

# UNITE HERE HEALTH

## Plan Unit 102 *Atlantic City Casinos*



## Summary Plan Description *Your Health and Welfare Benefits*



# UNITE HERE HEALTH

## Summary Plan Description

### Atlantic City Casinos—Plan Unit 102 (Actives)

*Effective January 1, 2017*

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

## 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-5
Summary of benefits .....	B-1
Prior authorization program .....	C-1
Medical benefits.....	D-1
Prescription drug benefits .....	D-13
Hearing aid benefit.....	D-23
Dental benefits .....	D-25
Vision benefits.....	D-33
Member Assistance Program (MAP) .....	D-37
Life and AD&D benefits .....	D-41
General exclusions and limitations .....	E-1
Coordination of benefits.....	F-1
Subrogation .....	F-5
Eligibility for coverage .....	G-1
Termination of coverage.....	G-13
Reestablishing eligibility.....	G-17
COBRA continuation coverage .....	G-21
Claim filing and appeal provisions .....	H-1
Definitions.....	I-1
Other important information.....	I-9
Your rights under ERISA.....	I-15
Important phone numbers and addresses.....	I-18
UNITE HERE HEALTH Board of Trustees.....	I-19

# ***Using this book***

Learn:

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

### Please take some time to review this book.

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

## What is UNITE HERE HEALTH?

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

Your coverage is being offered under Atlantic City Casinos Plan Unit 102 (Actives), which has been adopted by the Trustees of UNITE HERE HEALTH to provide medical and other health and welfare benefits through the Fund. Other SPDs explain the benefits for other Plan Units, including the retiree drug coverage benefits under Plan Unit 102 (Retirees).

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

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

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

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

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

## How do I use my SPD?

This SPD is broken into sections. You can get more information about different topics by carefully reading each section. A summary of the topics is shown at the start of each section. When you have questions, you should contact the Fund at **(888) 437-3480**. The Fund can help you understand your benefits.

Read your SPD for important information about what your benefits are (*see page B-2*), how your benefits are paid, and what rules you may need to follow. You can find more information about a

specific benefit in the applicable section. For example, you can get more information about your medical benefits in the section titled “Medical benefits.” If you want to know more about your life or AD&D benefits, read the section titled “Life and AD&D benefits.”

Some terms are defined for you in the section titled “Definitions” starting *on page I-2*. The SPD will also explain what some commonly used terms mean. When you have questions about what certain words or terms mean, contact the Fund.

# How can I get help?

A

UNITE HERE HEALTH  
1801 Atlantic Avenue, Suite 200  
Atlantic City, NJ 08401  
(888) 437-3480 or (609) 345-8212

## 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.
- When you have questions about self-payments.
- To update your address.
- To report changes in your family status
- To request new ID cards.
- To get forms or a new SPD.
- To find out if your provider got prior authorization for your care.
- To find out if your primary care provider (PCP) submitted a referral for specialist care.

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

---

*This booklet contains a summary in English of your plan rights and benefits under UNITE HERE HEALTH. If you have difficulty understanding any part of this booklet, you can visit or contact the Atlantic City regional office at 1801 Atlantic Avenue, Suite 200, Atlantic City, New Jersey 08401. Office hours are from 9:00 a.m. to 5:00 p.m. (Eastern Time), Monday through Friday. You may also call UNITE HERE HEALTH at (800) 419-HERE (TTY: (855) 386-3889 or (855) FUNDTTY) for assistance.*

*Este folleto contiene un resumen en inglés de sus derechos y beneficios de su plan bajo UNITE HERE HEALTH. Si usted tiene problemas entendiendo cualquier parte de este folleto, usted puede visitar o contactar la oficina regional en Atlantic City en 1801 Atlantic Avenue, Suite 200, Atlantic City, New Jersey 08401. El horario de la oficina es de 9:00 AM hasta las 5:00 PM de lunes a viernes. Usted también puede llamar a UNITE HERE HEALTH al (800) 419-HERE (TTY: (855) 386-3889 o (855) FUNDTTY) para asistencia.*



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

## Learn:

- ▶ About the UNITE HERE HEALTH—Health Center.
- ▶ Why you should get a primary care provider and why you should get referrals for specialty care.
- ▶ Why you should get preventive healthcare.
- ▶ How to reduce your costs for urgent care.
- ▶ Why you should call the Fund and why you should get prior authorization for your care.
- ▶ How to use network providers to save time and money.

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

### Use the UNITE HERE HEALTH—Health Center (Health Center) services

The Health Center has many services available at no cost to you, including primary care, laboratory services, pharmacy services, counseling services through video or in-person, physical therapy, ultrasounds, and x-rays. New services may become available from time to time, so be sure to call the Fund at **(888) 437-3480** to learn about all of the free services available.

Health Center services are not available to spouses who have other primary insurance that the Plan pays secondary to under coordination of benefits rules. You can get more information on [page I-6](#).

- ✓ Call for an appointment and visit the Health Center at:

UNITE HERE HEALTH—Health Center  
1801 Atlantic Avenue, 3rd Floor  
Atlantic City, NJ 08401  
**(609) 570-2400**

### Get a primary care provider and get referrals for specialist visits

You and each of your dependents should have a primary care provider (also called a “PCP”). You should get to know your PCP so he or she can help you get, and stay, healthier. Your PCP can help you find potential problems as early as possible and coordinate your specialist care.

Make sure your PCP provides a referral to the Fund before your first visit to a specialist. **You can save \$35 if your PCP submits a referral before you see a specialist** ([see page D-3](#)).

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

- ✓ Call the Fund at **(888) 437-3480** to get help finding a PCP or a specialist.

### Get preventive healthcare

Your Plan pays 100% for most types of preventive healthcare when you use network providers. Getting preventive healthcare helps you stay healthy by looking for signs of serious medical conditions. If preventive healthcare or tests show there is a problem, the sooner you get diagnosed, the sooner you can start treatment. Be sure to use a network provider. The Plan won't pay for preventive healthcare if you use a non-network provider. See pages [D-6](#), [D-16](#), and [I-7](#) for more information about preventive healthcare.

### Re-think emergency room care

Is it really an emergency? You can save money by going to an urgent care center or PCP for non-emergencies.

- ✓ If you need emergency care, call 911 or go to the nearest 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, help you get prior authorization for your care, and answer other questions for you.

- ✓ Call the Fund at **(888) 437-3480**.

### Get prior authorization for your care

You or your provider must get prior authorization before you get certain types of care. *See page C-2* for information about the types of services and supplies that require prior authorization. Horizon Direct Access and Optum network providers are responsible for getting the prior authorization. If you use a non-network provider, you will be responsible for getting the 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.

<b>Horizon</b> (medical)	<b>Optum</b> (mental health/substance abuse)	<b>eviCore</b> (diagnostic imaging and radiation therapy)
<b>(866) 899-0626</b>	<b>(866) 248-4094</b>	<b>(866) 496-6200</b>

### Use network providers

- ✓ Your costs can be extremely high when you use non-network providers. Always remember to ask your provider for in-network services only—including laboratory services.

### Reduce your costs with a network provider

The Plan generally pays more of the bill if you choose a network provider than if you choose non-network care. You only have to pay the difference between the network provider's discount-

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

ed rate (the Plan's allowable charge) and what the Plan pays for covered services. The network provider cannot charge you for the difference between the allowable charge and his or her actual charges for your covered services (sometimes called balance billing). This means that you will usually pay less out-of-pocket if you choose a network provider.

Here is a sample medical claim to show you how using a network provider usually saves you money. This example assumes you've already met your deductible. The numbers shown may not reflect actual charges or the Plan's allowable charge, but are intended to help you understand how staying in the network means less money out of your pocket.

2-day inpatient hospital stay		
	Network Provider	Non-Network Provider
A. Total charge	\$5,000	\$5,000
B. Network discount	-\$3,000	n/a
C. Plan's allowable charge ( <i>See page I-2</i> )	\$2,000	\$2,500
	What you pay	
D. Amount over allowable charge	\$0 (A minus B minus C)	\$2,500 (A minus C)
E. Your cost sharing	\$400 (20% coinsurance)	\$1,250 (50% coinsurance)
Your total payment	<b>\$400</b> (D plus E)	<b>\$3,750</b> (D plus E)

The Plan will apply network benefits to emergency treatment, treatment provided by non-network healthcare providers who specialize in emergency medicine, radiology, anesthesiology, or pathology, inpatient consultations with non-network providers, and when the network doesn't have a provider in the required specialty. However, the allowable charge will be 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-network provider charges.**

### Easier claims filing with a network provider

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

If you choose a non-network provider, you may have to pay the entire cost of your care yourself. The non-network provider may or may not file a claim for you. If the non-network provider requires you to pay the entire cost of your care yourself, you can file a claim with the Plan to get paid back for the Plan's share of your covered care. *See page H-2* for more information about filing claims.

### How do I stay in the network?

- Visit the Health Center. Call **(609) 570-2400** for an appointment.
- Horizon provides access to a national network of doctors, hospitals, and other healthcare providers. Your network is the Horizon Direct Access network for care in New Jersey. You also have access to the BlueCard PPO network throughout the country. Call **(800) 810-2583** to find a network provider or visit [www.horizonblue.com](http://www.horizonblue.com).
- Optum provides access to a network of doctors, clinicians, and other healthcare providers for mental health/substance abuse care. Call **(866) 248-4094** to find a network provider or visit [www.liveandworkwell.com](http://www.liveandworkwell.com).
- Hospitality Rx provides access to a select national network of participating pharmacies (called the True Choice network) that you must use in order to get benefits for prescription drugs. Not all pharmacies are in the network. For example, **CVS is in your network** while **Walgreens and Wal-Mart are not**. Contact Hospitality Rx at **(844) 813-3860** or go to [www.hospitalityrx.org](http://www.hospitalityrx.org) to find a network pharmacy.
- BeneCare provides access to a network of dental care providers. Contact BeneCare to find a dentist in the network at **(800) 843-4727**.
- Davis Vision provides access to a network of vision care providers. You can stay in the network by using any participating Davis Vision provider. Call **(800) 999-5431** to find a network provider.

If you have questions about your benefits, or if you need help finding a network provider, you can also call the Fund at **(888) 437-3480**.



# ***Summary of benefits***



## Summary of benefits

Please call your local Fund Office with questions about your benefits: **(888) 437-3480**.

B

### Medical Benefits

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

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 when you use non-network providers (*see page I-2*). In some cases, the cost-sharing shown is applicable to facility services, and the cost-sharing for any professional services is also required. For example, you pay 15% after the deductible for the facility fees for outpatient surgery in an ambulatory surgery center, and you pay 20% after the deductible for the related professional fees.

For medical services in New Jersey, your network is the **Horizon Direct Access network**. You also have access to the BlueCard PPO network throughout the United States. For mental health/substance abuse services, your network is the **Optum network**.

These services are **FREE** at the Health Center!



