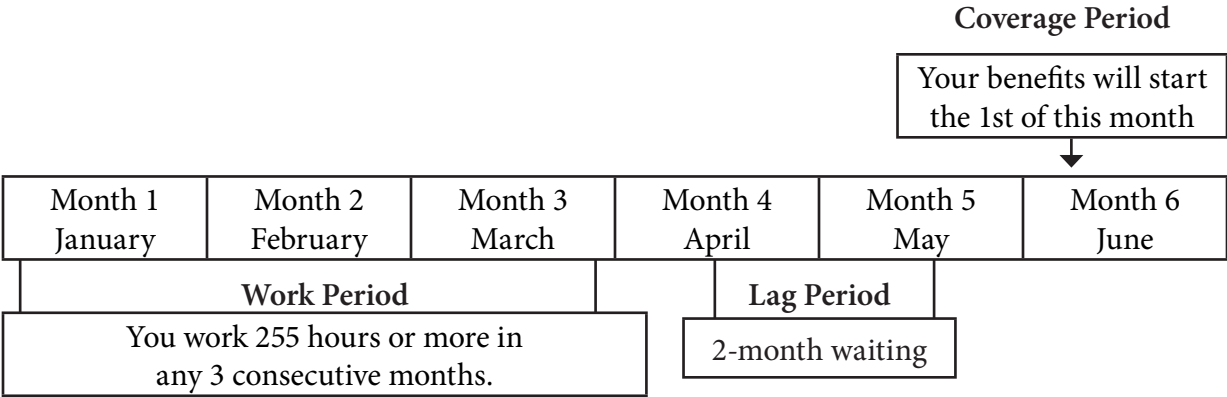
You're Eligible for medical and dental benefits on the 1st day of the 3rd month after you've worked 255 hours (or more) in 3 consecutive months (for example: January, February and March) and your Employer makes contributions on your behalf. This means your benefits will start on the 1st day of the 6th month (your coverage period).

Example: When you and your dependents' coverage begins

- You work at least 255 reported hours and contributions were paid by your Employer on your behalf in January, February and March (your work period).
- You will wait for your benefits in April and May (your 2-month waiting period or lag period).
- Your benefits will start on June 1st (your coverage period).

Eligibility for coverage

B



Continuing Eligibility

When you have met the initial Eligibility requirements, your coverage will continue when you work 100 hours in a month (about 25 hours a week) and your Employer continues to make the required contributions on your behalf under the terms of your CBA. Those hours will apply to Eligibility 2 months later.

Example: Keeping you and your dependents covered

- You’re already Eligible for benefits and your Employer makes contributions for 100 hours in January.
- You and your dependents will keep benefits for April.

If you work 100 hours and your Employer makes contributions for (your work period):	You and your dependent will be covered in (your coverage period):
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March

Hours Bank

If you have more than 100 hours reported and contributed for in covered employment in any month, your additional hours will be placed into an hours bank. If you don't have 100 hours reported and contributed for in a work month, hours from your bank will automatically be deducted to bring the total hours to 100 and maintain your Eligibility. The maximum number of hours you can have in your bank is 220, after deducting hours for the current month.

In the event you become inactive (no Eligibility for 12 consecutive months), all hours in your bank shall revert to the Plan, and you will need to reinstate your Eligibility in accordance with the Initial Eligibility provisions.

Hours Pay Up Option (Limited availability)

If you were hired prior to July 1, 2013, were in the Full Benefits (Legacy) Plan as of December 31, 2019, and elected in the Hours Pay Up Option for the plan year beginning January 1, 2020, you are eligible for the hours pay up option. You must work and have Employer contributions for at least 36 hours in a month to be able to use this self-pay option. Contact the Fund for more information.

Self-payments during remodeling or restoration

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

Self-payments during a strike

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

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

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

Eligibility for coverage

B

When dependent coverage starts

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

When you become Eligible for dependent coverage, you can choose coverage for 1 dependent or 2 or more dependents. Remember, you must enroll your dependents before the Plan will pay benefits for these claims (*see page B-4*).

If you enroll dependents when you become initially Eligible

Coverage for your dependents begins the same time yours does, as long as you provide all of the required enrollment materials by the deadline to enroll, plus begin making payments for the cost of your dependents' coverage.

If you add dependents after you become initially Eligible

- If you chose not to enroll your dependents when you became initially Eligible, you have to wait until the next open enrollment or special enrollment period (*see page B-9*) to enroll dependents.
- If you chose coverage for one dependent when you became initially Eligible, you have to wait until the next open enrollment or special enrollment period to enroll any additional dependents.
- If you elected coverage for 2 or more dependents or your family, when you became initially Eligible, you can add children at any time. The child's coverage will start as explained below:
 - If you have a new child (a child is born, adopted or placed with you for adoption, or moves to the U.S. to live with you), this is considered a special enrollment event, and the rules for special enrollment events (*see page B-9*) will determine when the child becomes covered.
 - You can enroll other children who meet the Fund's definition of "child" any time during the year. You don't have to wait for an open enrollment or special enrollment event. As long as you provide all required proof documentation within 30 days of telling the Fund you want to add the child, coverage for that child will start on the first day of the month following the date you tell the Fund about the child.

Continuing coverage for dependents

Your dependents will remain covered as long as you remain Eligible and you make any required payments for your dependents' coverage. Payments for the cost of dependent coverage is due on the 20th of the month prior to the month of coverage. However, you will have a 30-day grace period to make your payment, if you need it. If you stop paying or do not pay on a timely basis for dependent coverage, you must wait until the next annual enrollment period to enroll your dependents for coverage. Missed payments will result in a loss of coverage for the family members you have enrolled. It is important to make your payment on a timely basis. Payments must be made by check or money order, payable to UNITE HERE HEALTH, and mailed to:

UNITE HERE HEALTH

P.O. Box 809328
Chicago, IL 60680-9328

Enrollment periods

Open enrollment periods

Open enrollment periods give you the chance to elect coverage for your dependents. It also gives you a chance to change your coverage tier (for example, you decide to cover more than one dependent), if you only enrolled some of your dependents. If you want to enroll more dependents, you must provide the required enrollment material and arrange to make any required payments. Your open enrollment materials will describe the deadlines for enrollment and when coverage will start.

Special enrollment periods

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

- Termination of other group health coverage, including COBRA continuation coverage that your dependent had when you first became Eligible for coverage under the Plan (or your dependents first became Eligible for coverage under the Plan), unless the dependent lost coverage because you stopped making premium payments.
- Your marriage.
- The birth of your child.
- The adoption or placement for adoption of a child under age 26.

Eligibility for coverage

B

- A dependent previously residing in a foreign country comes to the United States and takes up residence with you.
- The loss of your or a dependent's Eligibility for Medicaid or Child Health Insurance Program (CHIP) benefits.
- When a dependent becomes Eligible for state financial assistance under a Medicaid or CHIP to help pay for the cost of UNITE HERE HEALTH's dependent coverage.

As long as you enroll your dependent within 60 days and you start making any required contributions, if you get married or the other coverage terminates (including coverage for Medicaid or a CHIP plan), or become Eligible for state financial assistance under a Medicaid or a CHIP, coverage for your dependents starts the first day of the month following the date of the event.

As long as you enroll your dependent within 60 days and you start making any required contributions, if your child is born, if you adopt a child, if a child is placed with you for adoption, or if a dependent comes to the United States to take up residence with you, coverage for your dependents starts on the date the child meets the definition of a dependent or the date the child comes to the United States to take up residence with you.

If you have questions about special enrollment periods or when coverage becomes effective, contact UNITE HERE HEALTH.

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

Retired Employees

You are Eligible for Retiree medical benefits only if you were Eligible for Retiree medical benefits under the Alaska HERE Plan and you elected Retiree coverage prior to January 1, 2020.

The Fund will advise you of the amount and method of paying the required monthly contribution for Retiree benefits.

Dependents of Retired Employees

Your dependents are also Eligible for coverage, if they meet the definition of an Eligible dependent, as described on [page B-3](#), and you make the required monthly contribution.

Special Enrollment Rules for Retirees

If, as a retired employee covered under this Plan, you acquire a new dependent (spouse or child) you may enroll them in this Plan provided you submit an enrollment form to the Fund within 60 days of the date the new dependent is acquired.

- For a new dependent acquired by marriage, coverage is effective the first of the month following the date of marriage to the Retiree.
- For a newborn dependent child, coverage is effective retroactively to the date of birth. For an adoption or placement for adoption, the effective date is the date of adoption or placement.

Surviving Family Members

If you die while covered under the Plan, medical coverage for your spouse and dependent children may continue as follows:

- Your spouse may continue coverage by electing and paying for the COBRA continuation coverage provisions (*see page K-2*). Additionally, after the maximum COBRA period has expired, the plan allows surviving spouses to continue self-payment until they remarry, die, or until the plan terminates, whichever occurs first.
- When your dependent child no longer meets the definition of an Eligible dependent, he or she may continue coverage under the COBRA continuation coverage provisions (*see page K-2*).

In order to continue coverage under the COBRA continuation provisions, your spouse or dependent must provide timely notice (*see page K-2* for details).

Retirees/dependents eligible for Medicare

Important! If a person in Retiree coverage is Eligible for Medicare coverage, the person must enroll in both parts A and B of Medicare.

If you are Eligible for Medicare, the Plan's Retiree medical benefits are paid on the assumption that you are enrolled in both Parts A and B of Medicare. If you have not enrolled, you could incur significant out-of-pocket expenses.

Medicare Part A covers general Hospital expenses and Part B covers doctor or medical expenses. The Fund strongly encourages all Retirees to contact the Social Security office to determine the procedures and timetables for enrollment in Medicare.

If you and/or your spouse start Medicare, it is your responsibility to notify the Fund and send a copy of your Medicare Card.

Eligibility for coverage

B

Medicare Part D Prescription Drug Coverage

The Plan's prescription drug program is not available for Medicare Eligible Retirees. However, Medicare prescription drug coverage is available to all individuals enrolled in Medicare Part D. You also may enroll in a Medicare prescription drug plan through another private health plan.

For More Information

For personalized help and more information about Medicare Parts A, B and D, visit www.medicare.gov or call (800) 633-4227.

Note: Retiree benefits are not guaranteed. The Board of Trustees provides these Retiree health and welfare benefits to the extent that money is available to pay for the program. The Board of Trustees retains full and exclusive authority, at its discretion, to determine the extent to which money is available for the program. This program is not guaranteed to continue indefinitely and may be terminated or modified at any time by the Board of Trustees.



Termination of Coverage

Learn:

- When your coverage and your dependents' coverage ends.

Termination of Coverage

B

Your and your dependents' coverage continues as long as you maintain your Eligibility as described *on page B-6* and you make any required contributions for your dependent's coverage. However, your coverage ends if one of the events described below happens. If your coverage terminates, you may be Eligible to make self-payments to continue your coverage (called COBRA continuation coverage). *See page K-2.*

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 844-427-8501.

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 month for which you worked and your Employer contributed for 100 hours, or for which you had 100 hours in your hours bank (unless you are Eligible for the Hours Pay Up option);
- The last day of the month before you enter the Armed Forces on active duty (except for temporary active duty of 31 days or less), although you may continue coverage on a self-pay basis under USERRA or COBRA continuation coverage rules.
- The last day of the month you are no longer Eligible for the Plan.
- The last day of the month for which your Employer was required to make a contribution on your behalf. For example, if your Employer's last required contribution on your behalf was for March, your coverage continues through the end of June.
- The last day of the coverage month for which you last made a timely Hours Pay up payment, if allowed to do so.
- The date of your death.

See page B-18 for special rules that apply if your Employer's CBA expires.

When dependent coverage ends

Your dependents' coverage will end the earliest of any of the following:

- The date the Plan is terminated.
- The date your (the employee's) coverage ends.
- The date the dependent enters any branch of the uniformed services.
- The last day of the month for which you made a timely dependent contribution.
- The last day of the month in which your dependent no longer meets the Plan's definition of a dependent.
- Upon your death, the last day of the Coverage period for which enough work hours were reported.
- Upon your death, the last day of the Coverage period for which a partial Hours Pay up is made when not enough work hours were reported.

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

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

You must provide proof of the mental or physical handicap within 30 days after the date coverage would end because of the child reaching age 26. You may also have to provide proof of the handicap periodically. (Special rules apply to children with a mental or physical handicap when a new Employer begins participation in the Alaska HERE Plan.) Contact the Fund for more information on how to continue coverage for a child with a serious handicap.

Certificate of creditable coverage

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

Termination of Coverage

B

Special termination rules

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

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

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

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

Then: Your coverage ends no later than the last day of the 2nd month following the month in which your Employer's contribution was due but was not made.

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

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

If: Your Employer withdraws in whole or in part from UNITE HERE HEALTH.

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

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

Retiree – Termination of coverage

Retiree coverage ends:

- The day the Retiree is no longer retired. This occurs on the first day of any month in which the Retiree works enough hours to restore active Eligibility under the Plan; or
- The day the Retiree dies; or
- If the monthly contribution is not paid on time in the correct amount. In this instance, coverage will end on the last day of the coverage period for which monthly contributions were made on time.

The effect of severely delinquent Employer contributions

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

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

Limited retroactive terminations of coverage allowed

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

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

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



Re-establishing Eligibility

Learn:

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

Re-establishing Eligibility

B

Re-establishing employee coverage

If you lose Eligibility, and your loss of Eligibility is less than 12 months, you can re-establish your Eligibility by satisfying the Plan's continuing Eligibility rules (*see page B-6*). If your loss of Eligibility lasts for 12 months or more you must again satisfy the Plan's initial Eligibility rules. If you lose Eligibility because of a leave of absence under the Uniformed Services Employment and Reemployment Rights Act, other rules apply.

Re-establishing dependent coverage

If you remain Eligible but your dependents' coverage terminates because you stop making the required payments, you will not be able to re-enroll your dependents until the next open enrollment period (*see page B-9*).

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

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

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

Family Medical Leave Act (FMLA) leaves of absence

For losses of Eligibility due to a leave of absence under FMLA, your dependents' coverage will be re-established on the first day of the month for which you once again begin making required payments for dependent coverage, as long as your payments begin as soon as you return to covered employment.

Loss of Eligibility other than termination of employment

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

Portability

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

- In order to qualify under this rule, within 60 days after you begin working for your new Employer, you, the union, or the new Employer must send written notice to the Services and Operations Department of UNITE HERE HEALTH stating that your Eligibility should be provided under the portability rules. Your Eligibility under the new Plan Unit will be based on that Plan Unit's rules to determine Eligibility for the employees of new Contributing Employers (immediate Eligibility).
- If written notice is not provided within 60 days after you begin working for your new Employer, your Eligibility under the new Plan Unit will be based on that Plan Unit's rules to determine Eligibility for the employees of current Contributing Employers.

Family and Medical Leave Act (FMLA)

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

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

Re-establishing Eligibility

B

The effect of uniformed service

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

- You provide your Employer with advance notice of your absence, whenever possible.
- Your cumulative length of absence for “Eligible service” is not more than 5 years.
- You report or submit an application for re-employment within the following time limits:
 - For service of less than 31 days or for an absence of any length to determine your fitness for uniformed service, you must report by the first regularly scheduled work period after the completion of service PLUS a reasonable allowance for time and travel (8 hours).
 - For service of more than 30 days but less than 181 days, you must submit an application no later than 14 days following the completion of service.
 - For service of more than 180 days, you must return to work or submit an application to return to work no later than 90 days following the completion of service.
- You begin making payments for dependent coverage upon your return to covered employment.

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

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

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



Prior Authorization

Learn:

- To get prior authorization for your care.
- Sign up for case management and utilization management.

Prior Authorization

C

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

Medical Rehabilitation Consultants works with you to help you find a provider, understand your treatment plan, and coordinate your healthcare and the information flow between your providers.

To get prior authorization, call toll free:
Medical Rehabilitation Consultants
(800) 827-5058

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

Get prior authorization for medical and surgical treatment

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

To get prior authorization, call toll free:
Medical Rehabilitation Consultants
(800) 827-5058

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

C-2

When to call for prior authorization

You or your Healthcare Provider should contact Medical Rehabilitation Consultants before any of the following:

- Adenoidectomy—surgical removal of the adenoids;
- Carpal Tunnel Release – surgery to release pressure on the median nerve in the wrist;
- Hemorrhoidectomy—surgical removal of hemorrhoids;
- Knee Arthroscopy (Diagnostic and Repair)—examination of the inside of the knee with a tiny camera (arthroscope);
- Pelvic Laparoscopy—examination of female organs by a scope;
- Surgical treatment of obesity;
- Tonsillectomy Adenoidectomy—surgical removal of the tonsils and adenoids;
- Tonsillectomy—surgical removal of the tonsils;
- Tympanostomy Tube Insertion—surgery to place drainage tubes in the ear; or
- Upper Gastrointestinal Endoscopy—examination of the esophagus, stomach and the first part of the small intestine by inserting a small tube (camera with a light) down the throat;
- Outpatient Surgery;
- Hospital stays;
- Inpatient services for mental health, behavioral health or substance abuse services;
- Rehabilitation services;
- Clinical Trials;
- Hospice services.

You should contact Medical Rehabilitation Consultants at least 7 days before receiving any of the above types of services and supplies. If you need emergency care, you should contact Medical Rehabilitation Consultants as soon as possible after you get the service or supply. If you are hospitalized because you are having a baby, you must call Medical Rehabilitation Consultants if your stay will be longer than 48 hours for normal childbirth, or 96 hours for a Cesarean section.

Prior Authorization

C

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

You do not need prior authorization in order to access obstetrical or gynecological care from a network Healthcare Provider who specializes in obstetrics or gynecology. The Healthcare Provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For help finding Healthcare Providers who specialize in obstetrics or gynecology, contact the Fund at **844-427-8501**.

See page E-6 for information about when Medical Rehabilitation Consultants must respond to your request for prior authorization and for information about how to appeal a prior authorization denial.

Case Management

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

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

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

However, in all cases, you and your Healthcare Provider make all treatment decisions.

You may be required to use the case management program in order to get benefits for transplants or travel and lodging costs. Otherwise, it is your choice whether or not to join the case management program, and whether or not to follow the program's recommendations.

C-4



Gold medical benefits

Learn:

- What you pay for healthcare.
- How Out-of-Pocket Limits protect you from large out-of-pocket expenses.
- What types of medical healthcare the Plan covers.
- What types of medical healthcare are not covered.

Gold medical benefits

Gold Plan Medical Benefits

In general, what you pay for medical care is based on what kind of care you get, where you get your care and whether you go to a Coalition/ PPO Provider or Any Provider Outside of Anchorage or a Non-PPO (Non-Coalition) Provider in the Municipality of Anchorage. For example, you pay less using an urgent care center instead of going to the emergency room. The annual Deductible applies to the services listed below, unless indicated it does not apply.

Unless shown otherwise, this table shows what you pay for your care (called your “cost-sharing”). You pay any Copays, your Coinsurance share, any amounts over a maximum benefit, and any expenses that are not covered, including any charges that are more than the Allowable Charge.

Annual Deductible and Out-of-Pocket Limits for Medical Care

Annual Deductibles: Coalition/ PPO Provider or Any Provider Outside of Anchorage (applies to all services unless otherwise noted)	\$250 person \$500 family	
Annual Deductibles: Non PPO (Non-Coalition) in the Municipality of Anchorage (applies to all services, unless otherwise noted)	\$500 person \$1,000 family	
Medical Out-of-Pocket Limits for Coalition/ PPO Provider or Any Provider Outside of Anchorage	\$3,000 person \$6,000 family	
Medical Out-of-Pocket Limits for Non-PPO (Non-Coalition) in the Municipality of Anchorage	\$8,750 person \$16,500 family	
	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non-Coalition) in Anchorage*

Office Visits

Preventive Healthcare (See page K-17)	No charge (Deductible does not apply)	No charge (Deductible does not apply)
---------------------------------------	---------------------------------------	---------------------------------------

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

Gold medical benefits

	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non- Coalition) in Anchorage*
Primary Care Provider (PCP) Office Visits	20% Coinsurance	20% Coinsurance
Telehealth Visits	No charge	Not covered
Specialist Office Visits	20% Coinsurance	20% Coinsurance
Mental Health/Substance Abuse Office Visits	20% Coinsurance	20% Coinsurance
Chiropractic Services (1 visit/day)	20% Coinsurance	20% Coinsurance
Routine Podiatry	20% Coinsurance	20% Coinsurance
Non-Routine Podiatry	20% Coinsurance	20% Coinsurance
Allergy Injections in an Office	20% Coinsurance	20% Coinsurance
Coalition Health Center		
Office visit and preventive service	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Emergency and Urgent Care		
Urgent Care Center	20% Coinsurance	20% Coinsurance
Hospital Emergency Room		
Emergency Care Provided in an ER	\$100 Copay plus 20% Coinsurance; Copay waived if admitted	\$100 Copay plus 20% Coinsurance; Copay waived if admitted
Routine Care Provided in an ER	\$100 Copay plus 20% Coinsurance	\$100 Copay plus 20% Coinsurance
Professional Ground Ambulance Services	20% Coinsurance	20% Coinsurance
Professional Air Ambulance Services	20% Coinsurance	20% Coinsurance

D

D-3

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

Gold medical benefits

D

	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non- Coalition) in Anchorage*
Outpatient Services		
Laboratory Services	20% Coinsurance	Non-hospital - 20% coinsurance Hospital - 30% coinsurance
Radiology (X-ray, Ultrasound, Fetal Monitoring)	20% Coinsurance	Non-hospital - 20% coinsurance Hospital - 30% coinsurance
Diagnostic Imaging (CT, MRI, PET) and Cardiac Imaging Testing	20% Coinsurance	Non-hospital - 20% coinsurance Hospital - 30% coinsurance
Outpatient Surgery		
Ambulatory Surgical Center	20% Coinsurance	30% Coinsurance for Non-PPO facility in the Municipality of Anchorage
Hospital Outpatient Department	20% Coinsurance	30% Coinsurance for Non-PPO facility in the Municipality of Anchorage
Physical, Speech, Occupational Therapy	20% Coinsurance	30% Coinsurance for Non-PPO facility in the Municipality of Anchorage

D-4

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

Gold medical benefits

	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non- Coalition) in Anchorage*
Radiation Therapy	20% Coinsurance	20% Coinsurance
Dialysis	20% Coinsurance	20% Coinsurance
Chemotherapy or Infusion Medication	20% Coinsurance	20% Coinsurance
Inpatient Treatment		
Inpatient Hospitalization Copay is waived after 4 or more stays/ person/ Calendar Year	\$350 Copay plus 20% Coinsurance	\$350 Copay plus 30% Coinsurance for Non-PPO facility in the Municipality of Anchorage
Skilled Nursing Facility— up to 100 days per confinement	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Wellness and Minor Care		
Wellness and Minor Care visit (Copay applies to your medical Plan Out-of-Pocket Limit.)	\$20 Copay	Not covered
Other Services and Supplies		
Diabetes Education	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Nutrition Education	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment	20% Coinsurance	20% Coinsurance
Home Healthcare Services — 100 visits/year	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Durable Medical Equipment	20% Coinsurance	20% Coinsurance

D

D-5

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

Gold medical benefits

	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non- Coalition) in Anchorage*
Hospice Care Inpatient: limited to 30 days	20% Coinsurance	20% Coinsurance
Orthotics (Other than podiatric orthotics)	20% Coinsurance	20% Coinsurance
Medical Foods	20% Coinsurance	20% Coinsurance
Transportation and Lodging for Certain Serious Medical Conditions	The Plan pays 100% up to \$3,500 annual maximum	
All Other Types of Medical Care	20% Coinsurance	20% Coinsurance

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

When a Non-PPO facility is used within the Municipality of Anchorage, the Allowed Amount for inpatient services is based on the PPO Coalition Contracted Rate. For physical therapy (outpatient services), the Allowed Amount will be equal to 50% of billed charges. This means you will be responsible for the difference in the Allowed Amount and the total amount the provider billed for the service. *See page D-8* for example of the benefits of using a PPO provider.

Commencement of legal action

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

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

PPO providers

Benefits are paid based on whether you use a PPO provider or a Non-PPO Provider. Your Plan lets you go to any doctor you want. If you go to a PPO provider in your MultiPlan PPO network, you will save money. The MultiPlan PPO network that you should use is based on what state you need to get care. If you go to a Non-PPO Provider (a provider that is not in your network), it may cost you more.

Below are the MultiPlan PPO networks to use by state:

If you're looking for providers in:	Your MultiPlan PPO Network is:
Alaska	Beech Street
Idaho, Montana, Washington	First Choice Health Network
All other states	PHCS Network

Finding a PPO Provider in the Multiplan PPO Network:

1. Go to www.multiplan.com
2. Click on "Find a Provider" in the top right corner of the page
3. Click on "Select a Network"
 - a. Choose "Beech Street" if you need a provider in Alaska
 - b. Choose "First Choice Health Network" if you need a provider in Idaho, Montana or Washington
 - c. Choose "PHCS" if you need a provider in any other state

If you need help finding a PPO provider, call:

MultiPlan
888-636-7427

Or

UNITE HERE HEALTH
844-427-8501

If you're in the Municipality of Anchorage, you must go to a Coalition PPO Provider for any of the services listed below to have benefits paid at the PPO level (*see page A-10* for a list of the Coalition PPO providers):

- Hospital Services
- Physical Therapy
- Hand Therapy

If you get these services in Anchorage from a provider who is not a Coalition provider, you will pay more.

Gold medical benefits

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

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

Sample claim – outpatient surgery in a Hospital			
	Coalition/ PPO	Non-PPO outside of Anchorage	Non-PPO (Non-Coalition) in Anchorage
A. Total charge	\$10,000	\$10,000	\$10,000
B. Network discount	-\$5,000	\$0	\$0
C. Plan's Allowable Charge (See page K-10)	\$5,000	\$4,500	\$5,000
What you pay			
D. Amount over allowable charge	\$0 (A minus B minus C)	\$5,500 (A minus B minus C)	\$5,000 (A minus B minus C)
E. Deductible (Individual)	\$250	\$250	\$500
F. Your Coinsurance share of the cost	\$950 (20%)	\$1,050 (20%)	\$1,350 (30%)
Your total payment	\$1,200	\$6,800	\$6,850

What you pay

You must pay your cost share such as Copays, and Coinsurance for your share of Covered Expenses. You must also pay any expenses that are not considered Covered Expenses (see page D-15 for information about excluded expenses), including any amounts over the Allowable Charge, or charges once a maximum benefit or limitation has been met.

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

Coinsurance

The Coinsurance covers your share of the healthcare you receive at the time of the service. For example, you pay your Coinsurance for all healthcare you receive during the office visit. You will pay an emergency room Copay and Coinsurance for all emergency care received during the emergency room visit.

See page K-11 for more information about what a Coinsurance is.

Deductible

There is a Deductible that applies to covered PPO expenses and a separate Deductible that applies to Non-PPO expenses. You only have to pay the Deductible once each year. Once you have paid your Deductible (sometimes called “satisfying your Deductible”), you do not have to make any more payments toward your Deductible for the rest of that year. The same rule applies if two or more members of your family satisfy the family Deductible. Once your family Deductible has been satisfied, no one else in your family has to pay Deductibles for covered services for the rest of that year.

Your \$250 individual and \$500 family PPO Deductibles apply to all services in which the PPO Deductibles apply, unless otherwise noted. Amounts you pay for prescription drugs or dental care will not apply to the medical plan Deductibles. A separate Deductible applies to dental benefits (see the dental benefits sections).

See page K-12 for more information about what a Deductible is

Copay

In addition to the Calendar Year Deductible you will also have a Copay if the following services are used:

- Hospital Admission: \$350 Copay per admission; waived after four or more stays per person per Calendar Year.
- Emergency Room Visit: \$100 Copay per visit; waived if directly admitted to the Hospital.

See page K-11 for more information about what a Copay is.

Out-of-Pocket Limit for PPO services and supplies

Your out-of-pocket cost sharing for most PPO medical Covered Expenses is limited to \$3,000 per person (\$6,000 per family) each year. Once your out-of-pocket costs for Covered Expenses meet these limits, the Plan will usually pay 100% for your (or your family's) PPO medical Covered Expenses during the rest of that year. Only your out-of-pocket cost sharing for medical healthcare applies to your \$3,000 Out-of-Pocket Limit (\$6,000 limit for your family). Amounts you pay out of pocket for prescription drugs or dental care will not apply to the \$3,000 or \$6,000 Out-of-Pocket Limits. A separate Out-of-Pocket Limit applies to prescription drug benefits (see page D-55) and to Non-PPO covered medical expenses.

See page K-17 for more information about what an Out-of-Pocket Limit is.

Gold medical benefits

Covered Benefits

What's covered

The Plan will only pay benefits for Injuries or Sicknesses that are not related to your job. Benefits are determined based on Allowable Charges for covered services resulting from Medically Necessary care and treatment prescribed or furnished by a Healthcare Provider.

- **Ambulatory surgical facility services**, including general supplies, anesthesia, drugs, and operating and recovery rooms. If you have multiple surgeries, Covered Expenses are limited to charges for the primary surgery. However, professional services for surgical procedures that would normally be performed in a provider's office are not covered.
- **Anesthesia** and its administration.
- **Artificial limbs and eyes**.
- **Birthing Center benefits** for female employees and dependent spouses only. If you or your dependent spouse uses a birthing center instead of a Hospital for childbirth and receives services and supplies which would be covered under the Plan as a Hospital expense, then the Plan will pay benefits in the same manner as for any other sickness.
- **Blood and blood plasma** and their administration.
- **Chemotherapy and infusion** services.
- **Chiropractic care** up to a total of 1 visit per day.
- **Durable Medical Equipment** and supplies for all non-disposable devices or items prescribed by a Healthcare Provider, such as wheelchairs, Hospital-type beds, respirators and associated support systems, infusion pumps, home dialysis equipment, monitoring devices, home traction units, and other similar medical equipment or devices, including supplies for DME.
 - 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.
- For employees and spouses only, pregnancy and pregnancy-related conditions, including childbirth, miscarriage, or abortion. However, routine Preventive Healthcare for a dependent child's pregnancy will also be considered a Covered Expense. Non-preventive care for a dependent child's pregnancy, including but not limited to ultrasounds, charges associated with a high-risk pregnancy, abortions, and maternity and delivery charges will not be covered.

- **Home healthcare services**, limited to a total of 100 visits per person each year for PPO and Non-PPO services combined. General housekeeping services or custodial care is not covered.
- **Hospice** services and supplies for a person who is terminally ill (life expectancy of less than 6 months). The services must be authorized by a Healthcare Provider.
- **Hospital charges** for room and board, and other inpatient or outpatient services.
- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- **Kidney dialysis** services.
- **Mastectomies**, including reconstruction of the breast upon which the mastectomy is performed, surgical treatment of the other breast to produce a symmetrical appearance, breast implants, and treatment of physical complications resulting from a mastectomy, including swollen lymph glands.
- **Medical 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. 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.
- **Medical services for organ transplants** are covered for the following procedures: kidney, heart, lung, heart/lung, liver, pancreas, kidney/pancreas, bone marrow/peripheral stem cell transplants and cornea. Covered transplant recipient benefits include:
 - The use of temporary mechanical equipment, pending the acquisition of “matched” human organs;
 - Multiple transplants during one operative session;
 - Replacements or subsequent transplants; and
 - Follow-up expenses for covered services (including immunosuppressant therapy).

When the transplant recipient is covered under this Plan, covered Donor expenses are paid up to \$5,000. Covered transplant Donor benefits include:

- Testing to identify suitable Donor(s);
- The expense for the acquisition of organs from a Donor;
- The expense of life support of a Donor pending the removal of usable organs;
- Transportation for a living Donor as provided for ambulance services under covered medical expenses; and
- Transportation of organs or a Donor on life support.

Gold medical benefits

D

The Plan will not pay the following:

- Any expenses when approved alternative remedies are available as determined by the Fund;
 - Any animal organ or mechanical equipment, device or organs, except as provided above;
 - Any financial consideration to the Donor other than a Covered Expense which is incurred in the performance of or in relation to transplant surgery;
 - Body organ transplants, except as provided above; and
 - Anything excluded under the General Exclusions and Limitations.
- Professional services for **diabetes education** and training for the care, monitoring, or treatment of diabetes.
 - Professional services for **nutrition counseling**.
 - **Nurse charges** for 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.
 - **Non-routine surgical podiatric services.** If more than one surgery is done during the same operation, Covered Expenses are limited to the Allowable Charge for the major procedure
 - Non-routine podiatric care, excluding x-rays. Podiatric orthotics are not covered.
 - Non-routine podiatric office visits are considered a specialist visit.
 - **Outpatient services** in a clinic or urgent care center or free-standing facility.
 - Outpatient rehabilitation services for **physical and occupational therapy**.
 - Outpatient **speech therapy services**
 - For adults, only speech therapy to restore speech lost as the result of Injury or Sickness is covered.
 - For dependent children, speech therapy is only covered to:
 - Screen, detect, and treat pervasive developmental disorders, such as autism and Asperger's.
 - Restore or improve speech for speech-language and developmental delay disorders caused by a non-chronic sickness, intra-uterine trauma, hearing loss, difficulty swallowing or acute Injury or Sickness.
 - Treat a speech delay associated with a specific disease, injury, or congenital defect, such as cleft lip and palate.

- **Oxygen** and rental equipment for its administration.
- **Phenylketonuria (PKU) treatment** coverage includes Medically Necessary formulas for you or your dependents. The Plan will pay expenses in the same manner and subject to the same conditions and limitations as for any other covered service.
- **Preventive Healthcare services** (*see page K-17*). The following limits apply to specific types of preventive care (other limits may apply to other types of preventive care based on your gender, age, and health status):
 - Cervical cancer screening (pap smears) once every 36 months for just the pap smear, or once every 60 months if both a pap smear and human papillomavirus screening are done together.
 - Routine mammograms for women are covered every 1-2 years if you are age 35 through age 74. Routine mammograms for women under 35, or older than 75, may be covered if you are at high-risk for breast cancer.
 - PSA tests for men are covered every year if you are between ages 40 and 69.
- **Professional medical and surgical service of a Healthcare Provider.**
The following rules apply:
 - If more than one surgery or procedure is done through the same incision or natural body cavity during the same operation, Covered Expenses are limited to the Allowable Charge for the major surgery or procedure.
 - Covered Expenses do not include incidental procedures performed through the same incision during one surgery.
- **Radiation therapy.**
- **Repair of sound natural teeth** and their supporting structures, if the Covered Expenses are the result of an injury, treatment must be received while you are covered under the Plan. You may have additional dental coverage under your dental benefits, if applicable—see the dental benefits section.
- **Routine foot care** (routine podiatry).
- **Skilled nursing facility care**, limited to total of 100 days per confinement each year for PPO and Non-PPO care combined. All of the following rules must be met:
 - The person must be under the care of a Healthcare Provider during the confinement.
 - The person must be confined as a regular bed patient.

Skilled nursing care facility benefits will be restored each new period of confinement. A new period of confinement begins at least 60 days after you were last confined in a skilled nursing care facility and satisfies the conditions described above.

Gold medical benefits

D

- **Sterilization procedures** for employees and spouses, and female dependent children.
- **Services of a surgical nurse** (a nurse who works under a surgeon to provide specialized nursing services before, during, and after surgery).
- **Surgical supplies and dressings**, including casts, splints, prostheses, braces, canes, crutches, and trusses.
- **Surgical treatment of Morbid Obesity** is covered up to a lifetime maximum of \$50,000. Contact the Fund for the criteria needed for this benefit. Because the cost of the surgery varies widely, we encourage you to inquire about the total cost of the procedure in advance.
- Transportation by a **professional ambulance service** to an area medical facility that is able to provide the required treatment. This includes by professional ambulance, railroad or commercial airline on a regularly scheduled flight. If you have no control over the ambulance getting called, for example when the ambulance is called by a healthcare professional, Employer, law enforcement, school, etc., the ambulance will be considered Medically Necessary. Contact the Fund (*see page A-4*) if you had no control over an ambulance being called. If transport is Medically Necessary, the Plan covers licensed air ambulance and/or round trip coach air or surface transportation for the patient within Alaska, or from Alaska to Seattle, Washington. If the patient is a child or a disabled adult, the Plan also covers air transport for an adult to accompany the patient. You must provide proof from your physician that air transport is necessary because treatment is not available in your locale or elsewhere in the state of Alaska. The Plan will not prepay for air transport.
- Treatment of **mental health conditions and substance abuse**, including inpatient and residential care, outpatient care, partial Hospitalization, intensive outpatient care, and ambulatory detoxification.
- Treatment of **tumors, cysts and lesions** not considered a dental procedure.
- Treatment of **temporomandibular joint (TMJ)** disorders, craniofacial disorders or orthognathic disorders.
- **X-rays and laboratory** work, including x-rays and laboratory work for chiropractic and non-routine podiatric care.

What's not covered

See page I-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 treatments, services, and supplies:

- Acupuncture. Except when used as an anesthetic agent for covered surgery.
- Ambulatory surgical facility fees for procedures normally performed in a provider's office.
- Any dental treatment of teeth or their supporting structures, other than those services covered under the dental benefit, unless otherwise specifically listed as a Covered Expense
- Any elective procedure, except sterilization or abortion, that is not to treat a bodily Injury or Sickness. The Trustees have the sole right and discretion to decide if a procedure is elective.
- Any services or supplies for or in connection with the treatment of teeth, natural or otherwise, and supporting structures. However, charges made by a Hospital or other facility for dental procedures covered under the dental benefit provisions, if applicable (see the dental benefits sections), will be covered if the procedure requires the patient to be treated in an institutional setting to safely receive the care. For example, if you suffer from a medical or behavioral condition, such as autism or Alzheimer's, that severely limits your ability to cooperate with the dentist providing the care, charges made by a Hospital or other facility will be considered a Covered Expense. Benefits for other types of dental care may be covered under the dental benefit as described in the dental section, if applicable.
- Eye or hearing exams, except as specifically stated as covered, or unless the exam is for the diagnosis or treatment of an accidental bodily injury or an illness.
- 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.
- Prescription drugs and medications, other than those used where they are dispensed. Prescription drugs may be covered under the prescription drug benefit shown on page D-55.
- Private duty nursing care.
- Services or supplies provided by a Non-PPO Provider if benefits are only payable for such services or supplies when a PPO provider is used.
- Surgery to modify jaw relationships including, but not limited to, osteoplasty and genioplasty procedures. However, Le Fort-type operations are covered when primarily to repair birth defects of the mouth, conditions of the mid-face (over or under development of facial features), or damage caused by accidental injury.



Silver medical benefits

Learn:

- What you pay for healthcare.
- How the network Out-of-Pocket Limits protect you from large out-of-pocket expenses.
- What types of medical healthcare the Plan covers.
- What types of medical healthcare are not covered.