Medical Benefits- What You Pay		Network	Non-Network
Deductible, per calendar year		\$350/person & \$700/family	
Office Visits			
All services available at the UNITE HERE HEALTH—Health Center are FREE!			
Preventive Healthcare ( <i>see page I-7</i> )		\$0	Not covered (except for non-hospital grade breast pumps and related supplies — limited to purchase of one pump per pregnancy))
		FREE at the Health Center!	
Primary Care Provider (PCP) Office Visit		\$20 copay/visit	50% after deductible
		FREE at the Health Center!	
Specialist Visit ( <i>other than shown below</i> )			
When your PCP provides a referral before your visit ( <i>see page D-3</i> )		\$40 copay/visit	50% after deductible
When your PCP does not provide a referral before your visit		\$75 copay/visit	
Mental Health Office Visit	FREE at the Health Center!	\$10 copay/visit	50% after deductible
Substance Abuse Office Visit		\$0 copay	

B-2




## Summary of benefits

B

Medical Benefits- What You Pay		Network	Non-Network
Chiropractic Services — up to 24 total visits per person each year		The Plan pays up to \$25/visit	Not covered
Acupuncture Treatment — up to 12 total visits per person each year		\$20 copay/visit	50% after deductible
Podiatry Office Visit — Routine & Non-Routine		\$25 copay/visit	Not covered
Allergy Injections in an Office		\$0	50% after deductible
Non-Routine Optometry Office Visit		\$20 copay/visit	
<b>Urgent and Emergency Care</b>			
Urgent Care Center		\$30 copay/visit	50% after deductible
<b>Hospital Emergency Room (facility services)</b>			
for emergency medical treatment		\$200 copay/visit and 15% after deductible (copay waived if admitted)	
for non-emergency medical treatment		\$200 copay/visit and 50% after deductible (copay waived if admitted)	
Professional Ambulance Services		\$130 copay/trip	
<b>Outpatient Services</b>			
<b>Laboratory Services</b>			
Non-Hospital	<b>FREE at the Health Center!</b> (and at two Quest locations in Pennsylvania)	15% after deductible	50% after deductible
Hospital		20% after deductible	
<b>Radiology — X-ray, including Chiropractic X-ray, and Ultrasound (including professional services)</b>			
Non-Hospital	<b>FREE at the Health Center!</b>	\$50 copay/visit	50% after deductible
Hospital		\$150 copay/visit	
<b>Diagnostic Imaging — CAT/CT, CTA, Cardiac CT, MRI, MRA, and PET scans, Nuclear Medicine, Cardiac Catheterization, and Echocardiograms (including professional services)</b>			
Non-Hospital		\$100 copay/visit	50% after deductible
Hospital		\$350 copay/visit	
<b>Outpatient Surgery (facility services)</b>			
In a provider's office		See applicable Office Visit above	50% after deductible
AtlantiCare Surgery Center		\$0	Not applicable
Other Ambulatory Surgical Centers		15% after deductible	50% after deductible
Hospital		\$200 copay/visit and 15% after deductible	

B-3

## Summary of benefits

Medical Benefits- What You Pay	Network	Non-Network
Physical, Speech, Occupational Therapy	15% after deductible Physical therapy is FREE at the Health Center! 	50% after deductible
Partial Hospitalization, Intensive Outpatient, and Ambulatory Detoxification Treatment ( <i>facility services</i> )	Mental Health: 15% after deductible Substance Abuse: \$0	
Other Outpatient Services at a Hospital ( <i>facility services</i> )	15% after deductible	
<b>Inpatient Treatment (Facility Services)</b>		
Inpatient Hospitalization — Hospice, Substance Abuse Treatment	\$0	50% after deductible
Inpatient Hospitalization — Hospital, Skilled Nursing Facility, Residential Facility, including Mental Health Treatment	20% after deductible	
<b>Other Services and Supplies</b>		
Diabetes Education	\$0	Not covered
Nutrition Counseling — up to 4 total visits per person each year		
Home Healthcare Services — including Kessler/AtlantiCare Home Health	\$0	50% after deductible
Hospice Care — including AtlantiCare Hospice		
Durable Medical Equipment	20% after deductible	Not covered
Prosthetics & Orthotics	20% after deductible	50% after deductible (no coverage for podiatric orthotics)
Sleep Studies	20% after deductible	50% after deductible
Habilitative Therapy for Children with Autism Spectrum Disorder — only for treatment that starts before June 1, 2018; certain other limits apply (see page D-9)	\$10 copay/day	
Medical Foods for Inborn Metabolic Errors	The Plan will reimburse you 100%, up to \$2,500 per person each year	
Travel and Lodging for Certain Serious Medical Conditions	The Plan pays 100% up to \$250 per day, and up to \$10,000 per episode of care	

B

B-4

## Summary of benefits


B

### Commencement of Legal Action

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

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

Medical Benefits- What You Pay	Network	Non-Network
Healthcare Professional Services — <i>may be required in addition to cost-sharing shown for facility services</i>	20% after deductible Mental Health: 15% after deductible Substance Abuse: \$0, except emergency room professional services is 15% after deductible	50% after deductible
All Other Covered Expenses	20% after deductible	50% after deductible

Prescription Drugs (Network Pharmacies & Mail Order Only)	Your Cost for Each Fill or Refill
Prescription Drugs and Supplies at the Health Center, including two locations in Pennsylvania ( <i>see page I-6</i> )	FREE! 
Preventive Healthcare Prescription Drugs and Supplies, including immunizations ( <i>see page I-7</i> )	\$0
Generic Prescription Drugs and Supplies on the Formulary	\$5
Brand Name Prescription Drugs and Supplies on the Formulary	\$15
Specialty Brand and Biosimilar Prescription Drugs	25%, up to a maximum of \$20
Prescription Drugs and Supplies NOT on the Formulary	Not covered

Out-of-Pocket Limits (Network Expenses Only)	
<b>Basic Out-of-Pocket Limit</b> The most coinsurance you pay out-of-pocket for covered network <i>medical expenses</i> in a calendar year	\$1,500 per person
<b>Safety Net Out-of-Pocket Limit</b> The most you pay out-of-pocket for <b>deductibles, copays, and coinsurance</b> for certain covered network <i>medical and prescription drug expenses</i> in a calendar year.	\$6,350 per person & \$12,700 per family

B-5

## Summary of benefits

B

### Life and Accidental Death & Dismemberment Benefit (*Employees Only*) - What the Plan Pays

Life Insurance	\$10,000
Accidental Death & Dismemberment Insurance ( <i>full amount</i> )	\$5,000

### Hearing Aid Benefit - What the Plan Pays

Maximum Benefit per 24-Month Benefit Period — benefit period begins when a hearing aid is first delivered	\$500
---	-------

### Dental Benefits

	BeneCare Network Providers	Non-Network Providers
Maximum Benefits		
Dental ( <i>Non-Orthodontic Services</i> )	\$1,500 per person every benefit year, including up to \$500 for non-network services	
Orthodontic Services	\$1,000 per child per lifetime	
Deductible	\$0	
Covered Services	You pay copays determined by a schedule of copayments	You pay the difference between the Plan's benefit (fee-for-service) and the dentist's charge

### Vision Benefits - What You Pay

Description of Services <i>benefits covered every 12 months, except as noted below</i>	Davis Vision Provider	Non-Network Provider
Eye Exam	\$10	<i>Plan benefits limited to persons residing outside the network coverage area and to \$100 for any combination of routine services, including materials (does not apply to exams for children under age 5)</i>
Frames, covered every 24 months	\$0 for frames in the Davis Vision Fashion or Designer collection You get a \$30 allowance for non-Davis collection frames	
Lenses	\$0	
Elective Contacts <i>(provided instead of glasses)</i>	\$45 You get up to a \$100 allowance for non-Davis Vision contacts (including exam and fitting)	
Medically Necessary Contacts for Keratoconus	Plan pays up to \$100 with prior approval	

B-6

## Summary of benefits

B

Member Assistance Program	
Counseling sessions at the Health Center (in-person or video)	Unlimited
Telephonic counseling sessions	Unlimited
Face-to-face counseling sessions ( <i>other than at the Health Center</i> ), including individual or group sessions	5 sessions per person each calendar year

B-7



# ***Prior authorization program***

Learn when and why you should call:

- ▶ To get prior authorization for your care.
- ▶ To sign up for the case management program.

## Prior authorization program

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

Horizon Blue Cross Blue Shield of New Jersey (Horizon) provides prior authorization for medical and surgical services, including: hospital pre-admission review, emergency admission review, prior authorization of certain outpatient services and supplies. Horizon has contracted with eviCore to manage prior authorization for certain non-emergency, outpatient diagnostic imaging services. EviCore also manages prior authorization for radiation therapy. Optum provides prior authorization for mental health/substance abuse services.

Important Phone Numbers for Prior Authorization	
To get prior authorization for:	Call:
Medical and surgical services	Horizon (866) 899-0626
Outpatient diagnostic imaging and radiation therapy	eviCore (866) 496-6200
Mental health/substance abuse services	Optum (866) 248-4094

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 certain services and supplies

You or your healthcare provider must get prior authorization before you get any of the types of care listed below. When you use a Horizon Direct Access network provider or Optum network provider, your provider is required to get the prior authorization for you. You will not be penalized if your network provider does not follow the prior authorization program.

If you use a provider that isn't a Horizon Direct Access provider or Optum network provider, you are responsible for getting the prior authorization, including when you use a BlueCard PPO provider. If you don't get prior authorization before you receive these types of care, a \$150 penalty may apply, and your claim may be denied. Making sure you get prior authorization first helps you avoid surprise medical bills. **If you get treatment, services, or supplies that are not approved, not covered, or are not medically necessary, you pay 100% of your care.**

In addition, for diagnostic imaging you must follow eviCore's scheduling requirements. EviCore will schedule your appointment at the imaging location nearest you. If you do not follow the scheduling requirements, your proposed procedure is not considered authorized and the Plan will not pay any benefits.



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

### When to call for prior authorization

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

- Any inpatient admission (*through Horizon or Optum*), regardless of the type of facility or care, including but not limited to skilled nursing facility care, hospice, residential treatment (*through Optum*), and, elective cesarean section (c-section) admissions under 38 weeks.
- Ambulance transportation that is non-emergent (ground or air).
- Arthroscopy (regardless of setting).
- Bariatric surgery, including gastric bypass and banding procedures.
- Blepharoplasty.
- Carpal tunnel release.
- Clinical trials.
- Cochlear implants.
- Diagnostic imaging services (*through eviCore*) as follows:
  - CT, CTA, and CAT scans (computed tomography scintiscan or computerized axial tomography scintiscan).
  - MRA and MRI (magnetic resonance imaging or magnetic resonance angiography).
  - PET scan (positron emission tomography scintiscan).
  - Cardiac catheterization.
  - Echocardiogram.
  - Nuclear medicine.
- Durable medical equipment over \$500. (This includes breast pumps costing over \$500.)
- Electromyogram.
- Excision of excess skin.
- Genetic testing.
- Gynecomastia (surgical treatment).

## Prior authorization program

- Habilitative therapy for children with autism spectrum disorder.
- Hip replacement.
- Home healthcare services, including home infusion.
- Hospice services.
- All hospital-based outpatient surgical procedures.
- Hyperbaric oxygen therapy.
- Certain injectable medications (call Horizon to find out if your injectable drug requires prior authorization).
- Knee replacement.
- Laminectomy.
- Lipectomy (removal of excessive fat/tissue).
- Mammoplasty (breast reduction).
- Medical foods for inborn errors of metabolism.
- Meniscectomy.
- Myelogram.
- Non-routine outpatient mental health and substance abuse services (*through Optum*), including:
  - Electro-convulsive treatment.
  - Extended outpatient visits lasting longer than 53 minutes.
  - Intensive outpatient programs.
  - Methadone maintenance.
  - Partial hospitalization programs.
  - Psychological testing.
  - Transcranial magnetic stimulation.
- Orthognathic jaw surgery, including treatment for temporomandibular joint disorder (TMJ) and other craniofacial disorders.
- Orthotics (including podiatric orthotics) over \$500.
- Percutaneous discectomy reduction.

## Prior authorization program

- Physical, occupational, and speech therapy.
- Prosthetics over \$500.
- Radiation therapy (*through eviCore*).
- Requests for the network level of benefits for non-network treatment or supplies when there aren't any network providers for that type of treatment or supply.
- Rhinoplasty and septoplasty.
- Sclerotherapy (surgery for varicose veins).
- Sleep study.
- Submucous resection.
- Transplant services.
- Travel and lodging.
- Uvulopalatopharyngoplasty (UPPP).

You should contact Horizon, Optum, or eviCore, as applicable, before getting any of the above types of services and supplies, or being admitted as an inpatient. This list changes from time to time. Contact the Fund at **(888) 437-3480** for the most up-to-date information.

If you need emergency care, you should call as soon as possible. For emergency admissions, be sure to call no later than the first business day following the admission. The \$150 penalty will not apply if it was not reasonable to meet this deadline and notification was provided as soon as reasonably possible. No prior authorization is required for emergency medical treatment you get in an emergency room or while you are in observation in the hospital or for services received at the UNITE HERE HEALTH—Health Center.

If you are hospitalized because you are having a baby, you must call Horizon if your stay will be longer than 48 hours for normal childbirth, or 96 hours for a Cesarean section. 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 healthcare provider who specializes in obstetrics or gynecology. The healthcare provider, however, may be required to comply with certain procedures, including obtaining prior authorization

## *Prior authorization program*

for certain services, following a pre-approved treatment plan, or procedures for making referrals. For help finding network providers who specialize in obstetrics or gynecology, call the Fund at **(888) 437-3480**.

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

## **Case management program**

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

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

The case manager may recommend treatments, services, or supplies that 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 and are responsible for all treatment decisions and any resulting consequences.

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

# ***Medical benefits***

## Learn:

- ▶ How to choose a primary care provider.
- ▶ How getting referrals for specialty care saves you money.
- ▶ 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.

## Medical benefits

See the Summary of Benefits *on page B-2* for a summary of what you pay for your medical healthcare.