Silver medical benefits

Silver Plan Medical Benefits

In general, what you pay for medical care is based on what kind of care you get, where you get your care and whether you go to a Coalition/ PPO Provider or Any Provider Outside of Anchorage or a Non-PPO (Non-Coalition) Provider in the Municipality of Anchorage. For example, you pay less using an urgent care center instead of going to the emergency room. The annual Deductible applies to the services listed below, unless indicated it does not apply.

Unless shown otherwise, this section shows what you pay for your care (called your “cost-sharing”). You pay any Copays, Deductibles, your Coinsurance share, any amounts over a maximum benefit, and any expenses that are not covered, including any charges that are more than the Allowable Charge.

Annual Deductible and Out-of-Pocket Limits for Medical Care

Annual Deductibles: Coalition/ PPO Provider or Any Provider Outside of Anchorage (applies to all services unless otherwise noted)	\$500 person \$1,000 family	
Annual Deductibles: Non PPO (Non-Coalition) in the Municipality of Anchorage (applies to all services, unless otherwise noted)	\$1,000 person \$2,000 family	
Medical Out-of-Pocket Limits for Coalition/ PPO Provider or Any Provider Outside of Anchorage	\$3,500 person \$7,000 family	
Medical Out-of-Pocket Limits for Non-PPO (Non-Coalition) in the Municipality of Anchorage	\$10,000 person \$20,000 family	
	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non-Coalition) in Anchorage*
Office Visits		
Preventive Healthcare (See page K-17)	No charge (Deductible does not apply)	No charge (Deductible does not apply)

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

Silver medical benefits

	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non- Coalition) in Anchorage*
Primary Care Provider (PCP) Office Visits	30% Coinsurance	30% Coinsurance
Telehealth Visits	No charge	Not covered
Specialist Office Visits	30% Coinsurance	30% Coinsurance
Mental Health/Substance Abuse Office Visits	30% Coinsurance	30% Coinsurance
Chiropractic Services (1 visit/day)	30% Coinsurance	30% Coinsurance
Routine Podiatry	30% Coinsurance	30% Coinsurance
Non-Routine Podiatry	30% Coinsurance	30% Coinsurance
Allergy Injections in an Office	30% Coinsurance	30% Coinsurance
Coalition Health Center		
Office and preventive services	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Emergency and Urgent Care		
Urgent Care Center	30% Coinsurance	30% Coinsurance
Hospital Emergency Room		
Emergency Care Provided in an ER	\$100 Copay plus 30% Coinsurance / Copay waived if admitted	\$100 Copay plus 30% Coinsurance / Copay waived if admitted
Routine Care Provided in an ER	\$100 Copay plus 30% Coinsurance	\$100 Copay plus 30% Coinsurance
Professional Ground Ambulance Services	30% Coinsurance	30% Coinsurance
Professional Air Ambulance Services	30% Coinsurance	30% Coinsurance

D

D-19

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

Silver medical benefits

D

	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non- Coalition) in Anchorage*
Outpatient Services		
Laboratory Services	30% Coinsurance	Non-hospital - 30% coinsurance Hospital - 40% coinsurance
Radiology (X-ray, Ultrasound, Fetal Monitoring)	30% Coinsurance	Non-hospital - 30% coinsurance Hospital - 40% coinsurance
Diagnostic Imaging(CT, MRI, PET) and Cardiac Imaging Testing	30% Coinsurance	Non-hospital - 30% coinsurance Hospital - 40% coinsurance
Outpatient Surgery		
Ambulatory Surgical Center	30% Coinsurance	40% Coinsurance for Non-PPO facility in the Municipality of Anchorage
Hospital Outpatient Department	30% Coinsurance	40% Coinsurance for Non-PPO facility in the Municipality of Anchorage
Physical, Speech, Occupational Therapy	30% Coinsurance	40% Coinsurance for Non-PPO facility in the Municipality of Anchorage

D-20

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

Silver medical benefits

	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non- Coalition) in Anchorage*
Radiation Therapy	30% Coinsurance	30% Coinsurance
Dialysis	30% Coinsurance	30% Coinsurance
Chemotherapy or Infusion Medication	30% Coinsurance	30% Coinsurance
Inpatient Treatment		
Inpatient Hospitalization Copay is waived after 4 or more stays/ person/ calendar year	\$350 Copay plus 30% Coinsurance	\$350 Copay plus 40% Coinsurance for Non-PPO facility in the Municipality of Anchorage
Skilled Nursing Facility— up to 100 days per confinement	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Wellness and Minor Care		
Wellness and Minor Care visit (Copay applies to your medical Plan Out-of-Pocket Limit.)	\$20 Copay	No Coverage
Other Services and Supplies		
Diabetes Education	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Nutrition Education	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment	30% Coinsurance	30% Coinsurance
Home Healthcare Services — 100 visits/year	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Durable Medical Equipment	30% Coinsurance	30% Coinsurance

D

D-21

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

Silver medical benefits

	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non- Coalition) in Anchorage*
Hospice Care Inpatient: limited to 30 days	30% Coinsurance	30% Coinsurance
Orthotics (Other than podiatric orthotics)	30% Coinsurance	30% Coinsurance
Medical Foods	30% Coinsurance	30% Coinsurance
Transportation and Lodging for Certain Serious Medical Conditions	The Plan pays 100% up to \$3,500 annual maximum	
All Other Types of Medical Care	30% Coinsurance	30% Coinsurance

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

When a Non-PPO facility is used within the Municipality of Anchorage, the Allowed Amount for inpatient services is based on the PPO Coalition Contracted Rate. For physical therapy (outpatient services), the Allowed Amount will be equal to 50% of billed charges. This means you will be responsible for the difference in the Allowed Amount and the total amount the provider billed for the service. *See page D-24* for example of the benefits of using a PPO provider.

Commencement of legal action

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

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

PPO providers

Benefits are paid based on whether you use a PPO provider or a Non-PPO Provider. Your Plan lets you go to any doctor you want. If you go to a PPO provider in your MultiPlan PPO network, you will save money. The MultiPlan PPO network that you should use is based on what state you need to get care. If you go to a Non-PPO Provider (a provider that is not in your network), it may cost you more.

Below are the MultiPlan PPO networks to use by state:

If you're looking for providers in:	Your MultiPlan PPO Network is:
Alaska	Beech Street
Idaho, Montana, Washington	First Choice Health Network
All other states	PHCS Network

Finding a PPO Provider in the Multiplan PPO Network:

1. Go to www.multiplan.com
2. Click on "Find a Provider" in the top right corner of the page
3. Click on "Select a Network"
 - a. Choose "Beech Street" if you need a provider in Alaska
 - b. Choose "First Choice Health Network" if you need a provider in Idaho, Montana or Washington
 - c. Choose "PHCS" if you need a provider in any other state

If you need help finding a PPO provider, call:

MultiPlan
888-636-7427

Or

UNITE HERE HEALTH
844-427-8501

If you're in the Municipality of Anchorage, you must go to a Coalition PPO Provider for any of the services listed below to have benefits paid at the PPO level (*see page A-10* for a list of the Coalition PPO providers):

- Hospital Services
- Physical Therapy
- Hand Therapy

If you get these services in Anchorage from a provider who is not a Coalition provider, you will pay more.

Silver medical benefits

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

See page A-9 for more information about how staying in the network can help you save time and money.

Sample claim – outpatient surgery in a Hospital			
	Coalition/ PPO	Non-PPO outside of Anchorage	Non-PPO (Non-Coalition) in Anchorage
A. Total charge	\$10,000	\$10,000	\$10,000
B. Network discount	-\$5,000	\$0	\$0
C. Plan's Allowable Charge (See page K-10)	\$5,000	\$4,500	\$5,000
What you pay			
D. Amount over Allowable Charge	\$0 (A minus B minus C)	\$5,500 (A minus B minus C)	\$5,000 (A minus B minus C)
E. Deductible (Individual)	\$500	\$500	\$1,000
F. Your Coinsurance share of the cost	\$1,350 (30%)	\$1,500 (30%)	\$1,600 (40%)
Your total payment	\$1,850	\$7,500	\$7,600

What you pay

You must pay your cost share such as Copays, and Coinsurance for your share of Covered Expenses. You must also pay any expenses that are not considered Covered Expenses (see page D-31 for information about excluded expenses), including any amounts over the Allowable Charge or charges once a maximum benefit or limitation has been met.

See page D-18 for a summary of your cost sharing.

Coinsurance

The Coinsurance covers your share of the healthcare you receive at the time of the service. For example, you pay your Coinsurance for all healthcare you receive during the office visit. You will pay an emergency room Copay and Coinsurance for all emergency care received during the emergency room visit.

See [page K-11](#) for more information about what a Coinsurance is.

Deductible

There is one Deductible that applies to covered PPO expenses and a separate Deductible that applies to covered Non-PPO expenses. You only have to pay the Deductible once each year. Once you have paid your Deductible (sometimes called “satisfying your Deductible”), you do not have to make any more payments toward your Deductible for the rest of that year. The same rule applies if two or more members of your family satisfy the family Deductible. Once your family Deductible has been satisfied, no one else in your family has to pay Deductibles for the rest of that year.

Your \$500 individual and \$1,000 family PPO Deductibles apply to all services in which the PPO Deductibles apply, unless otherwise stated. Amounts you pay for prescription drugs or dental care will not apply to the \$500 and \$1,000 Deductibles. A separate Deductible applies to dental benefits (see the dental benefits sections [Page D-74](#)).

See [page K-12](#) for more information about what a Deductible is.

Copay

In addition to the Calendar Year Deductible you will also have a Copay if the following services are used:

- Hospital Admission: \$350 Copay per admission; waived after four or more stays per person per Calendar Year.
- Emergency Room Visit: \$100 Copay per visit; waived if directly admitted to the Hospital.

See [page K-11](#) for more information about what a Copay is.

Out-of-Pocket Limit for PPO services and supplies

Your out-of-pocket cost sharing for most PPO medical Covered Expenses is limited to \$3,500 per person (\$7,000 per family) each year. Once your out-of-pocket costs for Covered Expenses meet these limits, the Plan will usually pay 100% for your (or your family's) PPO medical Covered Expenses during the rest of that year. Only your out-of-pocket cost sharing for medical healthcare applies to your \$3,500 Out-of-Pocket Limit (\$7,000 limit for your family). Amounts you pay out of pocket for prescription drugs or dental care will not apply to the \$3,500 or \$7,000 Out-of-Pocket Limits. A separate Out-of-Pocket Limit applies to prescription drug benefits ([see page D-55](#)) and to Non-PPO covered medical expenses.

See [page K-17](#) for more information about what an Out-of-Pocket Limit is.

Silver medical benefits

Covered Benefits

What's covered

The Plan will only pay benefits for Injuries or Sicknesses that are not related to your job. Benefits are determined based on Allowable Charges for covered services resulting from Medically Necessary care and treatment prescribed or furnished by a Healthcare Provider.

- **Ambulatory surgical facility services**, including general supplies, anesthesia, drugs, and operating and recovery rooms. If you have multiple surgeries, Covered Expenses are limited to charges for the primary surgery. However, professional services for surgical procedures that would normally be performed in a provider's office are not covered.
- **Anesthesia** and its administration.
- **Artificial limbs and eyes**.
- **Birthing Center benefits** for female employees and dependent spouses only. If you or your dependent spouse uses a Birthing Center instead of a Hospital for childbirth and receives services and supplies which would be covered under the Plan as a Hospital expense, then the Plan will pay benefits in the same manner as for any other sickness.
- **Blood and blood plasma** and their administration.
- **Chemotherapy and infusion** services.
- **Chiropractic care** up to a total of 1 visit per day.
- **Durable Medical Equipment** and supplies for all non-disposable devices or items prescribed by a Healthcare Provider, such as wheelchairs, Hospital-type beds, respirators and associated support systems, infusion pumps, home dialysis equipment, monitoring devices, home traction units, and other similar medical equipment or devices, including supplies for the DME.
 - 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.
- For employees and spouses only, **pregnancy** and pregnancy-related conditions, including childbirth, miscarriage, or abortion. However, routine Preventive Healthcare for a dependent child's pregnancy will also be considered a Covered Expense. Non-preventive care for a dependent child's pregnancy, including but not limited to ultrasounds, charges associated with a high-risk pregnancy, abortions, and maternity and delivery charges will not be covered.

- **Home healthcare services**, limited to a total of 100 visits per person each year for PPO and Non-PPO services combined. General housekeeping services or custodial care is not covered.
- **Hospice** services and supplies for a person who is terminally ill (life expectancy of less than 6 months). The services must be authorized by a Healthcare Provider.
- **Hospital charges** for room and board, and other inpatient or outpatient services.
- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- **Kidney dialysis** services.
- **Mastectomies**, including reconstruction of the breast upon which the mastectomy is performed, surgical treatment of the other breast to produce a symmetrical appearance, breast implants, and treatment of physical complications resulting from a mastectomy, including swollen lymph glands.
- **Medical 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. 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.
- **Medical services for organ transplants** are covered for the following procedures: kidney, heart, lung, heart/lung, liver, pancreas, kidney/pancreas, bone marrow/peripheral stem cell transplants and cornea. Covered transplant recipient benefits include:
 - The use of temporary mechanical equipment, pending the acquisition of “matched” human organs;
 - Multiple transplants during one operative session;
 - Replacements or subsequent transplants; and
 - Follow-up expenses for covered services (including immunosuppressant therapy).

When the transplant recipient is covered under this Plan, covered Donor expenses are paid up to \$5,000. Covered transplant Donor benefits include:

- Testing to identify suitable Donor(s);
- The expense for the acquisition of organs from a Donor;
- The expense of life support of a Donor pending the removal of usable organs;
- Transportation for a living Donor as provided for ambulance services under covered medical expenses; and
- Transportation of organs or a Donor on life support.

Silver medical benefits

D

The Plan will *not* pay the following:

- Any expenses when approved alternative remedies are available as determined by the Fund;
- Any animal organ or mechanical equipment, device or organs, except as provided above;
- Any financial consideration to the Donor other than a Covered Expense which is incurred in the performance of or in relation to transplant surgery;
- Body organ transplants, except as provided above; and
- Anything excluded under the General Exclusions and Limitations.
- Professional services for **diabetes education** and training for the care, monitoring, or treatment of diabetes.
- Professional services for **nutrition counseling**.
- **Nurse charges** for 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.
- **Non-routine surgical podiatric services.** If more than one surgery is done during the same operation, Covered Expenses are limited to the Allowable Charge for the major procedure.
 - Non-routine podiatric care, excluding x-rays. Podiatric orthotics are not covered.
 - Non-routine podiatric office visits are considered a specialist visit.
- **Outpatient services** in a clinic or urgent care center of free-standing facility.
- Outpatient rehabilitation services for **physical and occupational therapy**.
- Outpatient **speech therapy** services.
 - For adults, only speech therapy to restore speech lost as the result of Injury or Sickness is covered.
 - For dependent children, speech therapy is only covered to:
 - Screen, detect, and treat pervasive developmental disorders, such as autism and Asperger's.
 - Restore or improve speech for speech-language and developmental delay disorders caused by a non-chronic sickness, intra-uterine trauma, hearing loss, difficulty swallowing or acute Injury or Sickness.
 - Treat a speech delay associated with a specific disease, injury, or congenital defect, such as cleft lip and palate.

- **Oxygen** and rental equipment for its administration.
- **Phenylketonuria (PKU) treatment** coverage includes Medically Necessary formulas for you or your dependents. The Plan will pay expenses in the same manner and subject to the same conditions and limitations as for any other covered service.
- **Preventive Healthcare services** (*see page K-17*). The following limits apply to specific types of preventive care (other limits may apply to other types of preventive care based on your gender, age, and health status):
 - Cervical cancer screening (pap smears) once every 36 months for just the pap smear, or once every 60 months if both a pap smear and human papillomavirus screening are done together.
 - Routine mammograms for women are covered every 1-2 years if you are age 35 through age 74. Routine mammograms for women under 35, or older than 75, may be covered if you are at high-risk for breast cancer.
 - PSA tests for men are covered every year if you are between ages 40 and 69.
- **Professional medical and surgical service of a Healthcare Provider.**
The following rules apply:
 - If more than one surgery or procedure is done through the same incision or natural body cavity during the same operation, Covered Expenses are limited to the Allowable Charge for the major surgery or procedure.
 - Covered Expenses do not include incidental procedures performed through the same incision during one surgery.
- **Radiation therapy.**
- **Repair of sound natural teeth** and their supporting structures, if the Covered Expenses are the result of an injury. Treatment must be received while you are covered under the Plan. You may have additional dental coverage under your dental benefits, if applicable—see the dental benefits section.
- **Routine foot care** (routine podiatry).
- **Skilled Nursing Facility care**, limited to total of 100 days per confinement each year for PPO and Non-PPO care combined. All of the following rules must be met:
 - The person must be under the care of a Healthcare Provider during the confinement.
 - The person must be confined as a regular bed patient.

Skilled nursing care facility benefits will be restored each new period of confinement. A new period of confinement begins at least 60 days after you were last confined in a skilled nursing care facility and satisfies the conditions described above.

Silver medical benefits

D

- **Sterilization procedures** for employees and spouses, and female dependent children.
- **Services of a surgical nurse** (a nurse who works under a surgeon to provide specialized nursing services before, during, and after surgery).
- **Surgical supplies and dressings**, including casts, splints, prostheses, braces, canes, crutches, and trusses.
- **Surgical treatment of Morbid Obesity** is covered up to a lifetime maximum of \$50,000. Contact the Fund for the criteria needed for this Benefit. Because the cost of the surgery varies widely, we encourage you to inquire about the total cost of the procedure in advance.
- Transportation by a **professional ambulance service** to an area medical facility that is able to provide the required treatment. This includes by professional ambulance, railroad or commercial airline on a regularly scheduled flight. If you have no control over the ambulance getting called, for example when the ambulance is called by a healthcare professional, Employer, law enforcement, school, etc., the ambulance will be considered Medically Necessary. Contact the Fund (*see page A-4*) if you had no control over an ambulance being called. If transport is Medically Necessary, the Plan covers licensed air ambulance and/or round trip coach air or surface transportation for the patient within Alaska, or from Alaska to Seattle, Washington. If the patient is a child or a disabled adult, the Plan also covers air transport for an adult to accompany the patient. You must provide proof from your physician that air transport is necessary because treatment is not available in your locale or elsewhere in the state of Alaska. The Plan will not prepay for air transport.
- Treatment of **mental health conditions and substance abuse**, including inpatient and residential care, outpatient care, partial Hospitalization, intensive outpatient care, and ambulatory detoxification.
- Treatment of **tumors, cysts and lesions** not considered a dental procedure.
- Treatment of **temporomandibular joint (TMJ)** disorders, craniofacial disorders or orthognathic disorders.
- **X-rays and laboratory** work, including x-rays and laboratory work for chiropractic and non-routine podiatric care.

What's not covered

See page I-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 treatments, services, and supplies:

- Acupuncture. Except when used as an anesthetic agent for covered surgery.
- Ambulatory surgical facility fees for procedures normally performed in a provider's office.
- Any dental treatment of teeth or their supporting structures, other than those services covered under the dental benefit, unless otherwise specifically listed as a Covered Expense.
- Any elective procedure, except sterilization or abortion, that is not to treat a bodily Injury or Sickness. The Trustees have the sole right and discretion to decide if a procedure is elective.
- Any services or supplies for or in connection with the treatment of teeth, natural or otherwise, and supporting structures. However, charges made by a Hospital or other facility for dental procedures covered under the dental benefit provisions, if applicable (see the dental benefits sections), will be covered if the procedure requires the patient to be treated in an institutional setting to safely receive the care. For example, if you suffer from a medical or behavioral condition, such as autism or Alzheimer's, that severely limits your ability to cooperate with the dentist providing the care, charges made by a Hospital or other facility will be considered a Covered Expense. Benefits for other types of dental care may be covered under the dental benefit as described in the dental section, if applicable.
- Eye or hearing exams, except as specifically stated as covered, or unless the exam is for the diagnosis or treatment of an accidental bodily injury or an illness.
- 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.
- Prescription drugs and medications, other than those used where they are dispensed. Prescription drugs may be covered under the prescription drug benefit shown on page D-56.
- Private duty nursing care.
- Services or supplies provided by a Non-PPO Provider if benefits are only payable for such services or supplies when a PPO provider is used.
- Surgery to modify jaw relationships including, but not limited to, osteoplasty and genioplasty procedures. However, Le Fort-type operations are covered when primarily to repair birth defects of the mouth, conditions of the mid-face (over or under development of facial features), or damage caused by accidental Injury.



Bronze medical benefits

Learn:

- What you pay for healthcare.
- How the 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.

Bronze medical benefits

Bronze Plan Medical Benefits

In general, what you pay for medical care is based on what kind of care you get, where you get your care and whether you go to a Coalition/ PPO Provider or Any Provider Outside of Anchorage or a Non-PPO (Non-Coalition) Provider in the Municipality of Anchorage. For example, you pay less using an urgent care center instead of going to the emergency room. The annual Deductible applies to the services listed below, unless indicated it does not apply.

Unless shown otherwise, this section shows what you pay for your care (called your “cost-sharing”). You pay any Copays, Deductibles, your Coinsurance share, any amounts over a maximum benefit, and any expenses that are not covered, including any charges that are more than the Allowable Charge.

Annual Deductible and Out-of-Pocket Limits for Medical Care

Annual Deductibles: Coalition/ PPO Provider or Any Provider Outside of Anchorage (applies to all services unless otherwise noted)	\$750 person \$1,500 family	
Annual Deductibles: Non PPO (Non-Coalition) in the Municipality of Anchorage (applies to all services, unless otherwise noted)	\$1,500 person \$3,000 family	
Medical Out-of-Pocket Limits for Coalition/ PPO Providers or Any Provider Outside of Anchorage:	\$4,000 person \$8,000 family	
Medical Out-of-Pocket Limits for Non-PPO (Non-Coalition) in the Municipality of Anchorage	\$11,250 person \$22,500 family	
	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non-Coalition) in Anchorage*
Office Visits		
Preventive Healthcare (See page K-17)	No charge (Deductible does not apply)	No charge (Deductible does not apply)

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

Bronze medical benefits

	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non- Coalition) in Anchorage*
Primary Care Provider (PCP) Office Visits	40% Coinsurance	40% Coinsurance
Telehealth Visits	No charge	Not covered
Specialist Office Visits	40% Coinsurance	40% Coinsurance
Mental Health/Substance Abuse Office Visits	40% Coinsurance	40% Coinsurance
Chiropractic Services (1 visit/day)	40% Coinsurance	40% Coinsurance
Routine Podiatry	40% Coinsurance	40% Coinsurance
Non-Routine Podiatry	40% Coinsurance	40% Coinsurance
Allergy Injections in an Office	40% Coinsurance	40% Coinsurance
Coalition Health Center		
Office and preventive services	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Emergency and Urgent Care		
Urgent Care Center	40% Coinsurance	40% Coinsurance
Hospital Emergency Room		
Emergency Care Provided in an ER	\$100 Copay plus 40% Coinsurance / Copay waived if admitted	\$100 Copay plus 40% Coinsurance / Copay waived if admitted
Routine Care Provided in an ER	\$100 Copay plus 40% Coinsurance	\$100 Copay plus 40% Coinsurance
Professional Ground Ambulance Services	40% Coinsurance	40% Coinsurance
Professional Air Ambulance Services	40% Coinsurance	40% Coinsurance

D

D-35

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

Bronze medical benefits

D

	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non- Coalition) in Anchorage*
Outpatient Services		
Laboratory Services	40% Coinsurance	Non-hospital - 40% coinsurance Hospital - 50% coinsurance
Radiology (X-ray, Ultrasound, Fetal Monitoring)	40% Coinsurance	Non-hospital - 40% coinsurance Hospital - 50% coinsurance
Diagnostic Imaging(CT, MRI, PET) and Cardiac Imaging Testing	40% Coinsurance	Non-hospital - 40% coinsurance Hospital - 50% coinsurance
Outpatient Surgery		
Ambulatory Surgical Center	40% Coinsurance	50% Coinsurance for Non-PPO facility in the Municipality of Anchorage
Hospital Outpatient Department	40% Coinsurance	50% Coinsurance for Non-PPO facility in the Municipality of Anchorage
Physical, Speech, Occupational Therapy	40% Coinsurance	50% Coinsurance for Non-PPO facility in the Municipality of Anchorage

D-36

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

Bronze medical benefits

	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non- Coalition) in Anchorage*
Radiation Therapy	40% Coinsurance	40% Coinsurance
Dialysis	40% Coinsurance	40% Coinsurance
Chemotherapy or Infusion Medication	40% Coinsurance	40% Coinsurance
Inpatient Treatment		
Inpatient Hospitalization Copay is waived after 4 or more stays/ person/ calendar year	\$350 Copay plus 40% Coinsurance	\$350 Copay plus 50% Coinsurance for Non-PPO facility in the Municipality of Anchorage
Skilled Nursing Facility— up to 100 days per confinement	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Wellness and Minor Care		
Wellness and Minor Care visit (Copay applies to your medical Plan Out-of-Pocket Limit.)	\$20 Copay	Not covered
Other Services and Supplies		
Diabetes Education	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Nutrition Education	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment	40% Coinsurance	40% Coinsurance
Home Healthcare Services — 100 visits/ year	No charge (Deductible does not apply)	No charge (Deductible does not apply)
Durable Medical Equipment	40% Coinsurance	40% Coinsurance

D

D-37

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

Bronze medical benefits

	Coalition/ PPO Provider or Any Provider Outside of Anchorage*	Non-PPO (Non- Coalition) in Anchorage*
Hospice Care Inpatient: limited to 30 days	40% Coinsurance	40% Coinsurance
Orthotics (Other than podiatric orthotics)	40% Coinsurance	40% Coinsurance
Medical Foods	40% Coinsurance	40% Coinsurance
Transportation and Lodging for Certain Serious Medical Conditions	The Plan pays 100% up to \$3,500 annual maximum	
All Other Types of Medical Care	40% Coinsurance	40% Coinsurance

* Services received from a Non-PPO provider will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

When a Non-PPO facility is used within the Municipality of Anchorage, the Allowed Amount for inpatient services is based on the PPO Coalition Contracted Rate. For physical therapy (outpatient services), the Allowed Amount will be equal to 50% of billed charges. This means you will be responsible for the difference in the Allowed Amount and the total amount the provider billed for the service. *See page D-40* for example of the benefits of using a PPO provider.

Commencement of legal action

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

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

PPO providers

Benefits are paid based on whether you use a PPO provider or a Non-PPO Provider. Your Plan lets you go to any doctor you want. If you go to a PPO provider in your MultiPlan PPO network, you will save money. The MultiPlan PPO network that you should use is based on what state you need to get care. If you go to a Non-PPO Provider (a provider that is not in your network), it may cost you more.

Below are the MultiPlan PPO networks to use by state:

If you're looking for providers in:	Your MultiPlan PPO Network is:
Alaska	Beech Street
Idaho, Montana, Washington	First Choice Health Network
All other states	PHCS Network

Finding a PPO Provider in the Multiplan PPO Network:

1. Go to www.multiplan.com
2. Click on "Find a Provider" in the top right corner of the page
3. Click on "Select a Network"
 - a. Choose "Beech Street" if you need a provider in Alaska
 - b. Choose "First Choice Health Network" if you need a provider in Idaho, Montana or Washington
 - c. Choose "PHCS" if you need a provider in any other state

If you need help finding a PPO provider, call:

MultiPlan
888-636-7427

Or

UNITE HERE HEALTH
844-427-8501

If you're in the Municipality of Anchorage, you must go to a Coalition PPO Provider for any of the services listed below to have benefits paid at the PPO level (*see page A-10* for a list of the Coalition PPO providers):

- Hospital Services
- Physical Therapy
- Hand Therapy

If you get these services in Anchorage from a provider who is not a Coalition provider, you will pay more.

Bronze medical benefits

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

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

Sample claim – outpatient surgery in a Hospital			
	Coalition/ PPO	Non-PPO outside of Anchorage	Non-PPO (Non-Coalition) in Anchorage
A. Total charge	\$10,000	\$10,000	\$10,000
B. Network discount	-\$5,000	\$0	\$0
C. Plan's Allowable Charge (See page K-10)	\$5,000	\$4,500	\$5,000
What you pay			
D. Amount over Allowable Charge	\$0 (A minus B minus C)	\$5,500 (A minus B minus C)	\$5,000 (A minus B minus C)
E. Deductible (Individual)	\$750	\$750	\$1,500
F. Your Coinsurance share of the cost	\$1,700 (40%)	\$1,900 (40%)	\$1,750 (50%)
Your total payment	\$2,450	\$8,150	\$8,250

What you pay

You must pay your cost share such as Copays, and Coinsurance for your share of Covered Expenses. You must also pay any expenses that are not considered Covered Expenses (see page D-47 for information about excluded expenses), including any amounts over the Allowable Charge, or charges once a maximum benefit or limitation has been met.

See page D-34 for a summary of your cost sharing.

Coinsurance

Coinsurance covers your share of the healthcare you receive at the time of the service. For example, you pay your Coinsurance for all healthcare you receive during the office visit. You will pay an emergency room Copay and Coinsurance for all emergency care received during the emergency room visit.

See page K-11 for more information about what a Coinsurance is.

Deductibles

There is one Deductible that applies to covered PPO expenses and a separate Deductible that applies to covered Non-PPO expenses. You only have to pay the Deductible once each year. Once you have paid your Deductible (sometimes called “satisfying your Deductible”), you do not have to make any more payments toward your Deductible for the rest of that year. The same rule applies if two or more members of your family satisfy the \$1,500 family Deductible. Once your family Deductible has been satisfied, no one else in your family has to pay the Deductibles for the rest of that year.

Your \$750 individual and \$1,500 family PPO Deductibles applies to all services in which the PPO Deductibles apply. Amounts you pay for prescription drugs or dental care will not apply to the \$750 and \$1,500 Deductibles. A separate Deductible applies to dental benefits (see the dental benefits sections).

See page K-12 for more information about what a Deductible is.

Copay

In addition to the Calendar Year Deductible you will also have a Copay if the following services are used:

- Hospital Admission: \$350 Copay per admission; waived after four or more stays per person per Calendar Year.
- Emergency Room Visit: \$100 Copay per visit; waived if directly admitted to the Hospital.

See page K-11 for more information about what a Copay is.

Out-of-Pocket Limit for PPO services and supplies

Your out-of-pocket cost sharing for most PPO medical Covered Expenses is limited to \$4,000 per person (\$8,000 per family) each year. Once your PPO out-of-pocket costs for Covered Expenses meet these limits, the Plan will usually pay 100% for your (or your family’s) PPO medical Covered Expenses during the rest of that year. Only your PPO out-of-pocket cost sharing for medical healthcare applies to your \$4,000 Out-of-Pocket Limit (\$8,000 limit for your family). Amounts you pay out of pocket for prescription drugs or dental care will not apply to the \$4,000 or \$8,000 Out-of-Pocket Limits. A separate Out-of-Pocket Limit applies to prescription drug benefits (*see page D-55*).

See page K-17 for more information about what an Out-of-Pocket Limit is.

Bronze medical benefits

Covered Benefits

What's covered

The Plan will only pay benefits for Injuries or Sicknesses that are not related to your job. Benefits are determined based on Allowable Charges for covered services resulting from Medically Necessary care and treatment prescribed or furnished by a Healthcare Provider.

- **Ambulatory surgical facility services**, including general supplies, anesthesia, drugs, and operating and recovery rooms. If you have multiple surgeries, Covered Expenses are limited to charges for the primary surgery. However, professional services for surgical procedures that would normally be performed in a provider's office are not covered.
- **Anesthesia** and its administration.
- **Artificial limbs and eyes.**
- **Birthing Center benefits** for female employees and dependent spouses only. If you or your dependent spouse uses a birthing center instead of a Hospital for childbirth and receives services and supplies which would be covered under the Plan as a Hospital expense, then the Plan will pay benefits in the same manner as for any other sickness.
- **Blood and blood plasma** and their administration.
- **Chemotherapy and infusion** services.
- **Chiropractic care** up to a total of 1 visit per day.
- **Durable Medical Equipment** and supplies for all non-disposable devices or items prescribed by a Healthcare Provider, such as wheelchairs, Hospital-type beds, respirators and associated support systems, infusion pumps, home dialysis equipment, monitoring devices, home traction units, and other similar medical equipment or devices, including supplies for DME.
 - 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.
- For employees and spouses only, **pregnancy** and pregnancy-related conditions, including childbirth, miscarriage, or abortion. However, routine Preventive Healthcare for a dependent child's pregnancy will also be considered a Covered Expense. Non-preventive care for a dependent child's pregnancy, including but not limited to ultrasounds, charges associated with a high-risk pregnancy, abortions, and maternity and delivery charges will not be covered.

Bronze medical benefits

- **Home healthcare services**, limited to a total of 100 visits per person each year for PPO and Non-PPO services combined. General housekeeping services or custodial care is not covered.
- **Hospice** services and supplies for a person who is terminally ill (life expectancy of less than 6 months). The services must be authorized by a Healthcare Provider.
- **Hospital charges** for room and board, and other inpatient or outpatient services.
- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- **Kidney dialysis** services.
- **Mastectomies**, including reconstruction of the breast upon which the mastectomy is performed, surgical treatment of the other breast to produce a symmetrical appearance, breast implants, and treatment of physical complications resulting from a mastectomy, including swollen lymph glands.
- **Medical 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. 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.
- **Medical services for organ transplants** are covered for the following procedures: kidney, heart, lung, heart/lung, liver, pancreas, kidney/pancreas, bone marrow/peripheral stem cell transplants and cornea. Covered transplant recipient benefits include:
 - The use of temporary mechanical equipment, pending the acquisition of “matched” human organs;
 - Multiple transplants during one operative session;
 - Replacements or subsequent transplants; and
 - Follow-up expenses for covered services (including immunosuppressant therapy).

When the transplant recipient is covered under this Plan, covered Donor expenses are paid up to \$5,000. Covered transplant Donor benefits include:

- Testing to identify suitable Donor(s);
- The expense for the acquisition of organs from a Donor;
- The expense of life support of a Donor pending the removal of usable organs;
- Transportation for a living Donor as provided for ambulance services under covered medical expenses; and
- Transportation of organs or a Donor on life support.

Bronze medical benefits

D

The Plan will not pay the following:

- Any expenses when approved alternative remedies are available as determined by the Fund;
 - Any animal organ or mechanical equipment, device or organs, except as provided above;
 - Any financial consideration to the Donor other than a Covered Expense which is incurred in the performance of or in relation to transplant surgery;
 - Body organ transplants, except as provided above; and
 - Anything excluded under the General Exclusions and Limitations.
- Professional services for **diabetes education** and training for the care, monitoring, or treatment of diabetes.
 - Professional services for **nutrition counseling**.
 - **Nurse charges** for 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.
 - **Non-routine surgical podiatric services.** If more than one surgery is done during the same operation, Covered Expenses are limited to the Allowable Charge for the major procedure.
 - Non-routine podiatric care, excluding x-rays. Podiatric orthotics are not covered.
 - Non-routine podiatric office visits are considered a specialist visit.
 - **Outpatient services** in a clinic or urgent care center or free-standing facility.
 - Outpatient rehabilitation services for **physical and occupational therapy**.
 - Outpatient **speech therapy services**.
 - For adults, only speech therapy to restore speech lost as the result of Injury or Sickness is covered.
 - For dependent children, speech therapy is only covered to:
 - Screen, detect, and treat pervasive developmental disorders, such as autism and Asperger's.
 - Restore or improve speech for speech-language and developmental delay disorders caused by a non-chronic sickness, intra-uterine trauma, hearing loss, difficulty swallowing or acute Injury and Sickness.
 - Treat a speech delay associated with a specific disease, injury, or congenital defect, such as cleft lip and palate.

Bronze medical benefits

- **Oxygen** and rental equipment for its administration.
- **Phenylketonuria (PKU) treatment** coverage includes Medically Necessary formulas for you or your dependents. The Plan will pay expenses in the same manner and subject to the same conditions and limitations as for any other covered service.
- **Preventive Healthcare services** (*see page K-17*). The following limits apply to specific types of preventive care (other limits may apply to other types of preventive care based on your gender, age, and health status):
 - Cervical cancer screening (pap smears) once every 36 months for just the pap smear, or once every 60 months if both a pap smear and human papillomavirus screening are done together.
 - Routine mammograms for women are covered every 1-2 years if you are age 35 through age 74. Routine mammograms for women under 35, or older than 75, may be covered if you are at high-risk for breast cancer.
 - PSA tests for men are covered every year if you are between ages 35 and 69.
- **Professional medical and surgical service of a Healthcare Provider.**
The following rules apply:
 - If more than one surgery or procedure is done through the same incision or natural body cavity during the same operation, Covered Expenses are limited to the Allowable Charge for the major surgery or procedure.
 - Covered Expenses do not include incidental procedures performed through the same incision during one surgery
- **Radiation therapy.**
- **Repair of sound natural teeth** and their supporting structures, if the Covered Expenses are the result of an injury. Treatment must be received while you are covered under the Plan. You may have additional dental coverage under your dental benefits, if applicable—see the dental benefits sections.
- **Routine foot care** (routine podiatry).
- **Skilled Nursing Facility care**, limited to total of 100 days per confinement each year for PPO and Non-PPO care combined. All of the following rules must be met:
 - The person must be under the care of a Healthcare Provider during the confinement.
 - The person must be confined as a regular bed patient.

Skilled nursing care facility benefits will be restored each new period of confinement. A new period of confinement begins at least 60 days after you were last confined in a skilled nursing care facility and satisfies the conditions described above.

Bronze medical benefits

D

- **Sterilization procedures** for employees and spouses, and female dependent children.
- **Services of a surgical nurse** (a nurse who works under a surgeon to provide specialized nursing services before, during, and after surgery).
- **Surgical supplies and dressings**, including casts, splints, prostheses, braces, canes, crutches, and trusses.
- **Surgical treatment of Morbid Obesity** is covered up to a lifetime maximum of \$50,000. Contact the Fund for the criteria needed for this Benefit. Because the cost of the surgery varies widely, we encourage you to inquire about the total cost of the procedure in advance.
- Transportation by a **professional ambulance service** to an area medical facility that is able to provide the required treatment. This includes by professional ambulance, railroad or commercial airline on a regularly scheduled flight. If you have no control over the ambulance getting called, for example when the ambulance is called by a healthcare professional, Employer, law enforcement, school, etc., the ambulance will be considered Medically Necessary. Contact the Fund (*see page A-4*) if you had no control over an ambulance being called. If transport is Medically Necessary, the Plan covers licensed air ambulance and/or round trip coach air or surface transportation for the patient within Alaska, or from Alaska to Seattle, Washington. If the patient is a child or a disabled adult, the Plan also covers air transport for an adult to accompany the patient. You must provide proof from your physician that air transport is necessary because treatment is not available in your locale or elsewhere in the state of Alaska. The Plan will not prepay for air transport.
- Treatment of **mental health conditions and substance abuse**, including inpatient and residential care, outpatient care, partial Hospitalization, intensive outpatient care, and ambulatory detoxification.
- Treatment of **tumors, cysts and lesions** not considered a dental procedure.
- Treatment of **temporomandibular joint (TMJ)** disorders, craniofacial disorders or orthognathic disorders.
- **X-rays and laboratory** work, including x-rays and laboratory work for chiropractic and non-routine podiatric care.