### Network providers

The Plan pays benefits based on whether treatment is rendered by a network provider or a non-network provider.

For medical and surgical care in New Jersey, your network is the Horizon Direct Access network. For medical and surgical care outside New Jersey, your network is the BlueCard PPO network. To find network providers for medical and surgical care, contact:

**Horizon Blue Cross and Blue Shield of New Jersey (Horizon)**

toll free: **(800) 810-2583**

[www.horizonblue.com](http://www.horizonblue.com)

*(Click Find a Doctor or Hospital, and select the “Horizon Direct Access” plan.)*

To find network providers for mental health and substance abuse care, contact:

**Optum**

toll free: **(866) 248-4094**

[www.liveandworkwell.com](http://www.liveandworkwell.com)

*(Enter the access code “UHH” and then go to “Find a Provider”)*

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

### Choosing a PCP

You should choose a primary care provider (PCP) for yourself and for each of your dependents. You can all have the same PCP, or you can each choose different PCPs. For children, you may designate a pediatrician as your child’s PCP. You don’t have to tell the Fund who your PCP is and you can change your PCP at any time. Remember, you will usually pay less if you choose a network provider as your PCP.

A **primary care provider (PCP)** is defined as a healthcare provider specializing in the following fields:

- Family medicine
- General practice
- Geriatrics
- Internal medicine
- Pediatrics (for children)
- Obstetrics/gynecology

The Fund encourages you to pick a PCP. You have the right to designate any PCP, whether the provider participates in the network or not, who is available to accept you or your family members. For information on how to select a PCP, and for help finding participating PCPs, contact the Fund at **(888) 437-3480**.

### Specialist referral program

- ✓ Save money — Have your PCP send a referral for specialty care to the Fund before your specialist office visit and save money!
- ✓ You do not need a referral for: acupuncture, chiropractic care, diabetic education, gynecology or obstetric care, mental health or substance abuse care, non-routine optometry care, nutrition counseling, podiatry, or physical, occupational, or speech therapy.

If you need to see a specialist, ask your PCP to submit a referral to the Fund before your visit. Tell your PCP to go to [www.uhh.org](http://www.uhh.org), click the link for Providers, register if needed, and log in to submit your referral.

- If your PCP submits a referral for each type of specialty care you need before your office visit with a network specialist, your copay will be \$40. Any PCP can make this referral, including a non-network PCP.
- If your PCP does not submit a referral for the type of specialty care you need before your office visit with a network specialist, your copay will be \$75. Your copay will not be reduced to \$40 if your PCP provides the referral after the specialist visit. However, you should still have your PCP provide the referral before your next specialist visit so your future copays will only be \$40.
- If you choose a non-network specialist, you pay 50% of the allowable charges after the deductible for the visit.
- Certain types of care don't require a referral. For example, if you get acupuncture without an office visit, you don't need a referral. However, if you have an office visit with a specialist, and the specialist decides to perform acupuncture during your visit, the specialist office visit benefit applies, and a referral is required for the \$40 copay. Without a referral, your copay will be \$75.

Your PCP will determine how long the referral lasts, but not longer than 6 months. You don't need another referral for that type of specialist until the date the referral expires. If you need more visits with the specialist after that date, your PCP must submit another referral in order for you to continue to get the lower copay. If your PCP doesn't submit a new referral, you will pay the higher specialist copay.

If your PCP charges you for submitting a referral, you should ask them to waive the referral fee (which they may or may not do).

### What you pay

You must pay your cost-share (such as deductibles, copays, and coinsurance) for your share of covered expenses. You must also pay any expenses that are not considered covered expenses (*see page D-11* for information about excluded expenses), including any amounts over the allowable charge (*see page I-2* for the definition of an allowable charge) when you use non-network providers, or charges once a maximum benefit or limitation has been met.

Sometimes there are two types of charges for the same service— a facility fee (also sometimes called the technical component) and a professional fee. When both types of charges are billed for services you receive, you have to pay the cost-sharing applicable for both the facility services, and the professional services. For example, if you have outpatient surgery in at the AtlantiCare Surgery Center, you pay \$0 for the facility services, and you pay 20% after deductible for the professional services for your surgery.

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

### Deductibles

Your calendar year deductible applies to both network and non-network 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 \$350 individual deductible applies to each person covered by the Plan. However, once your family deductible has been satisfied, no one else in your family has to pay deductibles for the rest of that year.

Your \$350 individual and \$700 family deductibles only apply to the medical benefits (including mental health and substance abuse benefits). Amounts you pay for prescription drugs, vision care, or dental care will not apply toward the deductibles. In addition, the deductibles do not apply to certain medical benefits. *See page B-2* for which services require the deductible and which services are covered before you satisfy the deductible.

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

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

### Copays

You pay copays for certain types of care (*see page B-2*). The copay covers all healthcare you receive during a network office visit or urgent care center visit. For example, you only pay one office visit copay for all healthcare you receive during the office visit, even if you received other services at the same time. However, depending on how your provider bills for services, you might have to pay an office visit copay, plus deductible and coinsurance for any bloodwork (laboratory services) you get.



In certain situations, you pay the cost-sharing (deductible, coinsurance, copay) required for each of the services you receive. Sometimes this means you pay both a copay and coinsurance. However, you will never be required to pay multiple copays - you pay the highest copay amount. This could apply when you go to an office, but don't see the doctor or your doctor doesn't bill an office visit. If that happens, you pay the cost-sharing for each service you received. For example, if you have an ultrasound and a diagnostic imaging test during the same visit, you only pay the diagnostic imaging copay since it is the highest copay.

For care in an emergency room, you pay the emergency room copay, deductible, and coinsurance for all of the services you receive during the emergency room visit. You don't have to pay any other copays. For example, if you have an MRI during your emergency room visit, you don't have to pay the MRI copay. If you are admitted as an inpatient as a result of your emergency room visit, the emergency room cost-sharing is waived, and you pay the cost-sharing required for an inpatient stay.

If you are admitted as an inpatient, the deductible and coinsurance required for an inpatient stay applies to all of the services you receive during your inpatient stay. You don't have to pay copays for diagnostic imaging, x-rays, and ultrasounds you receive during your inpatient admission.

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

## Out-of-Pocket limit for network expenses

There are two types of out-of-pocket limits that limit how much you pay for network services.

### Basic out-of-pocket limit

The most coinsurance you pay for network medical services (including mental health/substance abuse services) in one calendar year is \$1,500 per person. However, your out-of-pocket costs for non-emergency medical treatment in an emergency room don't count toward your basic out-of-pocket limit, and the Plan won't pay 100% for these charges even if you have met the basic limit.

*The 50% coinsurance you pay for non-network services does not count toward your basic out-of-pocket limit.*

### Safety net out-of-pocket limit

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

## Medical benefits

NETWORK care only	Basic out-of-pocket limit \$1,500/person	Safety net out-of-pocket limit \$6,350/person & \$12,700/ family
Medical Deductible		✓
Medical Coinsurance	✓	✓
Medical Copays		✓
Pharmacy Copays and Coinsurance		✓

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

### What's covered

The Plan will only pay benefits for injuries or sicknesses that are not related to your job. Benefits are determined based on allowable charges for covered services resulting from medically necessary care and treatment prescribed or furnished by a healthcare provider.

- **Preventive healthcare services** (see page I-7) when a network provider is used. Non-network preventive healthcare services are not covered. However, non-hospital grade breast pumps (limited to one per pregnancy) and breast pump supplies will be covered when obtained from a non-network provider. The following limits apply to specific types of preventive healthcare (other limits may apply to other types of preventive healthcare 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. Cervical cancer screenings are only covered for women from age 21 to age 65 who have a cervix.
  - ▶ Routine mammogram screenings for women are covered once each calendar year.
  - ▶ Routine PSA (prostate-specific antigen) screening tests for men are covered once each calendar year.

If you do not meet the criteria (frequency, age, or health status requirements) for preventive care, it may not be covered under the Plan and *you will be responsible for 100% of the bill.*

- **Professional medical and surgical services of a healthcare provider.**
- Services provided at or by a **participating health center**, except for certain spouses with other primary coverage that the Plan pays secondary to under the Plan's coordination of benefits rules (see page I-6 for details about participating health centers and page F-1 for details about coordination of benefits).

- Treatment of **mental health/substance abuse disorders**, including inpatient and residential care, outpatient care, partial hospitalization, intensive outpatient programs, and ambulatory detoxification.
- **Chiropractic services** limited to a maximum benefit of \$25 per visit, and up to a total of 24 visits per person each year. Non-network chiropractic care is not covered. The Plan covers x-rays performed by a chiropractor with the cost-sharing required for radiology services.
- **Acupuncture services**, up to a total of 12 visits per person each year.
- **Podiatric services**, including routine and non-routine podiatry, and office surgery, provided by a network provider. Non-network podiatric services are not covered.
- Covered services performed in an **urgent care center**.
- Transportation by a **professional ambulance service** to an area medical facility that is able to provide the required treatment. If you have no control over the ambulance getting called, for example when the ambulance is called by a healthcare provider, employer, law enforcement, school, etc., the ambulance will be considered medically necessary. Contact the Fund if you had no control over an ambulance being called.
- **Radiology services**, including x-rays and ultrasounds.
- **Laboratory services**.
- **Diagnostic imaging**, including MRIs, MRAs, CAT/CT scans, CTA scans, cardiac CT scans, PET scans, cardiac catheterizations, echocardiograms and nuclear medicine.
- **Ambulatory surgical facility services**, including general supplies, anesthesia, drugs, and operating and recovery rooms. If you have multiple surgical procedures performed through the same incision or natural body orifice during the same operative session, the Plan may pay a lesser amount than the Plan would have paid if the procedures been performed alone. Facility fees for surgical procedures that would normally be performed in a provider's office are not covered.
- **Physical and occupational therapy services**.
- **Speech therapy services** as follows:
  - 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 autism spectrum disorders.
    - 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 sickness or injury.

## Medical benefits

- Treat a speech delay associated with a specific disease, injury, or congenital defect, such as cleft lip and palate.
- **Hearing examinations.**
- **Radiation therapy.**
- **Chemotherapy and infusion services.**
- **Kidney dialysis services.**
- **Hospital charges** for room and board, and other inpatient or outpatient services.
- Treatment of **pregnancy** and pregnancy-related conditions, including childbirth, miscarriage, or abortion, for participants and dependents.
- **Nursery services** and well-baby care, but not for a newborn child born to a covered dependent child.
- **Sterilization procedures** for employees and spouses. For female dependent children, FDA-approved sterilization procedures that are considered preventive healthcare (*See page I-7*).
- **Mastectomies**, including reconstruction of the breast upon which the mastectomy is performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, breast prostheses, and treatment of physical complications resulting from a mastectomy, including swollen lymph glands (lymphedema).
- **Medical services for organ transplants** if the following rules are all met:
  - The transplant must be covered by Medicare, including meeting Medicare's clinical, facility, and provider requirements.
  - You must use any case management program recommended by the Fund or its representative.
  - You must get prior authorization for the transplant from the Fund or its representative.
  - Donor expenses for your transplant are only covered if the donor has no other coverage.
  - Transplant coverage does not include your expenses if you are the organ donor.
- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- **Skilled nursing facility care.**
- Network professional services for **diabetes education** and training for the care, monitoring, or treatment of diabetes. Non-network expenses are not covered.
- Network professional services for **nutrition counseling**, limited to a total of 4 visits per person each year. Non-network expenses are not covered.

- **Home healthcare services.**
- **Hospice** services and supplies if you are terminally ill.
- **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. Non-network DME is not covered.
  - ▶ 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.
- **Prosthetics.**
- **Orthotics, including podiatric orthotics.**
- **Habilitative therapy** for children with autism spectrum disorder (only for treatment that begins between June 1, 2015 and May 31, 2018). *You, or your provider, must get prior authorization for habilitative therapy before the Plan pays benefits.* Plan benefits are limited to 30 hours per person each week, and up to 36 months starting on the first day the Plan pays for a habilitative therapy visit, for network and non-network services combined. "Habilitative therapy" includes applied behavioral analysis (ABA) therapy and similar types of treatment. It does not include physical, speech, or occupational therapy.
  - ▶ Your child must be at least 2 years old, but no more than 8 years old.
  - ▶ Your child must have a diagnosis of autism spectrum disorder, and have a prorated mental age of at least 11 months.
  - ▶ The provider supervising the habilitative therapy must be certified by the Behavioral Analyst Certification Board (BACB) as a Board Certified Behavior Analyst or Board Certified Behavior Analyst Doctorate (or is otherwise licensed to supervise this type of treatment).
  - ▶ The person providing the habilitative therapy must be certified by the BACB as a Board Certified Assistant Behavioral Analyst or Registered Behavioral Technician (or is otherwise licensed to provide this type of treatment).
  - ▶ The Plan will only pay benefits for services supplemental to any therapy for which your child is eligible through his or her school or school district. No benefits will be paid for therapy provided through the school or school district.