What's not covered

See page I-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 treatments, services, and supplies:

- Acupuncture. Except when used as an anesthetic agent for covered surgery.
- Ambulatory surgical facility fees for procedures normally performed in a provider's office.
- Any dental treatment of teeth or their supporting structures, other than those services covered under the dental benefit, unless otherwise specifically listed as a Covered Expense.
- Any elective procedure, except sterilization or abortion, that is not to treat a bodily Injury or Sickness. The Trustees have the sole right and discretion to decide if a procedure is elective.
- Any services or supplies for or in connection with the treatment of teeth, natural or otherwise, and supporting structures. However, charges made by a Hospital or other facility for dental procedures covered under the dental benefit provisions, if applicable (see the dental benefits sections), will be covered if the procedure requires the patient to be treated in an institutional setting to safely receive the care. For example, if you suffer from a medical or behavioral condition, such as autism or Alzheimer's, that severely limits your ability to cooperate with the dentist providing the care, charges made by a Hospital or other facility will be considered a Covered Expense. Benefits for other types of dental care may be covered under the dental benefit as described in the dental section, if applicable.
- Eye or hearing exams, except as specifically stated as covered, or unless the exam is for the diagnosis or treatment of an accidental bodily injury or an illness.
- 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.
- Prescription drugs and medications, other than those used where they are dispensed. Prescription drugs may be covered under the prescription drug benefit shown on page D-56.
- Private duty nursing care.
- Services or supplies provided by a Non-PPO Provider if benefits are only payable for such services or supplies when a PPO provider is used.
- Surgery to modify jaw relationships including, but not limited to, osteoplasty and genioplasty procedures. However, Le Fort-type operations are covered when primarily to repair birth defects of the mouth, conditions of the mid-face (over or under development of facial features), or damage caused by accidental injury.



Travel Benefit Program

Learn:

- What the Travel benefit covers.
- Who is Eligible.
- How to use the benefit.

Travel Benefit Program

This Travel Benefit Program is to allow participants to seek high quality, cost-effective care for major medical issues.

Eligibility

You will be Eligible for the payment of Travel benefits when:

- You or a covered dependent are undergoing a specific surgical procedure or cancer treatment;
- When it is determined that it is more reasonable and/or cost effective for you to receive treatment for your specific conditions outside the local service area;
- You use a network provider for services in the state where you are obtaining treatment; and
- You are not covered by Medicare (unless covered by the Alaska H.E.R.E. Plan under Medicare secondary payer rules).

The Travel Benefit is limited to your immediate family, which shall be defined as the covered enrolled participant, his or her legally married spouse and his or her children.

If the participant is not married, immediate family shall be defined as his or her parents, and his or her siblings.

Schedule of Benefits

Travel Benefits must be pre-authorized by Medical Rehabilitation Consultants, or its designee, and are subject to the following schedule of benefits:

- Payments of travel benefits is limited to \$3,500 annual maximum for all related treatment.
- The Travel Benefit includes reimbursement for public transportation expense, reimbursement for hotel/motel expenses, and reasonable reimbursement for meals.
- The Travel Benefit is not subject to a Deductible and is paid at 100% up to the \$3,500 annual benefit maximum.

How to Use this Benefit

You must make a request for prior approval of these benefits to Medical Rehabilitation Consultants. You can obtain the travel preauthorization form by calling the Fund. Your request will be reviewed based on the medical necessity of the treatment being provided. They will then notify you by telephone as to the approval or disapproval of the transportation allowance.

Upon completion of your travel, all receipts related to the travel must be submitted to the Fund on a Travel Expense form for reimbursement. Note that boarding passes are required for air transportation.

All travel receipts must be on official company stationary and include the date that the expenses were incurred, a description of each expense and cost of each expense. Cash register receipts will not be accepted.

If you have any questions, contact the Fund at **844-427-8501**.

Call Medical Rehabilitation Consultants to request prior authorization at (800) 827-5058.



Prescription drug benefits

Learn:

- What you pay for your covered prescription drugs.
- How the Out-of-Pocket Limit protects you from high-cost prescription drugs.
- How you can save money by using generic prescription drugs.
- What types of prescription drugs the Plan covers.
- The limits on the quantity of a prescription drug you can get at one time.
- What the mail order pharmacy is and how to use it.
- What the specialty order pharmacy is and when you must use it.
- What types of prescription drugs are not covered.

Prescription drug benefits

Who's Eligible

The prescription drug program is for Eligible Employees and dependents, as well as retired employees and dependents that are not Eligible for Medicare.

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

Caremark National Network is the preferred provider. If you use the services of a Caremark National Network participating pharmacy, the cost of the prescription may be reduced which means you pay a lower amount. For the current list of participating pharmacies, contact CVS Caremark at (866) 818-6911 or www.caremark.com.

When you use a pharmacy that is not part of the Caremark National Network (preferred providers), you will be required to pay the full cost for the covered drug at the time of purchase. You must then file a claim with Caremark for reimbursement; additionally, the Plan's coverage will be less than it would have been at a Caremark National Network participating pharmacy.

D

Prescription drug benefits

What you pay

You must pay the applicable Coinsurance and Copay shown below for each fill of a prescription drug. You must also pay any expenses that are not considered Covered Expenses (*see page D-60*) for information about excluded expenses, including any amounts over the Allowable Charge.

Gold Plan Prescription Drug Benefits	Your Copay for Each Fill or Refill
Out-of-Pocket Limit	\$2,350 per person/ \$4,700 per family
Preventive prescriptions or supplies (<i>see page K-17</i>), including immunizations	No charge
Generic prescription drugs	30% Coinsurance (\$5 minimum)
Diabetic oral medications, insulin and supplies	\$5 Copay retail/ \$10 Copay mail
Brand name prescription drugs	30% Coinsurance (\$5 minimum)
Specialty and biosimilar prescription drugs	30% Coinsurance (\$5 minimum)
Mail Order	30% Coinsurance (\$10 minimum)
Silver Plan Prescription Drug Benefits	Your Copay for Each Fill or Refill
Out-of-Pocket Limit	\$2,350 per person/ \$4,700 per family
Preventive prescriptions or supplies (<i>see page K-17</i>), including immunizations	No charge
Generic prescription drugs	40% Coinsurance (\$5 minimum)
Diabetic oral medications, insulin and supplies	\$5 Copay retail/ \$10 Copay mail
Brand name prescription drugs	40% Coinsurance (\$5 minimum)
Specialty and biosimilar prescription drugs	40% Coinsurance (\$5 minimum)
Mail Order	40% Coinsurance (\$10 minimum)
Bronze Plan Prescription Drug Benefits	Your Copay for Each Fill or Refill
Out-of-Pocket Limit	\$2,350 per person/ \$4,700 per family
Preventive prescriptions or supplies (<i>see page K-17</i>), including immunizations	No charge
Generic prescription drugs	50% Coinsurance (\$5 minimum)
Diabetic oral medications, insulin and supplies	\$5 Copay retail/ \$10 Copay mail
Brand name prescription drugs	50% Coinsurance (\$5 minimum)
Specialty and biosimilar prescription drugs	50% Coinsurance (\$5 minimum)
Mail Order	50% Coinsurance (\$10 minimum)

Drugs and supplies on the formulary are safe, effective, high-quality drugs. Prescription drugs and supplies may be added to or removed from the formulary from time to time. Contact CVS Caremark at (866) 818-6911 if you or your Healthcare Provider have questions about which prescription drugs and supplies are on the formulary.

Unless your Healthcare Provider requires a brand name drug, the prescription will be filled with the generic equivalent drug when available and permissible by law.

Prescription drug benefits

Prescription drug Out-of-Pocket Limit

Your Copays and Coinsurance for prescription drugs purchased through the prescription drug benefit are limited to \$2,350 per person each year (\$4,700 per family). Once your prescription drug Copays and Coinsurance total \$2,350 (\$4,700 for your family's prescription drug Copays and Coinsurance), the Plan will pay 100% for your (or your family's) covered prescription drugs and supplies during the rest of that year.

Amounts you pay for prescription drugs or supplies that are not covered do not count toward your Out-of-Pocket Limit. Only your Copays and Coinsurance for covered prescription drugs or supplies apply to your \$2,350 Out-of-Pocket Limit (\$4,700 limit for your family). Out-of-pocket payments you pay for medical healthcare or dental care will not apply to the \$2,350 or \$4,700 Out-of-Pocket Limits for prescription drugs. A separate Out-of-Pocket Limit applies to medical healthcare (*see page D-9*).

Generic prescription drug policy

If you or your provider chooses a brand name prescription drug when you could get a generic equivalent instead, you pay the difference in cost between the brand name prescription drug and the generic equivalent. For example, if you are in the Bronze Plan and the brand name prescription drug costs \$80, and the Fund's cost for the generic equivalent is \$30, the plan pays 50% of the cost of the generic or \$15 and you must pay the \$65 difference.

The generic prescription drug policy does not apply to certain prescription drugs that need to be closely monitored, or if very small changes in the dose could be extremely harmful. The 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 CVS Caremark. You or your Healthcare Provider can call CVS Caremark at (866) 818-6911 to get more information on the generic prescription drug policy.

What's covered

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

- FDA-approved prescription drugs which can legally be purchased only with a written prescription from a Healthcare Provider. This includes oral and injectable contraceptives, vitamins, and drugs mixed to order by a pharmacist, if it contains at least one medicinal substance and one prescription drug.
- Insulin and diabetic test strips.
- Disposable syringes and needles, and lancets.
- Prescription drugs and supplies that are Preventive Healthcare (*see page K-17*).
- Non-prescription (over-the-counter) Preventive Healthcare services and supplies, including immunizations (*see page K-17*).

Broader Retail Vaccination Network

Covered immunization and vaccines are now available at many preferred network pharmacies. Services by age range and vaccine may vary by location. Check with your local pharmacy regarding the types of services offered and if an appointment is needed.

Prior authorization

Call CVS Caremark at (866) 818-6911 for prior authorization.

If you have a prescription for certain drugs, your Healthcare Provider will need to provide your medical records to find out if the prescription drug is clinically appropriate for your medical situation. The list of prescription drugs that require prior authorization changes from time to time. Call CVS Caremark at (866) 818-6911 for a list of drugs on the prior authorization list.

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

Compound Medications

Compound medications are ad-hoc formulations mixed by a pharmacist that often contain multiple ingredients. These mixtures are not FDA approved, though the individual components may be. Some compound medications can be expensive with questionable effectiveness. Prior authorization is required for any compound medications that cost over \$500.

See page E-6 for information about appealing a request for prior authorization and for appealing a denial of prescription drug benefits.

Specialty Drugs

Specialty drugs often share the following characteristics: they are high in cost, require unique storage or shipping requirements, may require patient compliance and/or safety monitoring, could result in significant waste due to the high costs, and are generally prescribed for complex conditions such as multiple sclerosis, rheumatoid arthritis, and cancer, among others.

Specialty medications will require prior authorization. The provider that issues the prescription must first submit a prior authorization request form to CVS Caremark. After submission of the prior authorization request form, CVS Caremark will notify your provider if the request has been approved. If the request has been denied, CVS Caremark will describe your appeal rights.

Specialty drugs will also be limited to one fill, a 30-day supply per month. A trial and failure of one or more prerequisite preferred specialty drugs may be required before non-preferred specialty drugs are covered.

Prescription drug benefits

Fill and refill limits

Quantity limits

Each prescription fill or refill is limited to the amount prescribed by your Healthcare Provider. However, a prescription filled at a retail pharmacy will not be filled for more than a 30-day supply at one time (you can get refills up to the total amount your doctor prescribes). However, if purchasing more than a 30-day supply on the same day, any expense exceeding the supply limit will not be covered. If your physician is prescribing maintenance drugs, ask your physician to write two prescriptions:

- The first for your immediate needs; and
- The second for you to submit to the mail order program. If you use the mail order pharmacy, you can get up to a 90-day supply at a time.

For refill of mail order prescriptions, call CVS Caremark at (866) 818-6911 or visit www.caremark.com. Have your prescription number and a credit card available.

If you purchase more than a 90-day supply on the same day, any expenses exceeding the supply limit will not be covered.

Exceptions to the standard quantity limits

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

You or your Healthcare Provider can call for information about these quantity limits. Your Healthcare Provider may also call to get an exception to these rules. You can contact CVS Caremark at (866) 818-6911 or visit www.caremark.com.

Mail Service Program

You can save money by using the CVS Caremark mail order program. If you need a prescription drug to treat a chronic, long-term condition, you can order these prescription drugs through the mail service. Because the prices through mail service are generally lower than the retail prices, the amount you pay is generally lower, too. You can get up to a 90-day supply of your prescription drug (sometimes called “maintenance” prescription drugs). If you would like to begin receiving your prescription medications through Mail Service, please choose one of the options listed below:

- Call CVS Caremark at one of the following numbers:
 - Customer Care at 1-866-818-6911
 - Caremark’s FastStart program for Mail Service at 1-866-239-4543 or 1-800-875-0867
- CVS Caremark will reach out to your doctor on your behalf. Be sure to have your ID card, doctor’s contact information, prescription information and payment method ready for the representative.
- Ask your doctor to send a prescription to CVS Caremark Mail Service for maintenance medications once your doctor has determined the dose best for you. Your doctor may phone, fax, or electronically prescribe to Mail Service.
- Mail a 90-day prescription and a Mail Service Order Form (available online at www.caremark.com) to CVS Caremark. Allow at least two weeks from the day you submit your order for delivery of your medicine. If you choose this option, ask your doctor for a 30-day supply you can fill at retail while you wait for the Mail Service program.

If you purchase more than a 90-day supply on the same day, any expenses exceeding the supply limit will not be covered.

Prescription drug benefits

What's not covered

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

- Drugs that have been determined under the internal standards of the Food and Drug Administration to be “less-than-effective” in accordance with the Drug Efficacy Study Implementation (DESI).
- Prescription drugs that have not been approved by the FDA. However, you or your Healthcare Provider may ask for an exception through CVS's prior authorization program.
- Experimental or Investigational drugs.
- Fertility drugs.
- Prescriptions or refills in amounts over the quantity limits (*see page D-58*).
- Non-sedating antihistamines.
- Prescription drugs that have an over-the-counter equivalent or are otherwise available over-the-counter (unless the drugs or supplies are Preventive Healthcare—(*see page K-17*)). However, prescription drugs that have a higher dosage than their over-the-counter equivalents will be covered.
- Any prescription drugs that are considered a lifestyle prescription drug. Lifestyle prescription drugs are not primarily intended to prevent, treat, or cure a disease or manage pain. Examples of lifestyle drugs include but are not limited to prescription drugs used to treat erectile dysfunction, acne, or wrinkles. The Fund or its representative determines whether a prescription drug is considered a lifestyle prescription drug. Contact CVS Caremark at (866) 818-6911 or www.caremark.com.
- Any prescription drugs that are not self-administered, meaning a prescription drug that you cannot give to yourself. However, this type of prescription drug may be covered under the medical benefits.
- New-to-market prescription drugs until the Fund or its representative has reviewed and approved the drugs.
- High-cost “me too” prescription drugs, unless the Fund or its representative approves the prescription drugs for purchase. “Me-too” drugs usually have only very small differences in how they work, but are considered “new” prescription drugs with no generic equivalent. Often, the manufacturer charges high prices for these prescription drugs even though there are other prescription drugs available that work just as well for a lower cost. You can find out if a “me too” prescription drug is covered by contacting the Fund (*see page A-4*).
- Glucometers. You may be able to get one free glucometer by calling Customer Care at 1-866-818-6911.

Prescription drug benefits

- Rogaine and other drugs to prevent hair loss.
- Drugs used, consumed or administered at the place where it is dispensed, other than immunizations. (These drugs may be covered under your medical benefits.)
- Drugs for which you are required to use the case management program if you do not participate in the program. The Fund or its designated representative has the sole authority to determine whether or not an individual is participating in the case management program.
- Diagnostics or biologicals, other than thyrogen.
- Drugs used for cosmetic reasons.

D

D-61



Coalition Health Center

Learn:

- What is the Coalition Health Center.
- What types of medical healthcare you can receive.

Coalition Health Center

The Coalition Health Center provides basic primary and preventive care and chronic condition management. The Coalition Health Center treats patients age five years old and up in Anchorage and age two years old and up in Fairbanks.

Eligible Employees and dependents can access quality care and achieve financial peace of mind. The Coalition Health Center's primary care providers focus on injury and illness treatment, disease prevention, health promotion, patient education, and chronic disease management.

Coalition Health Center

Website: www.coalitionhealthcenter.com

D

What you pay

There is no charge for services received at the Coalition Health Centers.

Primary Care Services

- Sore throat and ear exams
- Minor injury and surgical procedures
- Physicals
- Headache
- Chronic disease screening, treatment, and management
- Rashes and allergies
- Cough or sinus problems
- Well-women and Well-man exams
- Immunizations
- Labs performed on-site
- Prescription medication dispensary

This list does not include all of the services. Please contact the Coalition Health Center for more information.

Anchorage: (907) 264-1370 Fairbanks: (907) 450-3300

D-64

Appointments

Appointments are necessary during normal business hours. Walk-ins are welcome for unexpected illness and injury only between 8:30 a.m. to 4:30 p.m. Monday through Friday.

Coalition Health Center Locations:

Anchorage (minimum patient age: 5 years old)

2741 Debarr Road, Suite C210
Anchorage, AK 99508
(907) 264-1370

Office Hours

Monday - Friday

- By Appointment: 7:30 a.m. - 6:30 p.m.
- Walk-Ins: 8:30 a.m. - 4:30 p.m.
(Acute/ Unexpected Needs only)

Saturday

- By Appointment only: 8:00 a.m. - 2:00 p.m.
(Same Day appointment based on availability)

Fairbanks (minimum patient age: 2 years old)

Ridgeview Business Park
575 Riverstone Way, Unit 1
Fairbanks, AK 99709
(907) 450-3300

Office Hours

Monday - Friday

- By Appointment: 7:30 a.m. - 6:30 p.m.
- Walk-Ins: 8:30 a.m. - 4:30 p.m.
(Acute/ Unexpected Needs only)

Saturday

- By Appointment only: 8:00 a.m. - 2:00 p.m.
(Same Day appointment based on availability)



Wellness and Minor Care Program

Learn:

- What you pay for healthcare.
- What types of medical healthcare service you can receive.

Wellness and Minor Care Program

The Wellness and Minor Care Program is provided in addition to your medical Plan and is provided through Primary Care Associates. This program is for active employees and their dependents as well as retired participants not yet Eligible for Medicare. Medicare-Eligible retired participants are not Eligible for this benefit. You are not required to use the Wellness and Minor Care Program. However, it does provide you with services that are not normally covered under the medical Plan. Also, by using this Program, you may pay less in out-of-pocket expenses, reduce your waiting time and eliminate claim forms.

What you pay

You pay a \$20 Copay per person per visit, except for Preventive Care Benefits, which you have a \$0 Copay. There is no Coinsurance or Deductible. Payment is due at the time of service. You do not have to fill out a claim form. The Copays will apply to your PPO Out-of-Pocket Limit.