## Medical benefits

- ▶ The habilitative therapy and treatment plan must get prior authorization from the Fund before treatment begins. The treatment notes and treatment plan must be reviewed by the Fund at least twice a year, and must show that:
  - Your child is demonstrating improvement.
  - You are trained to, and do, participate in the habilitative therapy.
  - You follow the treatment plan.
- ▶ *No Plan benefits will be paid for a course of habilitative therapy that starts on or after June 1, 2018.*
- **Medical foods** if you have an inborn error of metabolism (IEM). *You must get prior authorization for your medical food costs before the Plan will reimburse you.* The Plan will reimburse 100% of your costs for medical foods, up to a total of \$2,500 per person each year. To be reimbursed, the medical food must be: (1) ordered by and used under the supervision of a healthcare provider; (2) the primary source of your nutrition; and (3) labeled and used for dietary management of your IEM.
- Reimbursement for **travel, lodging, and meal costs** for transportation to get certain treatment more than 50 miles away from your home (as long as you travel within the United States). *You must get prior authorization for these expenses before the Plan will reimburse you.* Covered expenses only include travel, lodging and meal costs related to: (1) transplants, (2) cancer-related treatments, and (3) congenital heart defect care. The following rules apply:
  - ▶ The travel, lodging, and meal costs of one other person traveling with you will also be covered. (Two other people will be covered if the patient is a minor child.)
  - ▶ Reimbursement is limited to \$10,000 per episode of care for you and your traveling companion(s) combined. This includes up to \$250 each day for lodging and meal costs.
  - ▶ You must provide the Plan with your original receipts.
  - ▶ You must participate in any case management programs required by the Fund.
  - ▶ You cannot get reimbursed for expenses related to your participation in a clinical trial, or for an organ transplant if you are donating an organ instead of getting an organ.

The Fund may prearrange or prepay certain travel or lodging costs. More details about the benefit are available upon request.

- **Anesthesia** and its administration.
- **Blood and blood plasma** and their administration.
- **Surgical supplies, surgical dressings, casts, splints, and trusses.**
- Treatment of **tumors, cysts and lesions** not considered a dental procedure.

### What's not covered

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

- Ambulatory surgical facility fees for procedures normally performed in a provider's office.
- Any treatment, services or supplies for a child born to a covered dependent child.
- Prescription drugs and medications, other than those administered or consumed where they are dispensed. Prescription drugs may be covered under the prescription drug benefit shown on page D-14.
- Oral contraceptives or over-the-counter FDA-approved female contraceptive drugs, devices or supplies. These may be covered under the prescription drug benefit (See page D-14).
- Cosmetic, plastic, or reconstructive surgery, unless that surgery is either: (1) to treat an accidental injury, and the surgery is performed within 24 months after the accident, or (2) breast reconstruction following a mastectomy.
- To the extent of any penalty assessed for any treatment or services requiring the prior authorization program, when this mandatory program is not used as required.
- Eyeglasses or contact lenses, other than the first pair required as a result of and immediately following cataract surgery.
- Procedures to reverse a voluntary sterilization.
- Any services or supplies for dental care or in connection with the treatment of teeth, natural or otherwise, and supporting structures, unless specifically stated as covered. This exclusion includes but is not limited to:
  - ▶ Alveolar ridge augmentation or implant procedures, whether of natural or artificial materials, to stabilize or otherwise alter natural or artificial teeth.
  - ▶ Dental extractions.
  - ▶ Replacement or repair of dental appliances required as a result of accidental injury (including but not limited to bridgework).
  - ▶ Dental services for or in connection with routine care of the teeth and supporting oral tissues, or restorative services to replace natural teeth lost as a result of injury.

However, charges made by a hospital or other facility for dental procedures covered under the dental benefit provisions (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,

## Medical benefits

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.

- Treatment of temporomandibular joint (TMJ) disorders, craniofacial disorders or orthognathic disorders, unless UNITE HERE HEALTH or its representative provides written prior approval, and then only for the following conditions:
  - ▶ Severe rheumatoid arthritis involving multiple joints in which there is significant pathology.
  - ▶ Traumatic injuries causing disk rupture or ligament perforations.
  - ▶ Removal of prosthetic devices when their presence creates clear medical risk to the patient.
- 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.
- Physical examinations required in connection with employment or to obtain a medical certificate, including related to any of the following: for the purpose of purchasing life insurance, obtaining a marriage license, school exams, sports physicals.
- Immunizations required for travel purposes.
- Facility charges by a clinic when a healthcare professional also bills for an office visit in conjunction with the clinic visit.
- Hospital charges for personal comfort items, including but not limited to telephones, televisions, cosmetics, guest trays, magazines, and bed or cots for family members or other guests.
- Supplies or equipment for personal hygiene, comfort or convenience such as, but not limited to, air conditioning, humidifier, physical fitness and exercise equipment, tanning bed, or water bed. This exclusion does not apply to equipment or items that meet the Plan's requirements for durable medical equipment.
- Home construction for any reason.
- Private duty nursing services.
- Services, treatment or supplies provided by a non-network provider when Plan benefits are only payable when network providers are used.
- Hearing aids. Hearing aids are covered under the hearing aid benefit shown *on page D-23*.
- Eye exams, except as specifically stated as covered, or unless the exam is for the diagnosis or treatment of an accidental bodily injury or an illness. However, eye exams may be covered under the vision benefits.



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

## Prescription drug benefits

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

The Plan will only pay benefits if you buy your prescription drugs at a pharmacy that participates in the True Choice network. **Not all retail pharmacies are in your pharmacy network.** CVS is in your network. Walgreens, Duane Reade, Wal-Mart, USA Drugs, and certain independent local pharmacies are not in your network. **Drugs and supplies are FREE at the Health Center pharmacy, including two locations in Pennsylvania!**

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

Important Phone Numbers		
If you want to:	Call:	At:
Find a network pharmacy or ask questions about your benefits	The Fund	(888) 437-3480
Get prior authorization for prescription drugs or to ask which drugs require prior authorization	Hospitality Rx	(844) 484-4726
Get a free glucometer	One Touch (LifeScan products - use order code 739WDRX01)	(800) 227-8862
	True Test (Nipro products)	(866) 788-9618
Order from the mail-order pharmacy	WellDyneRx Home Delivery (through Hospitality Rx)	(844) 813-3860
Order from the specialty pharmacy	Walgreens Specialty Pharmacy	(877) 647-5807

You can also visit [www.hospitalityrx.org](http://www.hospitalityrx.org) for more information.

### What you pay

You must pay the applicable amount shown below for each fill of a prescription drug. You must also pay any expenses that are not considered covered expenses (*see page D-20* for information about excluded expenses).

Prescription Drugs (Network Pharmacies & Mail Order Only)	Your Cost for Each Fill or Refill
Prescription Drugs and Supplies at the Health Center, including two locations in Pennsylvania ( <i>see page I-6</i> )	FREE!
Preventive Healthcare Prescription Drugs and Supplies, including immunizations ( <i>see page I-7</i> )	\$0
Generic Prescription Drugs and Supplies on the Formulary	\$5
Brand Name Prescription Drugs and Supplies on the Formulary	\$15

Prescription Drugs (Network Pharmacies & Mail Order Only)	Your Cost for Each Fill or Refill
Specialty Brand and Biosimilar Prescription Drugs	25%, up to a maximum of \$20
Prescription Drugs and Supplies NOT on the Formulary	Not covered

The formulary is a list of drugs your plan covers. Drugs and supplies on the formulary are safe, effective, high-quality drugs and supplies. No benefits are paid for drugs not on the formulary unless you have tried all medically appropriate formulary options and the Fund approves the drug through the prior authorization program. Ask your healthcare provider to prescribe a drug that is on the formulary (available at [www.hospitalityrx.org](http://www.hospitalityrx.org)). Prescription drugs and supplies may be added to or removed from the formulary from time to time. Contact Hospitality Rx at **(844) 813-3860** if you or your healthcare provider have questions about which prescription drugs and supplies are on the formulary.

You must use the specialty pharmacy to get specialty and biosimilar prescription drugs. *See page D-19* for more information about the specialty pharmacy.

### Prescription drug out-of-pocket limit

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

Certain prescription drug expenses don't count toward your out-of-pocket limit. This includes any amounts you must pay in addition to your copay when you or your doctor chooses a brand name drug when a generic equivalent is available (see "*Generic prescription drug policy*" below), and any surcharge amounts you pay for early refills. These expenses do not count toward your out-of-pocket limit and you will continue to be responsible for these expenses even if you have met the out-of-pocket limit for the year.

You can get more information about your out-of-pocket limits on *page I-6* and on *page D-5*.

### Generic prescription drug policy

If you or your provider choose a brand name prescription drug when you could get a generic equivalent instead, you pay the difference in cost between the brand name prescription drug and the generic equivalent. For example, if the brand name prescription drug costs \$80, and the Fund's cost for the generic equivalent is \$30, you must pay the \$50 difference. You will also have to pay the \$5 generic prescription drug copay.

## Prescription drug benefits

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

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

### What's covered

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

- Formulary 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, as long as at least one part of the mixed-to-order drug is an FDA-approved prescription drug.
- The following formulary diabetic supplies: insulin, diabetic test strips, control solution for glucometers, disposable syringes and needles, and lancets.
- Formulary prescription and non-prescription (over-the-counter) preventive healthcare services and supplies, including immunizations (*see page I-7*).
- The following formulary single-source vitamins: ferrous sulfate, vitamin D, cyanocobalamin, vitamin K, potassium chloride, bicarbonate, phosphate, calcium acetate, niacin, and Galzin (zinc).

### Free glucometers

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

**(800) 227-8862** for OneTouch (LifeScan) products (order code 739WDRX01)  
or visit [www.OneTouch.orderpoints.com](http://www.OneTouch.orderpoints.com) (order code 739WDRX01)

**(866) 788-9618** for TrueTest (Nipro) products

If you don't want to use one of the Fund's free glucometers, you have to pay the full cost of the glucometer upfront. You may submit a claim under the medical benefits for the glucometer, but you may not be reimbursed for the full amount (see the cost-sharing required for durable medical equipment on *page B-4*).

### Safety and cost containment programs for prescription drugs

The Fund provides extra protection through several safety and cost containment programs. These programs may change from time to time, and the prescription drugs or types of prescription drugs that are part of these programs may also change from time to time. You and your health-care provider can always get the most current information by contacting the Fund at **(888) 437-3480**, calling **(844) 484-4726** for prior authorization questions, or visiting [www.hospitalityrx.org](http://www.hospitalityrx.org).

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

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

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

#### Prior authorization

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

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

#### Step therapy

In many cases, effective lower-cost alternatives are available for certain prescription drugs. A step therapy program will ask you to try over-the-counter, generic, or preferred formulary versions of prescription drugs first. If the first level of prescription drugs does not work for you, or causes serious side effects, you are “stepped up” to another level of prescription drugs.

For example, if you need an ARB (angiotensin receptor blocker)—used to treat high blood pressure—you may first be asked to try a generic version. If the generic version does not work or causes serious side effects, you may be asked to try a preferred formulary version. If this still does not work, you may be asked to try a non-preferred formulary version.

The list of prescription drugs that require step therapy changes from time to time. Contact the

## Prescription drug benefits

Fund at (844) 484-4726 with questions about which prescription drugs require prior authorization.

### Case management

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

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

### Fill and refill limits

#### Quantity limits

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

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

You generally cannot refill a prescription earlier than allowed under any applicable guidelines, safety or cost containment programs, or other Plan rules, but in some cases, you may be able to refill a prescription sooner. For example, if you plan to be out of the country when you would run out of a prescription drug, the Plan may approve an early refill one time each year for each affected prescription drug. If your prescription is lost or stolen, you may also get an early refill one time each year, for each applicable prescription drug.

An early refill is subject to the quantity limits explained above, **plus** the refill quantity will not exceed the time for which you are eligible for benefits. If your lost or stolen drug is approved for an early refill, the Fund may apply a surcharge of up to \$50 (or the cost of the drug, if less) in addition to the applicable copay, and you may be required to participate in the pharmacy case management program. However, the early refill surcharge will not apply at a participating Health Center.

Call the Fund if you will be out of the country when you would run out of a prescription drug, or if you lost your prescription or had it stolen.

### Exceptions to the standard quantity limits

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

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

### Mail-order pharmacy

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

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

**WellDyneRx Home Delivery**

**(844) 813-3860**

[www.mywdrx.com](http://www.mywdrx.com)

### Specialty pharmacy

You must use the specialty pharmacy to purchase all specialty prescription drugs or visit the on-site pharmacy at the UNITE HERE HEALTH—Health Center. The only exception is for drugs prescribed to treat HIV/AIDS. You should go to the specialty pharmacy for these drugs, but you can get these drugs from any network pharmacy.

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

**Walgreens Specialty Pharmacy**

**(877) 647-5807**

Walgreens Specialty Mail Order pharmacy is different than Walgreens retail pharmacies. Walgreens retail pharmacies (brick and mortar buildings) are still out of network.

### What's not covered

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

- Prescription drugs, vitamins, minerals, or supplies that are not included on the formulary, unless you receive an exception through the prior authorization program. You must try all of the medically appropriate drugs on the formulary before Hospitality Rx will review a request for coverage of a non-formulary drug.
- Prescription drugs that have not been approved by the FDA. However, the Fund may cover prescription drugs not approved by the FDA in certain situations. You or your healthcare professional may ask for an exception through the prior authorization program.
- Specialty prescription drugs, other than those used to treat HIV/AIDS, if you do not use the specialty pharmacy.
- Experimental or investigational drugs.
- Fertility drugs.
- Prescriptions or refills in amounts over the quantity limits (*see page D-18*).
- Non-sedating antihistamines.
- Over-the-counter proton pump inhibitors, except as may be covered at a participating health center.
- Vitamins, dietary supplements, or dietary aids, except those specifically listed as a covered expense.
- New-to-market prescription drugs until the Fund or its representative has reviewed and approved the prescription drug.
- High-cost “me too” drugs, unless the Fund or its representative approves an exception through the prior authorization program. “Me-too” drugs usually have only very small differences in how they work, but are considered “new” drugs with no generic equivalent. Often, the manufacturer charges high prices for these drugs even though there are other drugs available that work just as well for a lower cost.
- Drugs that require review under a safety or cost containment program (such as a drug that requires prior authorization, or a drug subject to the step therapy program) if that safety or cost containment program is not followed, or does not approve the drug.
- Drugs, medications, or supplies that are not for an FDA-approved indication, that are not covered under the Plan's or Plan's designee's claims processing guidelines or any other internal rule, including but not limited to any national guidelines used by the medical community.



- Glucometers, other than those the Fund gives to you for free. You may be able to get a glucometer through the medical benefits if you do not want to use one of the free ones, but you will usually have to pay part or all of the cost.
- Rogaine and other drugs to prevent hair loss.
- Drugs or medications used, consumed or administered at the place where it is dispensed, other than immunizations. (These drugs may be covered under your medical benefits. *See page D-6.*)
- Diagnostics or biologicals.
- Drugs used for cosmetic reasons.
- Weight control drugs, unless approved through the prior authorization program.
- Human growth hormone, except to treat emaciation due to AIDS.
- Drugs or other covered supplies not purchased from a network pharmacy.
- Medical foods (medical foods may be covered under the medical benefit - *See page D-9.*)

**D-22**

# ***Hearing aid benefit***

## Learn:

- ▶ What the Plan pays.
- ▶ What types of services and supplies aren't covered.

## Hearing aid benefit

The Plan provides benefits for hearing aids prescribed by any licensed hearing healthcare professional, including an audiologist, otologist, or otolaryngologist. You must get services while covered under the Plan. If you are examined and a hearing aid is ordered, but your eligibility ends before you get the hearing aid, no benefits are payable unless the hearing aid is delivered within 60 days of your exam and no more than 30 days after your coverage ends.

Hearing Aids	Benefit Maximum
<b>Maximum benefit per 24-month benefit period</b> The benefit period begins with the date a hearing aid is first delivered.	\$500

### What the Plan pays

Benefits for a hearing aid are payable up to a maximum of \$500 per benefit period. The benefit period starts with the date the hearing aid is delivered.

### What's not covered

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

- Hearing examinations (hearing exams are covered under the medical benefits – see page D-1).
- Hearing aids not prescribed by a licensed healthcare professional.
- Services for speech pathology, speech readings, or lessons in lip reading.
- Rental or purchase of amplifiers.
- Replacement of a hearing aid for any reason within 24 months of delivery.
- Hearing aid repair.
- Hearing aid batteries.

# ***Dental benefits***

## Learn:

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

## Dental benefits

UNITE HERE HEALTH has contracted with The Atlantic Southern Dental Foundation (BeneCare Dental Plans) to provide dental benefits for you and your dependents. Your dental benefits are provided under the terms of an insurance contract underwritten by BeneCare Dental Plans and administered by Dental Benefit Management, Inc. (BeneCare). If there is a conflict between this summary and the terms of the insurance contract, the insurance contract governs. Under state-specific requirements for your dental benefits, you may be able to enroll a dependent other than a spouse or child. Contact us if you want to enroll other dependents in your dental plan.

Dental Benefits		
	BeneCare Network Providers	Non-Network Providers
Maximum Benefits		
Dental ( <i>Non-Orthodontic Services</i> )	\$1,500 per person every benefit year, including up to \$500 for non-network services	
Orthodontic Services	\$1,000 per child per lifetime	
Deductible	\$0	
Covered Services	You pay copays determined by a schedule of copayments	You pay the difference between the Plan's benefit (fee-for-service) and the dentist's charge

See page D-31 for a list of the most common dental services covered by the Plan and what you pay.

### Network vs. non-network providers

The Plan pays benefits based on whether you get treatment from a network provider or a non-network provider. If you use a network provider, you may pay less for your dental care. Using a non-network dentist may cost you more.

To locate a network provider near you, contact:

**BeneCare**  
toll free: **(800) 843-4727**  
[www.benecare.com](http://www.benecare.com)  
(you will have to create an account)

### What you pay

When you use a network provider, preventive services like cleanings and x-rays and certain restorative services like a simple filling are covered at no cost to you. For other covered services, you have to pay a copayment.

When you use a non-network provider, the Plan pays the dentist's charge up to a maximum benefit for each covered dental service (sometimes called a fee-for-service benefit). You are responsible for any amounts over the Plan's maximum benefit up to the dentist's charge.

Whether you use a network or a non-network provider, you must also pay any expenses that are not considered covered expenses. *See page D-28* for information about excluded expenses.

## Maximum benefits

### Dental care maximum benefit for non-orthodontic care

The Plan pays up to \$1,500 per person each benefit year, including up to \$500 for non-network services. **A benefit year is the twelve-month period beginning every September 1.** Once the Plan pays the maximum for your dental care during a benefit year, the Plan will not pay any more benefits for your dental care for the rest of that benefit year.

### Orthodontic care maximum benefit

Orthodontic care is only covered for dependent children through age 19. The Plan pays 50% up to a lifetime maximum of \$1,000 per covered dependent child for both network and non-network orthodontic care combined. Orthodontic benefits are payable monthly over the estimated duration of treatment, as long as your dependent child remains eligible. Once the \$1,000 maximum is reached, the Plan will not pay any more benefits for the child's orthodontic care.

## Predetermination of dental benefits

If your dentist recommends dental work that is expected to cost more than \$250, or if you need orthodontic care, dentures, crowns, periodontics or bridgework, please ask your dentist to submit a request for predetermination of covered benefits to BeneCare directly. This step protects you and your dentist. You will know in advance how much the Plan will pay for your dental treatment, as long as you are still eligible for benefits.

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

## Alternate course of treatment

If there is a different type of treatment that would be at least as effective as your dental treatment, but costs less, the Plan payment will be based on the less expensive alternate type of treatment. This rule applies if the alternate type of dental treatment is both:

- Commonly used to treat your condition, as determined by BeneCare.

## Dental benefits

- Recognized by the dental profession to be appropriate based on current accepted national standards of dental practices.

### What's covered

Dental services provided by network or non-network dentists must be included in the Plan's schedule of dental benefits and must be necessary for any of the following:

- Preventive care.
- Treatment of dental disease or defect.
- Treatment of accidental injury.
- Orthodontic services, other than surgical services, for covered dependent children through age 19.

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

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

A covered service must be incurred while you are eligible to be covered. A temporary dental service is considered part of the final service, not a separate service.

The most common dental services covered by the Plan are shown *on page D-31*. For a complete list, call BeneCare at **(800) 843-4727**.

### What's not covered

The following types of dental treatments, services, and supplies are not covered:

- Charges incurred, or procedures started, before you or a dependent are covered by the Plan.
- Charges for more than two oral examinations or two prophylaxes (cleanings) during any 12-month period.
- Full-mouth x-rays more frequently than once every 36 consecutive months.
- More than one bitewing x-ray series in any 12-month period.
- Periodontal surgery procedures more than once per quadrant in any consecutive 36-month period.



- More than one periodontal scaling and root planing per quadrant in any one consecutive 36-month period.
- More than two periodontal maintenance procedures in any consecutive 12-month period, or in the absence of comprehensive periodontal therapy.
- Services which, in the professional judgment of the attending dentist, will not achieve satisfactory results.
- Services or supplies which are not necessary according to accepted standards of dental practice or which are experimental or investigational.
- Replacement of lost or stolen appliances; or charges for a duplicate prosthesis or appliance, or for the replacement of an existing prosthesis (bridge, partial, or denture) which is or can be made satisfactory.
- Adjustments or repairs to dentures performed within six months of installation.
- Replacement of a prosthesis within five years from the date the original was furnished unless any of the following are true:
  - ▶ The prosthesis is a restorative crown, and replacement is necessary, as determined by accepted standards of dental practice.
  - ▶ The replacement is made necessary by the initial placement of an opposing full prosthesis or the extraction of natural teeth.
  - ▶ The prosthesis is temporary and is being replaced by a permanent prosthesis.
  - ▶ The prosthesis, while in the oral cavity, has been damaged beyond repair as a result of injury while covered.
- Appliances, restorations, and procedures to change vertical dimension, including but not limited to occlusal guards and periodontal splinting.
- Space maintainers for children age ten or over.
- Cast inlays or non-abutment cast crowns, unless a tooth cannot be restored with amalgam or composite materials.
- Services for the treatment of temporomandibular joint (TMJ) disorders, craniofacial pain disorders, or orthognathic surgery (night guards, however, are covered).
- Implants or the placement of bone grafts or extra-oral substances in the treatment of periodontal disease.
- Dental treatment with respect to congenital or developmental malformations, unless such treatment would otherwise be covered.
- Any dentistry or dental surgery primarily cosmetic in nature, including characterization

or customization of dental prosthetics beyond community standards, as determined by BeneCare.

- General anesthesia, except for the following reasons:
  - Removal of one or more impacted teeth.
  - Removal of four or more erupted teeth.
  - Treatment of a physically or mentally impaired person, or of a child under age 11.
  - Treatment of a covered person who has a medical problem, when the attending physician requests in writing that the treating dentist administer general anesthesia.
- Hospital services other than covered dental procedures.
- Treatment, services, or supplies provided under the Plan's medical benefits.
- Sealants on teeth other than the first and second permanent molars, or more frequently than every 36-months, or for persons age 16 or older.
- Orthodontic procedures other than for covered dependent children through age 19.
- Surgical orthodontic procedures.
- Charges for a fixed prosthesis on any tooth with significant bone loss, unless certified in writing by a periodontist (other than the attending dentist) that the recommended treatment is appropriate and the prognosis for the affected tooth is good.
- Duplicate charges, charges for completion of reporting forms, charges for services that are incomplete, or charges for your failure to appear as scheduled for an appointment.
- Services in excess of the Plan's maximum benefits.
- Services that are incomplete.
- Training in plaque control or oral hygiene, or for dietary instruction.
- Services for any condition covered by worker's compensation law or any similar legislation.

### Benefits after coverage ends

If your coverage ends, Plan benefits will only be paid for allowable charges incurred for covered expenses before your coverage ends. However, if coverage ends while dental treatment is in progress, benefits will be extended for the services shown below if treatment by a network dentist will be finished within 90 days after coverage ends. For treatment by a non-network dentist, coverage will be extended to the end of the month following the month coverage ends.