Covered Clinic Services

Routine and Minor Care

Coverage includes treatment for conditions such as:

- Colds;
- Flu;
- Minor illness or accident;
- General minor medical care; and
- X-rays or lab tests

Preventive Care Benefits

Recommended preventive care benefits will be paid at 100% and no Copay, Deductible or Coinsurance will be applied. Preventive care is defined under federal law as:

- Evidence-based items or services with a rating of A or B in the current recommendation of the U.S. Preventive Services Task force.
- Immunization for routine uses in children, adolescents, and adults with a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control.
- With respect to infants, children, adolescents and women, evidence-based preventative care and screenings included in guidelines supported by the Health Resources and Services Administration.

Annual preventive mammograms are available for employees and spouses. They may be done at a local Hospital. When you visit a Primary Care Associates clinic, you will be given a referral notice to take with you to the Hospital to obtain the mammogram.

Wellness and Minor Care Program

Following your physical examination and/or tests, a referral may be made to a medical doctor of your choice to discuss the findings.

Preventive Care for Children

Physical exams for children age 2 and over, including sports physicals and children's immunization shots, such as:

- Smallpox
- Tetanus
- Mumps
- Polio
- Typhoid
- Rubella
- Diphtheria
- Measles
- Chicken Pox

If the clinic provides you with services that are not specifically covered under the Wellness and Minor Care Program, the associated charges could be submitted under the medical Plan and the medical Plan's provisions will apply. Medical records, including x-rays and lab test results, will be forwarded to your regular physician.

If you have questions about what is covered under the Wellness and Minor Care Program, please contact the Primary Care Associates clinic to inquire. You can contact them at the following:

- **Anchorage:** (907) 563-4006, (907) 345-4343, or (907) 562-1234
- **Eagle River:** (907) 694-7223

What's not covered

- Occupational accidents or illnesses;
- Treatment for infants under the age of one;
- Health maintenance exams for children under the age of two;
- Treatment for substance abuse;
- Treatment for chronic conditions; or
- Medicare Covered Expenses.

Wellness and Minor Care Program

Appointments

For non-emergency treatment, appointments are preferred but not required. Please call either clinic to make an appointment. When you arrive for your appointment, tell the receptionist you are covered by the Alaska HERE Plan.

Primary Care Associates

The Wellness and Minor Care Program is provided through Primary Care Associates at their clinics in Anchorage and Eagle River:

For scheduled appointments:

4100 Lake Otis Parkway, Suite 322
Anchorage, AK 99508
(907) 562-1234

For walk-in services:

4100 Lake Otis Pkwy, Suite 100
Anchorage, AK 99508
(907) 563-4006

12350 Industry Way, Suite 160
Anchorage, AK 99515 (on the corner of Huffman & Old Seward)
(907) 345-4343

17101 Snowmobile Lane, Suite 102
Eagle River, AK 99577
(907) 694-7223

D

D-70



Dental Benefits

Learn:

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

Dental Benefits

The dental plan is for active employees only. Coverage is not provided for dependents or retired participants. This part of the SPD summarizes your dental benefits.

Dental Benefits	
Calendar Year Deductible	\$50
Calendar Year Maximum	\$1,000
Coinsurance	50%*
Periodic Oral Exam	\$0 Copay*
Most X-rays	\$0 Copay*
Regular Periodic Cleaning (adult or child prophylaxis) – Up to 2 total per person each year	\$0 Copay*

* Services received will be covered up to the Usual & Customary Charge (UCC). Any amounts above the UCC will not be covered and you may receive a balance bill from the provider.

Advance Claim Review

Advance claim review helps you determine your out-of-pocket expense before authorizing your dentist to complete a recommended treatment plan. If treatment begins before advance claim review, you may experience unanticipated out-of-pocket expenses.

Before beginning dental treatment where the charges are expected to be \$400 or more, a description of the proposed treatment, including verifying material such as x-rays, written reports, and charges should be filed with the Plan. The Plan will then determine the estimated benefits payable and provide you and your dentist with a printed cost estimate.

A course of treatment is a planned program involving one or more visits and/or dentists for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment begins on the date a dentist first renders a service to correct or treat the diagnosed dental condition.

Emergency treatments, oral examinations including prophylaxis and dental x-rays are considered part of a course of treatment; however, these services may be rendered before an advance claim review is made.

What you pay

You will pay the Deductible and any required Coinsurance for your dental care. Many types of routine dental care, such as standard exams and x-rays, may have no Coinsurance or Copays.

You will also have to pay for any dental care that is not considered a Covered Expense, including any dental care you get more frequently than allowed.

What's covered

Covered Expenses are your dentists' charges for the services and supplies listed below which meet both of the following tests:

- They are Medically Necessary and customarily employed nationwide to treat the dental condition; and
- They are appropriate and meet professionally recognized national standards of quality.

When there are two or more alternatives for treating a condition, Covered Expenses will be limited to the Medically Necessary, customary and appropriate criteria shown above. See Limitations for Alternative Treatments, beginning on [page D-78](#).

There are limits on how often certain services and supplies are covered. If the amount of time shown below has not passed since the service or supply was last provided, you may have to pay 100% of the cost. You can always contact the Fund to find out the last time you got benefits for a certain service or supply. A time limit starts on the date you last got the service or supply. Time limits are measured in consecutive months or years.

Covered dental expenses include:

- Routine oral examinations, but not more than twice in a Calendar Year;
- Routine prophylaxis (cleaning and scaling of teeth) by a dentist or dental hygienist, but not more than twice in a Calendar Year;
- Fluoride treatment by a dentist or dental hygienist, but not more than once in a Calendar Year;
- Dental x-rays, but not more than:
 - One full-mouth series of x-rays (up to 14 intraoral x-rays and bitewings) in any period of three consecutive Calendar Years; and
 - Four supplemental bite-wing x-rays in a Calendar Year;
- Space maintainers;
- Extractions;

Dental Benefits

D

- Fillings, other than gold;
- General anesthesia given in connection with covered services when criteria is met;
- Periodontic procedure (treatment of the bone and soft tissue surrounding the tooth);
- Endodontic procedures (procedures, such as root canal work, used for the treatment of the dental pulp);
- Emergency treatment for the relief of dental pain, but only if no other benefit, other than dental x-rays, is payable under the Plan;
- The first placement of full or partial removable dentures, temporary dentures or fixed bridgework. This will include adjustments during the six-month period following placement. The placement must be needed as a result of the extraction of one or more natural teeth while covered under the Plan. The denture or bridgework must include the replacement of the teeth which were extracted. The Plan will not pay for replacement of third molars (wisdom teeth);
- The replacement or alteration of full or partial dentures or fixed bridgework which is Medically Necessary because of oral surgery:
 - Resulting from an accident;
 - For the repositioning of muscle attachments; or
 - For the removal of a tumor, cyst, torus or redundant tissue;
 - The replacement or alteration must be completed within 12 months from the day of surgery;
- The replacement of a full denture which is Medically Necessary because of:
 - Structural change within the mouth and when more than five years have gone by since the prior placement; or
 - The prior placement of an immediate or temporary denture when the replacement occurs within 12 months of the placement of the immediate or temporary denture;
- Addition of teeth to, or replacement of, an existing partial or full removable denture or fixed bridgework when:
 - The replacement or addition is needed to replace one or more additional natural teeth; or
 - The existing denture or bridgework was put in at least five years prior to its replacement;
- Inlays, gold fillings and the first placement of crowns, including precision attachments for dentures;

Dental Benefits

- The replacement of a crown restoration when the original crown was put in more than five years prior to the replacement;
- Repair or re-cementing of crowns, inlays, bridgework or dentures. The Plan will include the rebasing or relining of dentures;
- Treatment of craniomandibular/temporomandibular (TMJ) disorders as approved by the American Academy of Craniomandibular Disorders, to include:
 - Diagnosis and baseline records;
 - Behavior modification modalities;
 - Repair of an appliance; and
 - Orthopedic stabilization.

Services must be performed by a licensed dentist and includes any required supplies.

Before the Plan considers any benefits, the Plan may ask for supporting proof of loss, clinical reports, charts and x-rays.

D

D-77

Dental Benefits

Limitations for Alternative Treatments

The following examples illustrate the Plan's limitations when there are two or more ways of treating a condition.

Gold, baked porcelain restorations, crowns and jackets: If a tooth can be restored with a material such as amalgam and you and the dentist select another type of restoration, only the reasonable charges appropriate to the procedure using amalgam or similar material will be covered.

Reconstruction: Only charges for those procedures Medically Necessary to eliminate oral disease and to replace missing teeth will be covered. Appliances or restorations Medically Necessary to increase vertical dimension or restore the occlusion are considered optional and are not covered.

Partial dentures: If a cast chrome or acrylic partial denture will restore a dental arch satisfactorily and you and the dentist select a more elaborate or precision appliance, only reasonable charges appropriate to the cast chrome or acrylic denture will be covered.

Complete dentures: If you and the dentist decide on personalized restorations or specialized techniques as opposed to a standard procedure, only the reasonable charges appropriate to the standard procedure will be covered.

Dental Benefits after Termination of Coverage

Benefits for dentures, fixed bridgework, crowns or an identifiable procedure involving a tooth or its immediate gum area will be paid after coverage terminates if all the following conditions have been met:

- The item is finally installed or delivered no later than 30 days after termination of coverage;
- For a denture, impressions must have been taken before coverage terminated; and
- For any other item mentioned above, the teeth which will serve as retainers or support, or which are being restored, must have been fully prepared to receive the item, and impressions must have been taken before coverage terminated.

These benefits are subject to the Calendar Year maximum for the year in which coverage terminated, and all other conditions, limitations and exclusions of this Plan.

What's not covered

The Plan will not pay for:

- Any treatment, service or supply unless it is shown under Covered Dental Expenses;
- Treatment of the teeth or gums for cosmetic purposes, including realignment of teeth;
- Expenses incurred after coverage ends; however, the Plan will pay for prosthetics (an artificial replacement of one or more natural teeth), including bridges and crowns, which were fitted and ordered prior to the date coverage ends. You must receive the prosthetic device within 30 days after the coverage ends;
- Prosthetics, including bridges and crowns, started prior to the date you became covered under this Plan;
- Rebasing or relining of a denture less than six months after the first placement, and not more than one rebasing or relining in any two- year period;
- Replacement of lost or stolen prosthetics;
- Replacement of prosthetics less than five years after previous placement, except as provided under Covered Dental Expenses;
- A new denture or bridgework if the existing denture or bridgework can be made serviceable;
- Charges you are not required to pay, including charges for services furnished by any Hospital or organization which normally makes no charge if the patient has no Hospital, surgical, medical or dental insurance;
- Orthodontic care, treatment, services or supplies;
- Local anesthesia or analgesia or their administration;
- Procedures, restorations or appliances to change vertical dimension or to restore occlusion (proper contact between opposing teeth);
- Nightguards;
- Implants or related services;
- Sealants;
- Any expense paid in whole or in part by any other provision of the Plan;
- Anything excluded under the General Exclusions and Limitations; or
- Any expense in excess of the Usual and Customary Charges.



Life and AD&D Insurance Benefits

Learn:

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

Life and AD&D Insurance Benefits

Life and Accidental Death and Dismemberment (AD&D) insurance benefits are for Eligible Employees only. Dependents and Retirees are not Eligible for life and AD&D insurance benefits.

Event	Benefit	Who Receives
Life Insurance	\$20,000	Your beneficiary
Accidental Death & Dismemberment Insurance (full amount)	Up to \$20,000	Your beneficiary (if you die)

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

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

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

Life insurance benefit

Your life insurance benefit is \$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 and AD&D insurance benefits will continue if you provide proof of your total disability. Your benefits will continue until the earlier of the following dates:

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

Life and AD&D Insurance Benefits

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 described above, you may be able to convert your group life coverage to an individual policy of whole life insurance by submitting a completed application and the required premium to Dearborn National within 31 days after the date your coverage under the Plan ends.

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

Dearborn National
1020 31st Street
Downers Grove, IL 60615
(800) 348-4512

Terminal illness benefit

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

D

D-83

Life and AD&D Insurance Benefits

Accidental death & dismemberment insurance benefit

If you die or suffer a covered loss within 365 days of an accident that happens while you are Eligible for coverage, AD&D insurance benefits will be paid as shown below.

Event	Benefit	Who Receives
Death	\$20,000	Your beneficiary
Loss of both hands or feet	\$20,000	You
Loss of sight in both eyes	\$20,000	You
Loss of one hand and one foot	\$20,000	You
Loss of one hand or one foot	\$10,000	You
Loss of the sight in one eye	\$10,000	You
Loss of index finger and thumb on same hand	\$5,000	You

AD&D exclusions

AD&D insurance benefits do not cover losses caused by:

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

See your certificate for complete details.

Life and AD&D Insurance Benefits

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

Naming a beneficiary

- Your beneficiary is the person or persons you want Dearborn National to pay if you die. Beneficiary designation forms are available from the Fund. You can name anyone you want and you can change beneficiaries at any time. However, beneficiary designations will only become effective when a completed form is received.
- If you don't name a beneficiary, death benefits will be paid to your surviving relatives in the following order: your spouse; your children in equal shares; your parents in equal shares; your brothers and sisters in equal shares; or your estate. However, Dearborn National may pay up to any applicable limits, to anyone who pays expenses for your burial. The remainder will be paid in the order described above.
- If a beneficiary is not legally competent to receive payment, Dearborn National may make payments to that person's legal guardian.

Life and AD&D Insurance Benefits

Additional services

- In addition to the benefits described above, Dearborn National has also made the following services available. These services are not part of the insured benefits provided to UNITE HERE HEALTH by Dearborn National but are made available through outside organizations that have contracted with Dearborn National. They have no relationship to UNITE HERE HEALTH or the benefits it provides.
- **Online Will Preparation**—Online will preparation gives you the ability to easily and quickly create a will, free of charge. Online will preparation services are administered by ComPsych, a major provider of global employee assistance programs.
- **Beneficiary Resource Services**—Beneficiary Resource Services is available to beneficiaries of an insured person who dies and to an insured person who qualifies for the Terminal Illness Benefit. The program combines grief, legal, and financial counseling provided by Bensinger, DuPont & Associates, a nationwide organization utilizing masters degreed grief counselors, licensed attorneys, and Certified Consumer Credit Counselors. Services are provided via telephone, face-to-face contact, and referrals to local support resources.
- **Travel Resource Services**—Europe Assistance USA, Inc. provides 24-hour emergency medical and related services for short-term travel more than 100 miles from home. Services include: assistance with finding a doctor, Medically Necessary transportation, and replacement of drugs or eyeglasses. Other non-medical related travel services are also available. Europe Assistance USA, Inc. arranges and pays for covered services up to the program maximum.
- Contact the Fund at 844-427-8501 when you have questions about these benefits.



The John Wilhelm Endowed Scholarship Benefit

Learn:

- Who is Eligible to apply.
- How to apply.

The John Wilhelm Endowed Scholarship Benefit

The John Wilhelm Endowed Scholarship Benefit (“Scholarship Benefit”) provides an opportunity for you and your Eligible dependents to pursue an undergraduate education in the health sciences field at the University of Nevada, Las Vegas (“UNLV”).

Who’s Eligible

To be considered for this Scholarship Benefit, you or your Eligible dependent(s) must meet the following requirements:

- Fund Eligibility -- you must either be:
 - A current Eligible Employee who is participating in a Fund Plan of Benefits and who has at least 3 continuous years of historical Plan participation (any period of 36 consecutive months during which an Eligible Employee participated in a Fund Plan of benefits or a plan that merged into the Fund); or
 - An Eligible dependent of a current Eligible Employee as described above.
- Be formally admitted as a student to UNLV and pursuing an undergraduate degree in Public Health, Nursing or a major within the School of Allied Health Sciences;
- Have a 3.0 cumulative grade point average or higher; and
- Be enrolled as a part-time or full-time undergraduate student and have a class standing of a junior or higher.

How to apply for a Scholarship Benefit

You or your Eligible dependents must apply for the Scholarship Benefit through the UNLV financial aid and scholarship office by completing a Free Application for Federal Student Aid (“FAFSA”) and any other required application materials.

- The FAFSA and any other required materials must be completed and submitted to UNLV in accordance with the school’s deadline(s) for each academic year.
- Please contact UNLV Financial Aid and scholarship office for questions and information regarding other required application materials.

You can go to www.unlv.edu/finaid/checklist or call 702-895-3011 (press option 4).

How are the Scholarship Benefit Awards determined?

- The Fund will determine the amount and number of Scholarship Benefits that will be awarded each academic year.

The John Wilhelm Endowed Scholarship Benefit

- Depending on a number of factors, the amount of each Scholarship Benefit awarded and the number of Scholarship Benefits available may be different each academic year.
- The Fund and UNLV will verify the Eligibility status of each employee and dependent who apply.
- UNLV will select the Scholarship Benefit recipients. Preference will be given to Eligible Employees and Eligible dependents who demonstrate financial need on the FAFSA and to past recipients of the scholarship. All determinations regarding the award of scholarships shall be made in the sole and independent discretion of UNLV and shall be final and binding for all Eligible Employees and dependents. All determinations specifically regarding the Fund Eligibility requirement described above in the section titled “Who is Eligible for the Scholarship” shall be made in the sole and independent discretion of the Fund and shall be binding on all employees and dependents.
- Recipients may reapply for a Scholarship Benefit in subsequent years, provided they continue to meet the Eligibility criteria and remain in good standing with UNLV.
- Applicants who are not awarded a Scholarship Benefit may always reapply in subsequent years.
- The Scholarship Benefit will be paid solely from the “John Wilhelm Endowed Scholarship” at UNLV that has been established by UNITE HERE HEALTH.

Exclusions and Limitations

- The Scholarship Benefit will not be payable directly to the student; it will be used only for tuition at UNLV.
- The Scholarship Benefits do not cover coursework towards post-graduate degrees at UNLV.
- Scholarship Benefits are not guaranteed for every year. Scholarships will not be awarded if there are no qualified applicants in a particular year or if there are insufficient available funds in the Endowed Scholarship fund.
- Payment will only be made for the part of the tuition that exceeds any other financial aid, such as public or private financial assistance, fellowships, scholarships or grants.
- Scholarship Benefits may not be used to cover registration fees, student body fees, activity fees, books, supplies, equipment, tools, meals, lodging, parking or transportation.

Appeal rights

- If you or your Eligible dependent(s) receive a denial notice because you do not meet the Fund Eligibility requirement listed above in “Who is Eligible for the Scholarship,” you may appeal such determination within 60 days of receipt of the denial notice. *See page E-7.*



Claim Filing and Appeal Provisions

Learn:

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

Claim Filing and Appeal Provisions

Commencement of legal action

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

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

Non-assignment of claims

You may not assign your claim for benefits under the Plan to a Non-PPO Provider without the Plan's express written consent. A Non-PPO 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-PPO Providers, and providers are not permitted to change this rule or make exceptions on their own. If you sign an assignment with a provider without the Plan's written consent, it will not be valid or enforceable against the Plan. This means that a Non-PPO 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-PPO Provider directly for covered services rendered to you. Payment to a Non-PPO Provider in any one case shall not constitute a waiver of any of the Plan's rules regarding Non-PPO providers, and the Plan reserves all of its rights and defenses in that regard.

Filing claims (other than life/AD&D insurance)

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

In all cases, your claim for benefits must include all of the following information:

- Your name.
- Your Social Security number.

Claim Filing and Appeal Provisions

- A description of the injury, sickness, symptoms, or other condition upon which your claim is based.

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

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

All claims for benefits must be made as shown below. If you need help filing a claim, contact the Fund at **844-427-8501**.

See page E-9 for rules on filing life insurance appeals.