Coverage will only be extended for the following services:

- Amalgam restorations, if a temporary medicated filling has been placed before coverage ends.
- Minor adjustments to prosthetic devices placed before coverage ends.
- A crown, bridge, or inlay if the tooth had final preparation and the impressions were taken before coverage ends.
- A denture, if the final impressions were taken before coverage ends.
- Root canal work, if the pulp chamber was opened before coverage ends.

### Schedule of dental benefits

The most common dental services covered by the Plan are shown below. Contact BeneCare for the complete schedule, free of charge, or if you want to know about a specific service not listed below.

Dental Benefits  Description of Services	BeneCare Network Dentists	Non-Network Dentists
	What You Pay	Maximum the Plan Pays (You pay amounts over the maximum benefit)
<b>Diagnostic &amp; Preventive Services</b>		
Periodic Oral Examinations	\$0	\$9
Prophylaxis (cleanings) for Adults	\$0	\$23
Prophylaxis (cleanings) for Children	\$0	\$15
Full Mouth X-Rays	\$0	\$32
Bitewing X-rays, four films	\$0	\$14
Fluoride Treatments (topical) for Children, including Prophylaxis	\$0	\$24
<b>Restorative Services</b>		
Amalgam Restorations, limited to permanent teeth		
One tooth surface	\$0	\$17
Two tooth surfaces	\$0	\$23
Inlays, porcelain/ceramic, three surfaces	\$245	\$106
Crowns, resin with noble metal	\$175	\$140
Crowns, porcelain fused to high noble metal	\$190	\$167

## Dental benefits

Dental Benefits	BeneCare Network Dentists	Non-Network Dentists
Description of Services	What You Pay	Maximum the Plan Pays (You pay amounts over the maximum benefit)
Recent Crown	\$0	\$16
<b>Endodontics</b>		
Root Canal Therapy ( <i>excluding final restorations</i> )		
Two Canals	\$110	\$181
Three Canals	\$150	\$209
<b>Oral Surgery</b>		
Simple Extraction, single tooth	\$0	\$25
Surgical Extraction		
Removal of erupted tooth	\$0	\$29
Removal of impacted tooth, partially bony	\$60	\$72
<b>Prosthodontics</b>		
Removable Dentures, complete upper or lower	\$105	\$170
Fixed Bridgework ( <i>bridge pontics</i> )		
Pontic cast high noble metal	\$190	\$123
Pontic porcelain fused to high noble metal	\$190	\$128

### Commencement of Legal Action

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

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

# ***Vision benefits***

## Learn:

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

## Vision benefits

UNITE HERE HEALTH has contracted with Davis Vision to administer the vision benefits provided to you and your dependents.

Vision Benefits - What You Pay		
Description of Services <i>benefits covered every 12 months, except as noted below</i>	Davis Vision Provider	Non-Network Provider
Eye Exam	\$10	<i>Plan benefits limited to persons residing outside the network coverage area and to \$100 for any combination of routine services, including materials (does not apply to exams for children under age 5)</i>
Frames, covered every 24 months	\$0 for frames in the Davis Vision Fashion or Designer collection You get a \$30 allowance for non-Davis collection frames	
Lenses	\$0	
Elective Contacts <i>(provided instead of glasses)</i>	\$45 You get up to a \$100 allowance for non-Davis Vision contacts (including exam and fitting)	
Medically Necessary Contacts for Keratoconus	Plan pays up to \$100 with prior approval	

## Network and non-network vision providers

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

To locate a network provider near you, contact:

**Davis Vision**  
toll free: **(800) 999-5431**  
[www.davisvision.com/members](http://www.davisvision.com/members)  
*(Register for detailed information)*

If you choose a network provider, you can also get discounts on frames and contacts that are not in the Davis Vision collection.

All services must be received by a network provider, unless you or your covered dependent live outside the states of New York, New Jersey, Pennsylvania, and Florida. If you live outside these states and choose an out-of-area provider, you must pay the provider directly and then submit a claim for reimbursement (see [page H-3](#) for details). You can submit one claim per service each benefit period (12 or 24 months).

You can split your benefits by receiving your eye exam, lenses and frame or contact lenses on different dates or through different provider locations. Though, you may get better continuity of care and more benefit value by getting all services from one network provider.

### What you pay

You pay any copays shown in the chart at the beginning of this section. You also pay for any expenses the Plan does not cover, including costs that are more than any maximum benefit or allowance. You may also get discounts for any amounts over the Plan's network allowance.

### Upgrade options through network providers

If you use a network provider, you can get certain upgrades or options for a discounted fixed fee (in addition to any basic copay). Upgrades and options include, but may not be limited to, premier collection frames, progressive lenses, scratch protection plans, anti-reflective coatings, ultraviolet coating, polycarbonate lenses, high index lenses, and polarized and photosensitive lenses. Get your questions about upgrades and options answered by contacting Davis Vision, or by asking your network provider. Your cost for an upgrade depends on which upgrade(s) you pick.

### What the Plan pays

The Plan pays 100% of covered expenses after you make any applicable copay. If you use a non-network provider, the Plan only pays up to the maximum shown in the table for your vision care (you pay any charges over the maximums). However, if you are under age 5, any amounts the Plan pays for your vision exam will not count toward the \$100 maximum benefit for non-network services.

If a network provider believes you require additional treatment for visual impairment even after correction by regular lenses (low vision) and you get prior approval from Davis Vision, the Plan also pays 100% for supplemental testing and 75% for vision training, low vision prescription services, contact lenses, and optical and non-optical aids, up to a maximum benefit of \$1,000. The \$1,000 maximum benefit does not apply to children under age 5.

### What's covered

Benefits are available every 12 months (24 months for frames), measured from the first day of the month during which the covered expense was last incurred (the last date of service). For example, if you have an exam and get glasses on July 15, 2016, the next time the Plan would cover your exam and lenses would be July 1, 2017, and frames would be covered again starting July 1, 2018.

- Exams, consultations, or treatment by a licensed vision care professional (including dilation when professionally indicated).
- Plastic or glass lenses, including single vision, bifocal lenses, trifocal lenses, in any prescription range, including:

## Vision benefits

- ▶ Glass grey #3.
- ▶ Oversize lenses.
- ▶ Post-cataract lenses.
- ▶ Fashion tinting of plastic lenses or gradient tints.
- ▶ Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions of +/- 6.00 diopters or greater.
- ▶ Scratch-resistant coating.
- Frames.
- Standard contact lenses (soft, daily-wear, disposable, or planned replacement) in lieu of glasses.
  - ▶ Disposable contact wearers will receive two or four boxes/multi-packs of disposable contact lenses.
  - ▶ Planned replacement contact wearers will receive two boxes/multi-packs of contact lenses.
- Medically necessary contacts, with prior authorization from Davis Vision.

### What's not covered

See page E-2 for a list of the Plan's general exclusions and limitations. In addition to that list, the following vision treatments, services, and supplies are not covered under the vision benefits:

- Non-prescription lenses.
- Any type of lenses, frames, services, supplies, or options that are not specifically listed as covered, or that are not covered under the Davis Vision contract.
- Two pairs of glasses instead of bifocals.
- Contacts and eyeglasses during the same benefit cycle.
- Replacement of lost or broken lenses or frames before the beginning of the next benefit period. Davis Vision may include a breakage warranty. Contact Davis Vision for more information.
- Medical treatment of eye disease or injury (may be covered under "*Medical benefits*").



# ***Member Assistance Program (MAP)***

## Learn:

- ▶ What the Member Assistance Program is.
- ▶ What's covered.
- ▶ What's not covered.

## Member Assistance Program (MAP)

UNITE HERE HEALTH has contracted with Optum to administer the Member Assistance Program for you and your dependents.

Member Assistance Program	
Counseling sessions at the Health Center (in-person or video)	Unlimited
Telephonic counseling sessions	Unlimited
Face-to-face counseling sessions (other than at the Health Center), including individual or group sessions	5 sessions per person each calendar year

The Member Assistance Program provides help with personal and work place problems at no cost to you. Sessions can be in person, by telephone, or by video at Health Center, and can address a wide range of issues, including substance abuse, work or family conflicts, stress, depression, and grief counseling.

To find get more information about the MAP, find network providers, or get help 24 hours a day, 7 days a week, contact:

### Optum

toll free: **(866) 248-4094**

[www.liveandworkwell.com](http://www.liveandworkwell.com)

(Enter the access code "UHH")

Call **(609) 570-2400** for an appointment at the Health Center located at 1801 Atlantic Avenue, Atlantic City, New Jersey 08401. *Certain spouses may not have access to services provided at the Health Center (See page I-6 for more information).*

## What's covered

Counseling services available through the MAP include:

- Access to a 24-hour toll-free hotline and intervention service.
- Unlimited in-person and video counseling services at the Health Center.
- Assessment services.
- Short-term counseling sessions, in-person and over the telephone. In-person sessions are limited to 5 sessions per person each calendar year, except at the Health Center.
- Referral to community resources for legal, tax, eldercare, and childcare problems.
- Access to online tools and resources.

### **What's not covered**

No MAP benefits are provided for:

- Services not provided through Optum.
- Face-to-face counseling sessions after you meet the limit of 5 sessions per person each calendar year (not applicable to services at the Health Center). (Additional counseling services are covered under the medical benefits, and may require cost-sharing.)
- Services provided after your eligibility for coverage ends.



# ***Life and AD&D benefits***

## Learn:

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

## Life and AD&D benefits

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

Event	Benefit	Who Receives
Life Insurance	\$10,000	Your beneficiary
Accidental Death & Dismemberment Insurance (full amount)	\$5,000	You (or your beneficiary if you die)

Life insurance and AD&D insurance benefits are provided under an insured 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, free of charge, by contacting the Fund at **(888) 437-3480**.

### Life insurance benefit

Your life insurance benefit is \$10,000 and will be paid to your beneficiary(ies) if you die while you are eligible for coverage or within the 31-day period immediately following the date coverage ends.

#### Continuation if you become totally disabled

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

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

For purposes of continuing your life insurance benefit, you are totally disabled if an injury or a sickness is expected to prevent you from engaging in any occupation for which you are reasonably

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

### **Converting to individual life insurance coverage**

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

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

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

### **Terminal Illness Benefit**

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

### Accidental death & dismemberment insurance benefit

If you die or suffer a covered loss within 365 days of an accident that happens while you are eligible for coverage, AD&D benefits will be paid as shown below. However, the total amount payable for all losses resulting from one accident is \$5,000.

Your AD&D Benefit for a loss (death or dismemberment) within 365 days of an accident		
Event	Benefit	Who Receives
Death	\$5,000	Your beneficiary
Loss of both hands or feet	\$5,000	You
Loss of sight in both eyes	\$5,000	You
Loss of one hand and one foot	\$5,000	You
Loss of one hand and sight in one eye	\$5,000	You
Loss of one hand or one foot	\$2,500	You
Loss of the sight in one eye	\$2,500	You
Loss of index finger and thumb on same hand	\$1,250	You

#### AD&D exclusions

AD&D benefits do not cover losses resulting from or caused by:

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

See your certificate for complete details.

#### Additional accidental death & dismemberment insurance benefits

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



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

## Naming a beneficiary

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

If you don't name a beneficiary, death benefits will be paid to your first surviving relative in the following order: your spouse; your children in equal shares; your parents in equal shares; your brothers and sisters in equal shares; or your estate. However, Dearborn National may pay up to \$2,000 to anyone who pays expenses for your burial. The remainder will be paid in the order described above.

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

## Additional services

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

## *Life and AD&D benefits*

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

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

# ***General exclusions and limitations***

Learn:

- ▶ The types of care not covered by the Plan.

## General exclusions and limitations

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

- Treatment, services, or supplies that are not medically necessary in treating the injury or sickness as defined by UNITE HERE HEALTH (*see page I-5*).
- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a healthcare provider.
- Any injury, sickness, or dental or vision treatment which arises out of or in the course of any occupation or employment, or for which you have gotten or are entitled to get benefits under a workers' compensation or occupational disease law, whether or not you have applied or been approved for such benefits.
- Any treatment, services, or supplies:
  - For which no charge is made.
  - For which a person is not required to pay.
  - Which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish, or municipal hospital when there is no legal requirement to pay for such treatment, services, or supplies.
  - Which are provided by an individual who is related by blood or marriage to you, your spouse, or your child, or who normally lives in your home.
- Any charge which is more than the Plan's allowable charge (*see page I-2*).
- Experimental treatment (*see page I-4*), or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH.
- Preventive care, unless specifically considered preventive healthcare (*see page I-7*), or as otherwise stated as covered. If you don't meet the criteria for preventive healthcare the Plan otherwise covers, it might not be covered under the Plan.
- Any expense or charge for failure to appear for an appointment as scheduled, or charge for completion of claim forms, or finance charges.
- Any treatment, services, or supplies purchased or provided outside of the United States (or its Territories), unless for a emergency medical treatment. The decision of the Trustees in determining whether an emergency existed will be final.
- Any expense or charge incurred by a Person confined in a rest home, old age home, or a nursing home.