Healthcare claims

PPO providers will generally file the claim for you. However, if you need to file a claim for Hospital, medical, or surgical treatment and dental claims (for example because you used a Non-PPO Provider), you should send it to:

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

Prescription drug claims

If you use a participating pharmacy, the pharmacy should file a claim for you. However, if you need to file a claim for a prescription drug purchased at a participating pharmacy, you should send it to:

CVS Caremark
Customer Care Correspondence
PO Box 6590
Lee's Summit, MO 64064-6590

Claim Filing and Appeal Provisions

All other benefit claims

Any claims for any services or supplies denied because you are not Eligible or because you missed a payment or application deadline, should be mailed to:

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

Deadline for filing claims

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

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

Who may file benefit claims

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

Incomplete claims

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

When will your claim be decided?

Urgent	Pre-Service Claims	Post-Service Claims
within 72 hours (or 48 hours after requested missing information is received)	15 days (plus 15 more days if the Plan notifies you of the need for additional time)	30 days (plus 15 more days if the Plan notifies you of the need for additional time)

Claim Filing and Appeal Provisions

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

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

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

Claim denials

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

Appeal forms are available on the Fund's website: www.uhh.org or by calling 844-427-8501.

Filing appeals (other than Life and AD&D insurance)

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

All appeals must be in writing (except for appeals involving urgent care), signed, and should include the claimant's name, address, and date of birth, and your (the employee's) Social Security number. You should also provide any documents or records that support your claim. If you are appealing a denial of benefits that qualifies as a request for urgent or emergency care, you can orally request an expedited (accelerated) appeal of the denial by calling **844-427-8501**. All necessary information may be sent by telephone, facsimile or any other available reasonably effective method.

See page E-9 for rules on filing life insurance and AD&D claim appeals.

Claim Filing and Appeal Provisions

Two levels of appeal for prior authorization denials made by Medical Rehabilitation Consultants

First level of appeal. If you disagree with MRC's decision to deny prior authorization of a medical/ surgical or mental health/ substance abuse benefit, you have two opportunities to appeal the decision.

An appeal of a prior authorization denial must be sent within 180 days of your receipt of the claim denial to:

Medical Rehabilitation Consultants

111 W. Cataldo Avenue, Suite #200
Spokane, WA 99201
www.medrehabconsultants.com

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

The Appeals Subcommittee

UNITE HERE HEALTH

711 N. Commons Drive
Aurora, Illinois 60504

Two levels of appeals for prescription drug denials made by CVS Caremark

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 the CVS Caremark's denial letter to:

CVS Caremark

Customer Care Correspondence

PO Box 6590
Lee's Summit, MO 64064-6590

Claim Filing and Appeal Provisions

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

The Appeals Subcommittee

UNITE HERE HEALTH

711 N. Commons Drive

Aurora, Illinois 60504

Appeal for most other claims

If you disagree with all or any part of a healthcare or dental claim denial, and you wish to appeal the decision, you must follow the steps in this section. You must submit an appeal within 180 days of your receipt of the healthcare claim denial letter to:

The Appeals Subcommittee

UNITE HERE HEALTH

711 N. Commons Drive

Aurora, Illinois 60504

The Appeals Subcommittee will not enforce the 180-day filing limit when:

- You could not reasonably file the appeal within the 180-day 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.

Appeal for late payments, late dependent contributions or late applications for coverage

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

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

Claim Filing and Appeal Provisions

You must submit your appeal within 180 days of the date the late self-payment or late application was refused. Send your written application for appeal to:

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

What are your appeal rights?

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

When will your appeal be decided?

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

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

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

Many types of claims must be appealed directly to the contracted groups that provide certain services under the Plan. Your claim determination will let you know when this is the case. You may also receive an appeal denial from such a group, explaining that it has been automatically referred to the Plan's Appeals Committee for a second review. In other cases, you must file a written request for a second review by the Appeals Committee. When that happens, the times listed above are divided into two - half for each of the two appeal stages.

External appeals (Independent Review Organization)

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

If the IRO reverses the Plan's adverse redetermination decision, then the Plan will provide coverage and/or payment of the claim within twenty-four hours of notification of the IRO decision. If the IRO upholds the adverse redetermination decision, the IRO will communicate the decision to the Plan and the Eligible person. The Plan will provide denial letters with the specific reason for the denial and the contact information for the HHS Office of Consumer Assistance.

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.

Filing life/AD&D insurance claims and appeals

The rules for filing and appealing claim denials for life/AD&D insurance are governed by the Fund's contracts with the provider, and so are different from the other claims and appeals rules.

Claim Filing and Appeal Provisions

Life and AD&D insurance claims

Contact UNITE HERE HEALTH to file a claim for benefits:

UNITE HEREHEALTH

P.O. Box 6020
Aurora, IL 60598-0020
844-427-8501

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

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

The claim processing rules, time limits, and appeal procedures the provider must follow are described in the contract with the provider. Generally, the provider will respond to your claim within 90 days (but may request a 90-day extension). You can file an appeal within 60 days of the provider's decision. The provider will generally respond to your appeal within 60 days (but may request a 60-day extension). If you have questions about how the provider's claim and appeal process works, contact the Fund at 844-427-8501.



Coordination of Benefits

Learn:

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

Coordination of Benefits

The Plan's coordination of benefits provisions only apply to medical benefits and dental benefits. No coordination of benefits applies to prescription drug benefits, and life or AD&D insurance 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 be more than 100% of allowable expenses.

This Plan coordinates benefits with the following types of plans:

- Group, blanket, or franchise insurance coverage.
- Any other group coverage, including labor-management trustees plans, employee organization benefit plans, or Employer organization benefit plans.
- Any coverage under governmental programs or provided by any statute, except Medicaid.
- Any automobile insurance policies (including "no fault" coverage) containing personal injury protection provisions.
- This Plan will not coordinate benefits with Health Maintenance Organizations (HMOs) or reimburse an HMO for services provided.

Which plan pays first

The first step in coordinating benefits is to determine which plan pays first (the primary plan) and which plan pays second (the secondary plan). If the Fund is primary, it will pay its full benefits. However, if the Fund is secondary, the benefits it would have paid will be used to supplement the benefits provided under the other plan, up to 100% of allowable expenses. Contact the Fund (*see page A-4*) for more information about how the Plan determines allowable expenses when it is secondary.

Order of payment

The general rules that determine which plan pays first are summarized below. Contact the Fund (*see page A-4*) when you have any questions.

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

- With respect to plans that have COB and cover dependent children under age 18 whose parents are not separated, plans that cover the parent whose birthday falls earlier in a year pay before plans covering the parent whose birthday falls later in that year.
- With respect to plans that have COB and cover dependent children under age 18 whose parents are separated or divorced:
 - Plans covering the parent whose financial responsibility for the child's healthcare expenses is established by court order pay first.
 - If there is no court order establishing financial responsibility, the plan covering the parent with custody pays first.
 - If the parent with custody has remarried and the child is covered as a dependent under the plan of the stepparent, the order of payment is as follows:
 1. The plan of the parent with custody.
 2. The plan of the stepparent with custody.
 3. The plan of the parent without custody.
- With respect to plans that have COB and cover adult dependent children age 18 and older under both parents' plans, regardless of whether these parents are separated or divorced, or not separated or divorced, the plan that covers the parent whose birthday falls earlier in a year pays before the plan covering the parent whose birthday falls later in the year, unless a court order requires a different order.
- With respect to plans that have COB and cover adult dependent children age 18 and older under one or more parents' plan and also under the dependent child's spouse's plan, the plan that has covered the dependent child the longest will pay first.

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

COB and prior authorization

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

Coordination of Benefits

Special rules for Medicare

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

- The Plan is primary for the first 30 months a person is Eligible for and entitled to Medicare because of end stage renal disease (ESRD).
- Medicare is primary with respect to any coverage under the Plan provided for you after employment ends (such as COBRA coverage).
- If you are a retired employee and you and your spouse are Eligible for Medicare, Medicare is always your primary plan, and any benefits from the Retiree Plan will only be available after Medicare has processed your claim.

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

If you and your dependent are both employees under this Plan

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

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



Repayment and Subrogation

Learn:

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

Repayment and Subrogation

The Plan's subrogation provisions only apply to medical and prescription drug benefits. No subrogation applies to dental, life or AD&D insurance benefits.

The Plan's right to recover payments

When injury is caused by someone else

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

Typical examples include injuries sustained:

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

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

Statement of facts and repayment agreement

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

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

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

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

Repayment and Subrogation

Settling your claim

Before you settle your claim with a third party, you or your attorney should contact UNITE HERE HEALTH (see page A-4) to obtain the total amount of medical bills paid. Upon settlement, UNITE HERE HEALTH is entitled to reimbursement for the amount of the benefits it has paid or the full amount of the settlement or other recovery you or a dependent receive, whatever is less.

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

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

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

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



Out-of-Country Emergency Claims

Learn:

- How Emergency claims are paid if you are Out of the Country.

Out-of-Country Emergency Claims

For out-of-country emergency claims to be considered for payment, the Plan must have sufficient, credible evidence that your medical services were actually and appropriately provided by a Healthcare Provider who the Plan also considers appropriate, for the care of an Eligible person, and for an emergency condition covered by the Plan.

Out-of-country emergency claims not meeting the Plan's requirements are excluded from coverage and payment. The following are the Plan's requirements for coverage and payment of out-of-country emergency claims:

- The charges must be denominated in U.S. currency;
- The Plan has the right to require:
 - That the service be submitted under an itemized bill (HCFA/UB); and
 - That the services be identified with a current CPT and ICD-10 code; and
 - Proper and sufficient medical records be provided; and
 - A personal interview with the Eligible Person who received the services; and
 - An Independent Medical Examination (IME) of the Eligible Person who received the services. The IME will be done by a physician selected and paid for by the Plan; and
- The claim must be for a covered benefit and satisfy all other Plan requirements and guidelines for coverage and payment of claims.



Other Important Information

Learn:

- Important information about UNITE HERE HEALTH and your benefits.

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?

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

The Plan provides life and accidental death & dismemberment (AD&D) benefits through fully insured contracts. The life and AD&D benefits are funded and guaranteed under a group contract underwritten by Dearborn National.

The Plan also contracts with other organizations to help administer certain benefits. Prescription drug benefits are administered by CVS Caremark. Prior authorization and other utilization review services, and case management for the Plan's medical benefits are provided by Medical Rehabilitation Consultants.

Remedies for fraud

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

Interpretation of Plan provisions

For claims subject to independent external review (*see page E-9*), the IRO has the authority to make decisions about benefits, and decide all questions about claims, submitted for independent external review.

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,

Other Important Information

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

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

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

Amendment or termination of the Plan

The Trustees 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 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 termination of UNITE HERE HEALTH, or any Plan Unit, or any schedule of benefits will depend on the financial condition of UNITE HERE HEALTH.

Other Important Information

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.

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.

Free choice of provider

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

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

Workers' Compensation

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

Type of Plan

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

Other Important Information

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 office 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 UNITE HERE HEALTH. Service of legal process may also be made upon a Plan trustee. The CEO's address and phone number are:

UNITE HERE HEALTH

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

Employer identification number

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

Plan number

The Plan Number is 501.

Plan year

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

H

H-5



General Exclusions and Limitation

Learn:

- What types of medical healthcare are not covered.

General Exclusions and Limitation

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

- Any Injury or Sickness for which the covered person is entitled to benefits, either in whole or in part, under a workers' compensation or occupational disease, obtained or which should have been obtained under law;
- Any expense which is in excess of the Usual and Customary Charges for covered services from other than a PPO Provider;
- Any expense which is in excess of the Contracted Rate for covered services from a PPO Provider;
- Any expense or charge for services or supplies not Medically Necessary or not recommended by a physician;
- Any expense incurred after coverage ends (except as specifically provided under any extended benefits provisions in the Plan);
- Any loss, expense or charge which results, whether the person is sane or insane, from an intentionally self-inflicted Injury or Sickness or suicide or attempted suicide;
- Any loss, expense or charge resulting from the person's participation in a riot or in the commission of a felony;
- Any expense or charge which the person does not have to pay or for charges that are made simply because coverage exists;
- Any expense or charge for custodial care, developmental care or domiciliary care except as specifically described under Covered Medical Expenses;
- Any loss, expense or charge which results from cosmetic or reconstructive surgery, except:
 - For injuries;
 - The repair of defects which result from surgery for which the covered person was paid benefits under the Plan;
 - For reconstructive breast surgery because of a mastectomy; or
 - For all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast;

General Exclusions and Limitation

- Any loss, expense or charge which results from appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by the Administration Office, and present significant symptomatic medical problems) or any treatment of obesity (except for surgery to treat Morbid Obesity when required criteria is met);
- Any expense or related charge for orthopedic shoes, orthotics or other supportive devices for the feet;
- Any expense or charge in connection with dental work, dental surgery or oral surgery, (unless specifically provided), including:
 - Treatment involving any tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or
 - Surgery or splinting to adjust dental occlusion;
- Any loss, expense or charge for sex transformations or any treatment or service related to sexual dysfunction;
- Any expense or charge for the promotion of fertility including (but not limited to):
 - Fertility tests;
 - Reversal of surgical sterilization; and
 - Any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any similar treatment or method;
- Chelation therapy except for acute arsenic, gold, mercury or lead poisoning;
- Charges for services or supplies (including drugs) which are:
 - Not Medically Necessary,
 - Not provided in accord with generally accepted professional medical standards; or
 - For Experimental/Investigational treatment.
- Any expense or charge which is primarily for the covered person's education, training or development of skills needed to cope with an Injury or Sickness except diabetic education as described;
- Any expense or charge incurred for Acupuncture Treatment (except when used as an anesthetic agent for covered surgery);

General Exclusions and Limitation

- Any expense or charge for services or supplies which are provided or paid for by Federal government or its agencies except for:
 - The Veterans Administration, when services are provided to a veteran for a disability which is not service-connected;
 - A military Hospital or facility, when services are provided to a Retiree (or dependent of a Retiree) from the armed services;
 - A group health plan established by a government for its own civilian employees and their dependents; or
 - Medicaid, if required by a Medicaid assignment of benefits;
- Any loss, expense or charge which results from an act of declared or undeclared war or armed aggression;
- Any loss, expense or charge:
 - Which is incurred while the covered person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and
 - For which any government body or its agencies are liable;
- Any expense or charge which is primarily for a person's convenience or comfort or that of the person's family, caretaker, physician or other medical provider;
- Any expense or charge if the payment is prohibited by any law of the jurisdiction in which the individual resides at the time the benefit liability is incurred;
- Contact lenses except for initial placement of contact lenses required because of cataract surgery or initial lens implant required because of cataract surgery;
- Charges for eye examinations, eye refractions or the fitting or cost of visual aids, vision therapy, radial keratotomy or similar surgery done in treating myopia except for corneal graft;
- Charges for hearing aids or cochlear implants;
- Vitamins, nutritional supplements, unless supplement is the only (or primary) source of caloric intake;
- Dependent child pregnancy;
- Genetic testing;
- Naturopath services;
- Duplicate Durable Medical Equipment or specialized equipment such as sports packages;
- Duplicate prosthesis or specialized equipment such as sports packages;

General Exclusions and Limitation

- Ramps, hand rails or other modifications to the home;
- Helmet therapy;
- Phone consultations, missed appointments, filling out forms, or other physician fee when patient was not physically seen;
- Charges incurred for any illness or injury caused by the act or omission of another person (known as a third party), and where an opportunity for recovery exists from the third party and/or under an automobile, homeowners, commercial premises, renter's, medical malpractice, or other insurance or liability policy. The Plan may advance payment of benefits pending recovery from the third party or insurers;
- Charges incurred while you are confined in a Hospital operated by the United States of America or an agency thereof (except as otherwise required by law); or
- Charges on account of donating your human organ or tissue, however, if you are the recipient of a donated human organ the Donor's medical expenses are covered up to the Donor limit as specified on [page D-11](#).



Your Rights under ERISA



Your Rights under ERISA

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

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

Receive information about your Plan and benefits

ERISA provides that all Plan participants shall be entitled to:

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

Continue group health Plan coverage

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

Prudent actions by Plan fiduciaries

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

Enforce your rights

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

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

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

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

Assistance with your questions

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

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



COBRA continuation coverage

Learn:

- How you can make self-payments to continue your coverage.

COBRA continuation coverage

K

COBRA continuation coverage is not automatic. It must be elected and the required premiums must be paid when due. A premium will be charged under COBRA as allowed by federal law.

If you or your dependents lose coverage under the Plan, you have the right in certain situations to temporarily continue coverage beyond the date it would otherwise end. This right is guaranteed under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

Who can elect COBRA continuation coverage?

Only qualified beneficiaries are entitled to COBRA continuation coverage, and each qualified beneficiary has the right to make an election.

You or your dependent is a qualified beneficiary if you or your dependent loses coverage due to a qualifying event and you or your dependent were covered by the Plan on the day before the earliest qualifying event occurs. However, a child born to, or placed for adoption with, you (the employee) while you have COBRA continuation coverage is also a qualified beneficiary.

If you want to continue dependent coverage or add a new dependent after you elect COBRA continuation coverage, you may do so in the same way as active employees do under the Plan.

What is a qualifying event?

A qualifying event is any of the following events if it would result in a loss of coverage:

- Your death.
- Your loss of Eligibility due to:
 - Termination of your employment (except for gross misconduct).
 - A reduction in your work hours below the minimum required to maintain Eligibility.
- The last day of a leave of absence under FMLA if you don't return to work at the end of that leave.
- Divorce or legal separation from your spouse.
- A child no longer meeting the Plan's definition of dependent (*see page B-3*).
- Your coverage under Medicare. (Medicare coverage means you are Eligible to receive coverage under Medicare; you have applied or enrolled for that coverage, if an application is necessary; and your Medicare coverage is effective.)
- Your Employer withdraws from UNITE HERE HEALTH.

K-2

What coverage can be continued?

By electing COBRA continuation coverage, you have the same benefit options and can continue the same healthcare coverage available to other employees who have not had a qualifying event. Your COBRA coverage options are based on which benefit options you had on the day before the qualifying event.

In addition to medical benefits, COBRA continuation coverage includes prescription drug benefits and dental benefits for employees. For dependents, COBRA continuation coverage includes medical and prescription drug benefits. Life and AD&D benefits cannot be continued. However, you may be able to convert your life insurance to an individual policy. Contact the Fund for more information.

How long can coverage be continued?

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

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

However, you may be able to continue coverage for yourself and your dependents for up to an additional 11 months, for a total of 29 months. The Social Security Administration must determine that you or a covered dependent are disabled according to the terms of the Social Security Act of 1965 (as amended) any time during the first 60 days of continuation coverage.

- Up to 36 months from the date coverage would have originally ended for all other qualifying events, as long as those qualifying events would have resulted in a loss of coverage despite the occurrence of any previous qualifying event.

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

- Qualifying events shall be considered in the order in which they occur.

COBRA continuation coverage

K

- If additional qualifying events, other than your coverage by Medicare, occur during an 18-month or 29-month continuation period, affected qualified beneficiaries may continue their coverage up to 36 months from the date coverage would have originally ended.
- If you are covered by Medicare and subsequently experience a qualifying event, continuation coverage for your dependents can only be continued for up to 36 months from the date you were covered by Medicare.
- If continuation coverage ends because you subsequently become covered by Medicare, continuation coverage for your dependents can only be continued for up to 36 months from the date coverage would have originally ended.