## General exclusions and limitations

- Any charges incurred while you are confined in a hospital, nursing home, or other facility or institution (or a part of such facility) which are primarily for education, training, or custodial care.
- Sex transformation for any reason.
- Treatment for or in connection with infertility, other than for diagnostic services, including but not limited to in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and fertility drugs and medications of any kind.
- Weight loss programs or treatment, except as specifically stated as covered (for example, diabetes education, nutrition counseling, or preventive healthcare services).
- Any smoking cessation treatment, program, drug, or device to help you stop smoking or using tobacco, other than preventive healthcare services or as otherwise stated as covered.
- Any charges incurred for treatment, services, or supplies as a result of a declared or undeclared war or any act thereof; or any loss, expense or charge incurred while a person is on active duty or in training in the Armed Forces, National Guard, or Reserves of any state or any country.
- Any elective procedure (other than sterilization or abortion, or as otherwise specifically stated as covered) that is not for the correction or cure of a bodily injury or sickness.
- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault.
- Massage therapy, rolfing, acupuncture, or biofeedback training.
- Naturopathy or chiropractic.
- Athletic training.
- Education or training, unless specifically stated as covered.
- Services provided by or through a school, school district, or community or state-based educational or intervention program, including but not limited to any part of an Individual Education Plan (IEP).
- Court-ordered or court-provided treatment of any kind, including any treatment otherwise covered by this Plan when such treatment is ordered as a part of any litigation, court ordered judgment or penalty.
- Treatment, therapy, or drugs designed to correct a harmful or potentially harmful habit rather than to treat a specific disease, other than services or supplies specifically stated as covered.
- Megavitamin therapy, primal therapy, psychodrama, or carbon dioxide therapy.

## *General exclusions and limitations*

- Services, treatment, or supplies for Christian Science.
- Any expense greater than the Plan's maximum benefits, or any expense incurred before eligibility for coverage begins or after eligibility terminates, unless specifically provided for under the Plan.
- Services, treatment, or supplies provided by a non-network provider when Plan benefits are only payable if the service, treatment, or supply is provided by a network provider.
- A service or item that is not covered under the Plan's claims processing guidelines or any other internal rule, guideline, protocol or similar criterion that the Plan relies upon.

# ***Coordination of benefits***

## Learn:

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

## Coordination of benefits

The Plan's coordination of benefits provisions only apply to medical benefits. However, coordination of benefits does not apply to the services at the UNITE HERE HEALTH—Health Center. Your dental benefits are subject to coordination of benefits using the rules set forth in the state specific group coordination of benefits rules for New Jersey (N.J.A.C. 11:4-28, et seq.). These rules may be slightly different than the rules shown below. If you have any questions about coordination of benefits for dental, contact BeneCare.

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

This Plan coordinates benefits with the following types of plans:

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

This Plan will not coordinate benefits with health maintenance organizations (HMOs) or reimburse an HMO for services provided.

### Which plan pays first

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

### Order of payment

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

- This Plan always pays secondary to automobile insurance policies (including but not limited to “no fault” coverage with personal injury protection (PIP)). *(If you live in New Jersey or another state that requires PIP, you may need to choose whether your auto or medical insurance will pay as primary if you get in an accident. Even if you choose your medical plan as primary, this Plan will only pay secondary to your auto policy.)*



- 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, prior authorization, and referrals

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

## Coordination of benefits

ments. The Plan will accept the prior authorization or utilization management determinations made by the primary plan. In addition, you will not be required to have a referral from your primary care provider in order to pay the lower office visit copay for specialty care.

### 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 - *see page G-22*).

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 spouse are both employees under this Plan

If both you and your spouse are covered as employees under this Plan and you or your spouse cover the other person as your dependent, the Plan will coordinate benefits with itself (internal coordination of benefits). Any benefit maximums and copay requirements will be administered as if only one employee had coverage under the Plan.

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.

However, with respect to your medical benefits, internal coordination of benefits will only apply to the following services:

- Services, treatment, and supplies from network providers, except for non-emergency medical treatment in a hospital emergency room.
- Non-network services for emergency medical treatment in a hospital emergency room.
- Services of non-network healthcare professionals specializing in radiology, anesthesiology, pathology, or emergency medicine, or for inpatient consultations.

# ***Subrogation***

## Learn:

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

### The Plan's right to recover payments

#### When injury is caused by someone else

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

Typical examples include injuries sustained:

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

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

#### Statement of facts and repayment agreement

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

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

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

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

### Settling your claim

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

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

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

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

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



# ***Eligibility for coverage***

## Learn:

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

## Eligibility for coverage

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. If you have questions about your CBA, talk to your union representative.

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

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

## Who is eligible for coverage

### Employees

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

- You work for an employer who is required by a CBA to contribute to UNITE HERE HEALTH on your behalf.
- The contributions required by that CBA are received by UNITE HERE HEALTH.
- You meet the Plan's eligibility rules.

### Dependents

If you have dependents when you become eligible for coverage, you can also sign up (enroll) your dependents for coverage during your initial enrollment period. Coverage for your dependents is available at no cost to you as long as employer contributions continue to be made on your behalf and you continue to work the minimum hours necessary to maintain your eligibility.

You must enroll all dependents you want covered by the Plan. Your dependents' coverage will start when yours does (not before). You cannot decline coverage for yourself and enroll your dependents. You can add dependents after your coverage starts. See *“When dependent coverage starts”* starting on page G-10 for more information.

## Who your dependents are

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



- Your legal **spouse** who meets the Plan's additional requirements, **but only if you meet one of the following requirements**. If you do not meet one of these requirements, you will not be able to cover your spouse under this Plan.
  - ▶ You are an employee who was eligible for coverage under Plan Unit 102 for at least one month during the 2016 calendar year, or you establish initial eligibility as of January, February, or March of 2017; or
  - ▶ You satisfy the initial eligibility requirements as an employee of a new contributing employer, or under a new classification (as defined by the minimum standards for acceptance of your CBA), that starts participating in the Fund on or after January 1, 2017; or
  - ▶ You were employed by the Trump Taj Mahal, were eligible for coverage for at least one month under Plan Unit 102 during the 2014 calendar year, and you get hired by a contributing employer between July 1, 2016 through June 30, 2017.
- Your **same-sex domestic partner**, if all of the following are true:
  - ▶ Your domestic partner was enrolled in the Plan on December 31, 2015.
  - ▶ Your domestic partner continues to qualify as a dependent (under the Plan's eligibility rules, termination rules, and verification of other insurance coverage requirements).
  - ▶ You do not disenroll your domestic partner on or after January 1, 2016.
  - ▶ You are not required to re-establish initial eligibility on or after January 1, 2016.
- » **In addition to the above, your spouse or domestic partner will not be a covered dependent under this Plan if your spouse works for a non-contributing employer (one that does not make employer contributions to UNITE HERE HEALTH) that has 50 or more employees and:**
  - **Your spouse is entitled to the employer's group health plan coverage**, but is not enrolled and covered under the plan (including when the employer offers an incentive to abstain from enrolling), or
  - **The employer offers a payment**, additional compensation, or other incentive and stops offering its group health plan.
- Your **children** who are under age 26, including:
  - ▶ Biological children, including children entitled to coverage under a Qualified Medical Child Support Order.
  - ▶ 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.

## Eligibility for coverage

- ▶ Children for whom you are the legal guardian or for whom you have sole custody under a state domestic relations law.
- ✓ Federal law requires UNITE HERE HEALTH to honor Qualified Medical Child Support Orders. UNITE HERE HEALTH has established procedures for determining whether a divorce decree or a support order meets federal requirements and for enrollment of any child named in the Qualified Medical Child Support Order. To obtain a copy of these procedures at no cost, or for more information, contact the Fund.

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 G-15*.

## Enrollment requirements

### Employees

Once you become eligible, coverage is automatic.

### Dependents

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

You must enroll all dependents you want covered by the Plan, including dependents you acquire after your coverage becomes effective. You can enroll your dependents at any time, but the date your dependent's coverage begins will be determined by the date the dependent enrollment form and required documentation is provided to and accepted by UNITE HERE HEALTH.

*See page G-10* for information about when coverage for your dependents starts.

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

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

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

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

### When your coverage begins (initial eligibility)

Your coverage begins at 12:01 a.m. on the first day of the coverage period corresponding to the first work period for which contributions are required on your behalf.

For purposes of establishing initial eligibility:

- **Work Period** means a period of six consecutive calendar months for which one or more of your employers must make contributions to UNITE HERE HEALTH on your behalf and during which you are credited with at least 1 hour of work in each month and a total of at least 720 hours of work.
- **Lag Period** means the two consecutive calendar months between the end of a work period and the beginning of the corresponding coverage period.
- **Coverage Period** means the calendar month during which you are covered if you meet the eligibility rules during the corresponding work period.

#### Example: Establishing Initial Eligibility

Work Period	Lag Period	Coverage Period
June through November	December and January	February

Suppose you work during the months of June, July, August, September, October, and November, employer contributions are required on your behalf for each month, and you are credited with at least one hour of work in each month and a total of 720 hours for the 6-month period. Your coverage will begin on February 1 and will continue through the rest of the month.

## Eligibility for coverage

### Continuing eligibility

Once you establish eligibility, you continue to be eligible as long as you work the required number of hours in a job classification covered by your CBA during the corresponding work period.

For purposes of continuing eligibility:

- **Work Period** means a calendar month for which you are credited with at least 120 hours of work and for which your employer must make a contribution to UNITE HERE HEALTH on your behalf.
- **Lag Period** means the two consecutive calendar months between the end of a work period and the beginning of the corresponding coverage period.
- **Coverage Period** means the calendar month during which you are covered if you meet the eligibility rules during the corresponding work period.

Example - Continuing Eligibility		
Work Period	Lag Period	Coverage Period
December	January and February	March
January	February and March	April
February	March and April	May

Suppose you became covered February 1 because you met all of the requirements for the June through November work period. If a contribution is required on your behalf and you are credited with at least 120 hours of work for December, your coverage continues during March. A contribution and credit for 120 hours of work for January continues your coverage for April, February will continue your coverage for May, and so on.

### Vacation bank (certain casino employers only)

- ✓ You must submit the vacation bank form no later than 3 months after the month during which the time off is taken.

In general, contributions to UNITE HERE HEALTH are based on straight time hours. However, contributions made by certain casino employers also include overtime hours, holiday pay, vacation pay, and other paid time off for which employer contributions are specified as required in the applicable collective bargaining agreement. Those contributions help you maintain eligibility.

As of each anniversary of your date of hire, certain casino employers make a payment to UNITE HERE HEALTH corresponding to the paid time off contributions made on your behalf. The Plan uses these contributions to create a “vacation bank.”

The vacation bank hours may only be used in an amount equal to the approved time off actually taken from your employer during the work period in which you fail to meet the minimum work requirements necessary for eligibility. Hours will be applied at a minimum of 8 hours per day and a maximum of 40 hours per week. Any hours shortfall remaining after vacation bank hours are applied can only be made up by making a self-payment, disability credit hours, or FMLA hours. To use your banked vacation hours, you have to certify the hours requested represent time you actually took off. You can get a copy of the vacation bank form on [www.uhh.org](http://www.uhh.org) or by calling the Fund. Follow the instructions on the form to give the completed form to the Atlantic City Fund Office by mail, fax, or in-person. When you provide the form to UNITE HERE HEALTH, you authorize the Fund to apply all or part of your banked hours to the work period for which you are short hours because of time taken off.

Banked vacation hours are not portable from one employer to another and cannot be carried forward from one year to the next. Unused hours are forfeited to UNITE HERE HEALTH.

### Self-payments for continuing eligibility

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

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

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

To be eligible to make a self-payment, you must have a minimum of 300 applied hours in the 12 months immediately preceding the work period for which you are making a self-payment. “Applied hours” includes vacation hours, but does not include self-pay, FMLA, or disability credit hours. Additionally, the work period for which you are making the self-payment must immediately follow a work period for which you were credited with at least 120 hours of work. The amount of self-payment required is the difference between 125 hours and the actual hours you were credited with for the work period.