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

Notifying UNITE HERE HEALTH when qualifying events occur

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

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

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

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

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

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

K-4

COBRA continuation coverage

K

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

- For divorce or legal separation: spouse's name, Social Security number, address, telephone number, date of birth, and a copy of one of the following: a divorce decree or legal separation agreement.
- For a dependent child's loss of Eligibility: the name, Social Security number, address, telephone number, date of birth of the child, date on which the child no longer qualified as a dependent under the plan; and the reason for the loss of Eligibility (i.e., age, or ceasing to meet the definition of a dependent).
- For your death: the date of death, the name, Social Security number, address, telephone number, date of birth of the Eligible dependent, and a copy of the death certificate.
- For your or your dependent's disability status: the disabled person's name, the date on which the disability began or ended, and a copy of the Social Security Administration's determination of disability status.

If you or your dependent does not provide the required notice and documentation, you or your dependent will lose the right to elect COBRA continuation coverage.

In order to protect your family's rights, you should keep the Fund informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund or that the Fund sends you.

Election and payment deadlines

COBRA continuation coverage is not automatic. You must elect COBRA continuation coverage, and you must pay the required payments when they are due.

When the Fund gets notice of a qualifying event, it will determine if you or your dependents are entitled to COBRA continuation coverage.

- If you or your dependents are not entitled to COBRA continuation coverage, you or your dependent will be mailed a notice that COBRA continuation coverage is not available within 14 days after UNITE HERE HEALTH has been notified of the qualifying event. The notice will explain why COBRA continuation coverage is not available.
- If you or your dependents are entitled to COBRA continuation coverage, you or the dependent will be mailed a description of your COBRA continuation coverage rights and the applicable election forms. The description of COBRA continuation coverage rights and the election forms will be mailed within 45 days after UNITE HERE HEALTH has been notified of the qualifying event. These materials will be mailed to those entitled to continuation coverage at the last known address on file.

K-5

COBRA continuation coverage

K

If you or your dependents want COBRA continuation coverage, the completed election form must be mailed to UNITE HERE HEALTH within 60 days from the earliest of the following dates:

- The date coverage under the Plan would otherwise end.
- The date the Fund sends the election form and a description of the Plan's COBRA continuation coverage rights and procedures, whichever occurs later.

If your or your dependents' election form is received within the 60-day election period, you or your dependents will be sent a premium notice showing the amount owed for COBRA continuation coverage. The amount charged for COBRA continuation coverage will not be more than the amount allowed by federal law.

- UNITE HERE HEALTH must receive the first payment within 45 days after the date it receives your election form. The first payment must equal the premiums due from the date coverage ended until the end of the month in which payment is being made. This means that your first payment may be for more than one month of COBRA continuation coverage.
- After the first payment, additional payments are due on the first day of each month for which coverage is to be continued. To continue coverage, each monthly payment must be postmarked no later than 30 days after the payment is due.

Payments for COBRA continuation coverage must be made by check or money order, payable to UNITE HERE HEALTH, and mailed to:

UNITE HERE HEALTH

P.O. Box 809328
Chicago, IL 60680-9328

K-6

Termination of COBRA continuation coverage

COBRA continuation coverage will end when the maximum period of time for which coverage can be continued is reached.

However, on the occurrence of any of the following, continuation coverage may end on the first to occur of any of the following:

- The end of the month for which a premium was last paid, if you or your dependents do not pay any required premium when due.
- The date the Plan terminates.
- The date Medicare coverage becomes effective if it begins after the person's election of COBRA (Medicare coverage means you are entitled to coverage under Medicare; you have applied or enrolled for that coverage, if application is necessary; and your Medicare coverage is effective).
- The date the Plan's Eligibility requirements are once again satisfied.
- The end of the month occurring 30 days after the date disability under the Social Security Act ends, if that date occurs after the first 18 months of continuation coverage have expired.
- The date coverage begins under any other group health plan.

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

To get more information

If you have any questions about COBRA continuation coverage, your rights, or the Plan's notification procedures, please call UNITE HERE HEALTH at **844-427-8501**.

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



Definitions

Learn:

- Definitions of some of the terms the Plan uses.

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

Definitions

K

Acupuncture Treatment

The piercing of specific peripheral nerves with needles to relieve the discomfort of painful disorders or for therapeutic purposes.

Allowable Charges

An Allowable Charge is the amount of charges for covered treatments, services, or supplies that the Plan uses to calculate the benefits it pays for a claim. The Allowable Charge may be less than the provider's actual charges. This usually happens if you choose a Non-PPO Provider. You must pay any difference between the provider's actual charges and the Allowable Charges. Any charges that are more than the Allowable Charge are not covered. The Plan will not pay benefits for charges that are more than the Allowable Charge.

The Board of Trustees has the sole authority to determine the level of Allowable Charges the Plan will use. In all cases, the Trustees' determination will be final and binding.

- Allowable Charges for services furnished by PPO 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-PPO Provider means you pay more out-of-pocket costs. The Plan calculates benefits for Non-PPO Providers based on established discounted rates. The Plan will not pay the difference between what a Non-PPO Provider actually charges, and what the Plan considers an Allowable Charge. You pay this difference in cost. (This is sometimes called "balance billing.")

Birthing Center

Eligible persons are covered for services rendered at a licensed birthing center in the state in which they operate, or if licensing is not required in the state of operation, the center must meet the American Public Health Association Guidelines for the operation of Birthing Centers. Covered services will include Licensed Birthing Center and Licensed Nurse Midwives who are employed in the Birthing Centers licensed by the state and who are provided with appropriate medical supervision.

Calendar Year

The period commencing on January 1 of each year and ending on December 31 of the same year.

K-10

Coinsurance

Your share of the costs of a Covered Expense, calculated as a percent (for example, 40%) of the Allowable Charge for the service. You pay your Coinsurance plus any Deductibles or Copays. For example, under the Bronze Plan, if the Allowable Charge for network Durable Medical Equipment is \$100, your 40% Coinsurance equals \$40. (This assumes you have met your \$750 Deductible). Your Coinsurance counts toward your Out-of-Pocket Limits.

Contracted Rate

The rate negotiated with PPO facilities in Anchorage for covered services. The Contracted Rate may be less than the expense charged by a Non-PPO facility. All such covered services are subject to this Contracted Rate definition. In no event will the Contracted Rate exceed the billed amount or the amount for which the covered person is responsible.

Copay or Copayment

A fixed amount (for example, \$10) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

For example, each time you go to the emergency room, a \$100 Copay applies. It is the same for all Plans. Your Copayments count toward your Out-of-Pocket Limits.

Cosmetic Services

Those services and procedures intended to improve appearance. Cosmetic Services do not include reconstructive services, which are services and procedures primarily to restore bodily function or to correct significant deformity resulting from accidental injury, trauma, congenital condition or previous therapeutic process. Cosmetic Services include those intended to prevent or treat a Mental Health/Substance Abuse Disorder through a change in bodily form.

Mastectomies and reconstruction following a mastectomy, will not be considered cosmetic or reconstructive surgery (*see page D-11*).

Covered Expense

A treatment, service or supply for which benefits are paid under the Plan. **Covered Expenses** are limited to the Allowable Charge.

Definitions

K

Deductible

The amount you owe for Covered Expenses before the Fund begins paying benefits.

For example, under the Bronze Plan, the Fund will not start paying PPO medical benefits on your behalf until you meet your \$750 PPO individual **Deductible**. A Deductible applies to both PPO and Non-PPO expenses. You only have to pay the Deductible once each year. Once you have paid your Deductible (sometimes called “satisfying your Deductible”), you do not have to make any more payments toward your Deductible for the rest of that year. The same rule applies if two or more members of your family satisfy the \$1,500 PPO family Deductible. Once your family Deductible has been satisfied, no one else in your family has to pay Deductibles for the rest of that year.

The Deductible may not apply to all services, including services that have a Copay. For example, home health care services will be paid by the Fund before your or your family’s Deductible is met.

Amounts you pay for healthcare that the Plan does not cover will not count toward your Deductible. This includes, but is not limited to, excluded services and supplies, charges that are more than the Allowable Charge, amounts over a benefit maximum or limit and other charges for which the Plan does not pay benefits. Your Deductibles count toward your Out-of-Pocket Limits.

You can get more information about your medical Deductibles in the appropriate section of this SPD.

Donor

A person who undergoes a surgical operation for the purpose of donating a body organ(s) for transplant surgery.

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.

K-12

Eligible Employee

Any employee who is Eligible for benefits under the Plan, according to the standards and provisions set forth in the Eligibility rules of the Plan.

Eligible or Eligibility

Being entitled to the benefits payable under the provisions of the Plan by virtue of having fulfilled the Plan's Eligibility requirements.

Emergency Medical Treatment

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

Employer or Contributing Employer

An Employer of employees who, by reason of a Collective Bargaining Agreement with the Union, is obligated to make Contributions to this Fund or to a welfare fund which has merged with this Fund or will hereafter do so. The term Employer will also mean a local union or Trust fund established pursuant to Section 186 of the Labor Management Relations Act of 1947, if such local Union or Trust fund is accepted for participation in the Fund.

Experimental, Investigational, or Unproven (Experimental or Investigational)

Experimental, Investigational, or Unproven procedures or supplies are those procedures or supplies which are classified as such by agencies or subdivisions of the federal government, such as the Food and Drug Administration (FDA) or the Office of Health Technology Assessment of the Centers for Medicare & Medicaid Services (CMS); or according to CMS's Medicare Coverage Issues Manual.

However, routine patient costs associated with clinical trials are not considered Experimental, Investigational, or Unproven.

Definitions

K

Healthcare Provider

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

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

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

A **specialist** is a Healthcare Provider who does not practice in one of the specialties listed above.

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

You do not need prior authorization in order to access obstetrical or gynecological care from a network Healthcare Provider who specializes in obstetrics or gynecology. The Healthcare Provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For help finding participating Healthcare Providers who specialize in obstetrics or gynecology, contact the Fund at **844-427-8501**.

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.

Hospital

Facilities which are licensed by the proper authority in the area in which they are located:

- A place which is licensed as a general hospital by the proper authority of the area in which it is located;

K-14

- A place which:
 - Is operated for the care and treatment of resident inpatients;
 - Has a registered graduate nurse (RN) always on duty;
 - Has a laboratory and x-ray facility; and
 - Has a place where major surgical operations are performed;

or

- A facility which is accredited by the Joint Commission on the Accreditation of Healthcare Facilities, American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities if the function of such facility is primarily of a rehabilitative nature, provided such rehabilitation is specifically for treatment of a physical disability. Such facility need not have major surgical facilities.

When treatment is needed for a mental disease or disorder, hospital can also mean a place which meets these requirements:

- Has rooms for resident inpatients;
- Is equipped to treat mental diseases or disorders;
- Has a resident psychiatrist on duty or on call at all times;
- As a regular practice, charges the patient for the expense of confinement; and
- Is licensed by the proper authority of the area in which it is located.

A hospital does not include a hospital or institution or part of a hospital or institution which is licensed or used principally as a convalescent home, rest home, nursing home or home for the aged.

Injuries and Sicknesses

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

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

The Plan only pays benefits for Preventive Healthcare for a pregnant dependent child. **Maternity charges for a pregnant dependent child that are not Preventive Healthcare** (*See page K-17*) **are not covered by the Plan.** “Non-preventive maternity care” includes but is not limited to ultrasounds, care for a high-risk pregnancy, and the actual childbirth and delivery. No benefits are payable for the child of your child (unless the child meets the Plan’s definition of a dependent—*see page B-3*).

Definitions

K

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

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

Medically Necessary

Medically Necessary services, supplies, treatment are:

- Consistent with and effective for the Injury or Sickness being treated;
- Considered good medical practice according to standards recognized by the organized medical community in the United States; and
- Not Experimental or Investigational (*see page K-13*), nor Unproven as determined by appropriate governmental agencies, the organized medical community in the United States, or standards or procedures adopted from time-to-time by the Trustees. However, with respect to mastectomies and associated reconstructive treatment, Allowable Charges for such treatment is considered Medically Necessary for Covered Expenses incurred based on the treatment recommended by the patient's Healthcare Provider, as required under federal law.

The Board of Trustees has the sole authority to determine whether care and treatment is Medically Necessary, and whether care and treatment is Experimental or Investigational. In all cases, the Trustees' determination will be final and binding. However, determinations of medical necessity and whether or not a procedure is Experimental or investigative are solely for the purpose of establishing what services or courses of treatment are covered by the Plan. All decisions regarding medical treatment are between you and your Healthcare Provider and should be based on all appropriate factors, only one of which is what benefits the Plan will pay.

Mental and Nervous Disorders/ Alcohol and Drug Abuse

A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind, and chemical dependency, drug addiction, or other substance abuse disorders.

Morbid Obesity

Means the following:

- BMI (Body Mass Index) equal to or greater than 40 that has persisted for at least 5 years; or
- BMI (Body Mass Index) equal to or greater than 35 and less than 40 for at least 5 years with at least one clinically significant comorbidity, such as a serious cardiopulmonary problem, Type 2 diabetes, hypertension, coronary artery disease, obstructive sleep apnea, or pulmonary hypertension.

K-16

Non-Preferred Provider Organization (Non-PPO)

Providers of healthcare services who have not contracted with The Fund or its designee to provide such services to Eligible Persons. Such term will also refer to those health benefits, services, and/or supplies that are payable under the Plan, and which are subject to the applicable Copayments, and/or payment percentage(s) specified in the Plan's applicable schedules of benefits, and for which the Eligible Person may choose his provider of health services.

Nurse Midwife

A person who is certified by the American College of Nurse Midwives or is licensed as such by the state where services are rendered.

Out-of-Pocket Limit

In order to protect you and your family, the Plan limits what you have to pay for your cost-sharing (Copays, Coinsurance, and Deductibles) for medical care and for prescription drugs. This is called an Out-of-Pocket Limit. Once your out-of-pocket costs for Covered Expenses meets the in-network Out-of-Pocket Limit, the Plan will usually pay 100% for your (or your family's) network Covered Expenses during the rest of that year.

Medical care or treatment received at a Non-PPO Provider will count towards your Non-PPO Provider Out-of-Pocket limit. When you reach the out-of-pocket maximum for Non-PPO Providers, the Plan pays 100% of most covered expenses for the remainder of that calendar year.

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

Preferred Provider Organization (PPO) (network provider)

Providers who have been contracted with the Fund to provide such services at established rates.

Preventive Healthcare

Under the medical and prescription drug benefits, the Plan covers Preventive Healthcare at 100%—there is no cost to you—when you meet any age, risk, or frequency rules. Preventive Healthcare is defined under federal law as:

- Services rated “A” or “B” by the United States Preventive Services Task Force (USPSTF).
- Immunization recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention.

Definitions

K

- Preventive care and screenings for women as recommended by the Health Resources and Services Administration.
- Preventive care and screenings for infants, children, and adolescents provided in the comprehensive guidelines supported by the Health Resources and Services Administration.
- PSA tests (prostate-specific antigen tests) for males between ages 40 and 69.

You may need a prescription in order to get Preventive Healthcare under the prescription drug benefits.

The Plan may cover certain Preventive Healthcare more liberally (for example, more frequently or at earlier/later ages) than required. For example, mammograms may be covered for women under age 35 who are at high risk for developing breast cancer.

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

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

Retiree

An employee who elected and enrolled in Retiree medical benefits coverage under the Alaska HERE Plan prior to January 1, 2020.

Skilled Nursing Facility

An institution (or part of an institution) which is licensed to provide skilled nursing care to resident patients and is or could be certified as a Skilled Nursing Facility under Medicare.

Usual and Customary Charge

The payment basis for a claim where the reasonable and prevailing charge for the procedure, service or supply item is determined by the lowest of the following amounts:

- The billed amount for the medical care providers' actual charges;
- The charge usually made by that provider for performing that procedure; or
- The customary charge based on a profile of charges made for the same procedure, service or supply item in the same geographical area by other providers that have performed the same procedure or service or have provided the same supply item.

K-18



UNITE HERE HEALTH
Board of Trustees



UNITE HERE HEALTH Board of Trustees

Union Trustees

K

- **D. Taylor**
Chairman of the Board
President UNITE HERE
1630 S. Commerce Street
Las Vegas, NV 89102
- **Brian Lang**
President
UNITE HERE Local 26
33 Harrison Avenue, 4th Floor
Boston, MA 02111
- **Bill Granfield**
President
UNITE HERE Local 100
275 Seventh Avenue, 10th
Floor
New York, NY 10001
- **Terry Greenwald**
Secretary/Treasurer
Bartenders Local 165
4825 W. Nevso Drive
Las Vegas, NV 89103
- **Leonard O'Neill**
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504
- **Geoconda Arguello-Kline**
Secretary/Treasurer
Culinary Union Local 226
1630 S. Commerce Street
Las Vegas, NV 89102
- **Thomas Walsh Garcia**
President Emeritus
UNITE HERE Local 11
464 S. Lucas Avenue, Suite 201
Los Angeles, CA 90017
- **Karen Kent**
President
UNITE HERE Local 1
218 S. Wabash Avenue,
7th Floor
Chicago, IL 60604
- **Connie Holt**
Secretary/Treasurer
UNITE HERE Local 217
425 College Street
New Haven, CT 06511
- **Clete Kiley**
UNITE HERE
218 S. Wabash Avenue,
7th Floor
Chicago, IL 60604
- **Jim DuPont**
Local Union Support Director
UNITE HERE
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504
- **Donna DeCaprio**
Financial Secretary Treasurer
UNITE HERE Local 54
1014 Atlantic Avenue
Atlantic City, NJ 08401
- **Bob McDevitt**
President
UNITE HERE Local 54
1014 Atlantic Avenue
Atlantic City, NJ 08401
- **Bill Biggerstaff**
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504
- **Marvin Jones**
UNITE HERE Local 878
530 East 4th Avenue
Anchorage, AK 99501

UNITE HERE HEALTH Board of Trustees

Employer Trustees

K

- **Arnie Karr**
Secretary of the Board
President
Karr & Associates
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504
- **Michael O'Brien**
VP Corporate HR Services
Caesars Palace
1 Caesars Palace Drive
Las Vegas, NV 89109
- **Jim Claus**
Executive Vice President
Tishman Hotel Corporation
100 Park Avenue, 18th Floor
New York, NY 10017
- **Frank Muscolina**
Geneva HRM Advisors, LLC
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504
- **Russ Melaragni**
Vice President of Associate
& Labor Relations
Hyatt Hotels & Resorts
71 South Wacker Drive
Chicago, IL 60606
- **Harold Taegel**
Senior Director Labor
Relations
Sodexo
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504
- **George Greene**
Vice President Labor Relations
Starwood Hotels and Resorts
715 West Park Avenue, Unit
354
Oakhurst, NJ 07755
- **David Colella**
Vice President & Managing
Director
The Colonnade Hotel
120 Huntington Avenue
Boston, MA 02116
- **Paul Ades**
Senior VP Labor Relations
Hilton Worldwide
7930 Jones Branch Drive
McLean, VA 22102
- **Bob Kovacs**
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504
- **Cynthia Moehring**
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504
- **Bill Noonan**
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504
- **Cynthia Kiser Murphey**
President & COO
New York-New York
3790 Las Vegas Boulevard
South
Las Vegas, NV 89109
- **Christine Andrews**
Vice President
People & Culture
Hostmark Hospitality Group
1300 East Woodfield Road,
Suite 400
Schaumburg, IL 60173
- **Richard Ellis**
c/o UNITE HERE HEALTH
711 N. Commons Drive
Aurora, IL 60504
- **Terry Ryan**
VP Labor/Employee Relations
Delaware North Companies
250 Delaware Avenue
Buffalo, NY 19202

UNITE HERE HEALTH

P.O. Box 6020

Aurora, IL 60598-0020

(630) 236-5100