## Eligibility for coverage

However, from the November 2016 work period through the October 2017 work period, if you meet all of the following requirements, you will be permitted to begin self-payments each time you meet the 300 hour requirement as described above, even if you were not credited with 120 hours of work in the previous work period. To be eligible for the transition period, you must:

- ▶ have eligibility for the January 2017 coverage period, and
- ▶ have 500 applied work hours or less during the 2016 calendar year, and
- ▶ still be employed (not terminated).

This exception will end starting with the November 2017 work period.

Self-payments can only be made for up to 12 consecutive months (reduced by any months for which disability credit hours are earned). Self-payments cannot be made after your employment terminates.

If you are totally disabled, you may make self-payments immediately after your total disability ends, but the maximum number of consecutive work periods for which self-payments may be made will be reduced by the number of whole and partial months for which you received disability credit hours and the number of months of consecutive self-payments made immediately prior to your disability. Once you reach the maximum of 12 months of self-payments, you cannot make another self-payment until you re-establish eligibility.

Contact the Atlantic City Fund office to make self-payments.

### Self-payments during remodeling or restoration

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

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

### Self-payments during a strike

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

- Your CBA has expired.
- Your employer is involved in collective bargaining with the union and an impasse has been reached.

- The union certifies that affirmative actions are being taken to continue the collective bargaining relationship with the Employer.

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

### Disability credit hours to continue eligibility

You can continue eligibility while you are totally disabled if you meet all of the following:

- You have established initial eligibility.
- You became totally disabled (*see page I-8*) because of injury or sickness, including childbirth.
- You were actively working during the month you became totally disabled.
- You were credited with 120 hours of work or made a self-payment for continued eligibility for the work period before you become totally disabled.
- You are:
  - ▶ under the regular care of a healthcare professional who provides written certification of your total disability, or
  - ▶ entitled to workers' compensation benefits under applicable State law, and you provide acceptable notice of such eligibility to UNITE HERE HEALTH.

If you meet these requirements, you will be credited with up to 6 hours per day for each day that you are totally disabled, but not more than 30 hours per week or 125 hours a month.

**If you are an employee of a contributing employer with less than 50 employees**, the maximum number of disability credit hours allowed during any one 12-month period is 780 hours (6 months).

**If you are an employee of contributing employer with 50 or more employees** and your total disability starts on or after January 1, 2017, the maximum number of disability credit hours allowed during any one 12-month period is 375 hours (3 months).

## Eligibility for coverage

Example - Continuing Eligibility through Disability Credit Hours				
		Work Period		Coverage Period
	Active work credit for	February	continues coverage for	May
Disability begins March 1	Disability credit hours for	March	continues coverage for	June
	Disability credit hours for	April	continues coverage for	July
Disability ends May 1	Active work credit for	May	continues coverage for	August

### When dependent coverage starts

Dependent coverage cannot start before your coverage starts. Dependent coverage cannot continue after your coverage ends (except in certain limited circumstances, see [page G-22](#)). Remember, you must enroll each of your dependents and provide any required documentation before the Plan will pay benefits ([see page G-4](#)).

#### If you enroll dependents when you become initially eligible

If you satisfactorily enroll your dependents within 60 days of the date your coverage initially begins, coverage for those dependents begins on the same date your coverage begins.

#### If you add dependents after you become initially eligible

You can add your dependents at any time.

If you satisfactorily enroll your dependents within 60 days of the following **special enrollment events**, coverage for those dependents begins on the date of the event:

- Your marriage.
- A child is born, or a child under age 26 is adopted or placed for adoption.
- A dependent previously living in a foreign country begins living with you.
- You or your dependent lose coverage under a Medicaid or State Child Health Insurance Program (CHIP) program or become eligible for premium assistance under a Medicaid or CHIP program.
- Termination of coverage under another group health plan, other insurance, or COBRA continuation coverage that was in effect on the date you became eligible to enroll dependents for coverage (unless you didn't make payments toward the cost of such coverage).



## Eligibility for coverage

- Your spouse, who previously didn't meet the Plan's additional requirements for spouse coverage related to other insurance, either:
  - ▶ Enrolls in his or employer's group health plan, or
  - ▶ Terminates employment with an employer who provides payment, additional compensation, or any other incentive to its employees and terminates group health insurance.

If you don't enroll your dependent within 60 days of the date you establish initial eligibility or within 60 days of one of the special enrollment events above, your dependent's coverage will begin on the first day of the month following the date you enroll your dependent and the required documentation is provided to and accepted by the Fund.

*Example: When dependent coverage begins*

Dependent Enrollment Materials Submitted to and Accepted by UNITE HERE HEALTH:			
	Within 60 days of establishing initial eligibility	Within 60 days of a special enrollment event	After 60 days of initial eligibility/special enrollment event
Dependent Coverage Begins:	Date you establish initial eligibility	Date of the special enrollment event	First of the month following the date you submit all required enrollment materials

### Continued coverage for dependents

Your dependents will remain covered as long as you remain eligible *and* they continue to meet the definition of a dependent.

### Disenrolling a dependent

You can disenroll certain dependents, meaning you can have their coverage under the Plan terminated. If you want to disenroll your spouse or domestic partner, you must provide your spouse's or domestic partner's written, notarized consent along with the Plan's disenrollment form. If you want to disenroll your child, you just need to provide the disenrollment form; no consent is required. However, you cannot disenroll a child whose coverage is required under the terms of a Qualified Medical Child Support Order.

Disenrollment is effective on the first day of the month following the date UNITE HERE HEALTH receives the required disenrollment material.

If you disenroll your domestic partner, you will not be able to re-enroll him or her, unless they become your legal spouse, and meet the Plan's requirements for spouse coverage.

### **Re-enrolling a disenrolled dependent**

You can re-enroll a dependent you previously disenrolled if that dependent still meets the Plan's definition of a dependent, except for a domestic partner. A re-enrolled dependent's coverage will be effective on the first day of the month following a date which is three months after the date UNITE HERE HEALTH receives the required enrollment material, unless the dependent is satisfactorily enrolled within 60 days of a special enrollment event (*see page G-10*) and coverage would become effective earlier.

# ***Termination of coverage***

Learn:

- ▶ When your coverage and your dependents' coverage ends.

## Termination of coverage

Your and your dependents' coverage continues as long as you maintain your eligibility as described *on page G-6* and your dependents continue to meet the definition of a dependent. 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 G-22.*

If you (the employee) are absent from covered employment because of uniformed service, you may elect to continue healthcare coverage under the Plan for yourself and your dependents for up to 24 months from the date on which your absence due to uniformed service begins. For more information, including the effect of this election on your COBRA rights, contact UNITE HERE HEALTH at **(888) 437-3480**.

### When employee coverage ends

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

- The date the Plan is terminated.
- The last day of the coverage period for which your employer was required to make a contribution on your behalf during the corresponding work period (*see page G-5*). For example, if your employer's last required contribution on your behalf was for the August work period, your coverage continues through the end of November.
- The last day of the coverage period for which you were credited with the maximum number of disability credit hours allowed during one 12-month period.
- The last day of the coverage period for which you last made a timely self-payment, if allowed to do so.
- The day you enter uniformed service, unless coverage is otherwise continued under the Plan's continuation provisions or the terms of the Uniformed Services Employee and Reemployment Rights Act of 1994, as amended.

*See page G-16* for special rules that apply if your employer's CBA expires.

### When dependent coverage ends

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

- The date the Plan is terminated.
- Your (the employee's) coverage ends.
- The dependent enters uniformed service.
- The last day of the last coverage period for which you made a timely self-payment, if allowed to do so.

- The date the disenrollment of your dependent takes effect (*see page G-11*).
- The last day of the month in which your dependent no longer meets the Plan's definition of a dependent.

If your child is age 26 or older and disabled, his or her coverage may be continued under the Plan. In order to continue coverage, the child must have been diagnosed with a physical or mental handicap, must not be able to support himself or herself, and must continue to depend on you for support. Coverage for 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 the child becomes age 26. The Fund may also require you to provide proof of the handicap periodically. Contact the Fund for more information on how to continue coverage for a child with a serious handicap.

### 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.

### Special termination rules

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

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

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

**If:** Your employer's Collective Bargaining Agreement expires, a new Collective Bargaining Agreement is not established during the 12-month period immediately following the CBA's expiration, and your employer does not make the required contributions to UNITE HERE HEALTH,

## Termination of coverage

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

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

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

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

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

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

### 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 employers 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.

# ***Reestablishing eligibility***

## Learn:

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

### Reestablishing employee coverage

If you lose eligibility, and your loss of eligibility is 12 consecutive months or less, you can reestablish your eligibility by satisfying the Plan's continuing eligibility rules (*See page G-6*). If your loss of eligibility lasts for more than 12 months 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 (see "The effect of uniformed service" below).

### Portability

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

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

### Family and Medical Leave Act (FMLA)

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

### 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.



## Reestablishing eligibility

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

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

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

- ✓ Your 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 at **(888) 437-3480**.

**G-20**

# ***COBRA continuation coverage***

Learn:

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

## COBRA continuation coverage

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

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

### Who can elect COBRA continuation coverage?

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

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

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

### What is a qualifying event?

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

- Your death.
- Your loss of eligibility due to:
  - ▶ Termination of your employment (except for gross misconduct).
  - ▶ A reduction in your work hours below the minimum required to maintain eligibility.
- The last day of a leave of absence under FMLA if you don't return to work at the end of that leave.
- Divorce or legal separation from your spouse.
- A child no longer meeting the Plan's definition of dependent (*see page G-2*).
- Your coverage under Medicare. (Medicare coverage means you are eligible to receive coverage under Medicare; you have applied or enrolled for that coverage, if an application is necessary; and your Medicare coverage is effective.)
- Your employer withdraws from UNITE HERE HEALTH.

### What coverage can be continued?

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

### How long can coverage be continued?

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

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

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

- Up to 36 months from the date coverage would have originally ended for all other qualifying events (*see page G-22*), as long as those qualifying events would have resulted in a loss of coverage despite the occurrence of any previous qualifying event.

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

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

## COBRA continuation coverage

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

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

### Notifying UNITE HERE HEALTH when qualifying events occur

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

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

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

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

You should use UNITE HERE HEALTH's forms to provide notice of any qualifying event, if you or a dependent are determined by the Social Security Administration to be disabled, or if you are no longer disabled. You can get a form by calling the Fund at **(888) 437-3480**.

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

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

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

## COBRA continuation coverage

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

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

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

### Election and payment deadlines

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

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

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

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

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

## COBRA continuation coverage

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

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

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

UNITE HERE HEALTH  
Attn: Operations Department  
P. O. Box 6557  
Aurora, IL 60598-0557

## Termination of COBRA continuation coverage

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

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

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

If termination of continuation coverage ends for any of the reasons listed above, you will be



## *COBRA continuation coverage*

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 **(888) 437-3480**.

For more information about health insurance options available through a Health Insurance Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

**G-28**

# ***Claim filing and appeal provisions***

Learn how you file claims and appeal a denied claim:

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

## Claim filing and appeal provisions

### Filing a benefit claim

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

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

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

- Diagnoses.
- Dates of service(s).
- Identification of the specific service(s) furnished, including, for dental services, the appropriate American Dental Association (ADA) Current Dental Terminology (CDT) code.
- 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.
- For dental claims, the patient's date of birth.

Claims for life or AD&D benefit claims must include a certified copy of the death certificate. All claims for benefits must be made as shown below. If you need help filing a claim, contact the Fund at **(888) 437-3480**.

#### Medical claims, other than mental health or substance abuse claims

Network providers will generally file the claim for you. However, if you need to file a claim, for example because you used a non-network provider, all claims for hospital, medical, or surgical treatment must be mailed to Horizon Blue Cross and Blue Shield of New Jersey.

**Horizon Cross and Blue Shield of New Jersey**

P. O. Box 0199

Newark, New NJ 07101-0199

However, claims for reimbursement for medical foods and travel and lodging expenses should be sent to UNITE HERE HEALTH. Be sure to include a completed claim form and itemized receipts.

**UNITE HERE HEALTH**

Attention: Claims Manager

P.O. Box 6020

Aurora, IL 60598-0020

## Claim filing and appeal provisions

### **Mental health or substance abuse claims**

Network providers will generally file the claim for you. However, if you need to file a claim, for example because you used a non-network provider, all claims for mental health and substance abuse treatment must be mailed to Optum.

**Optum**  
P. O. Box 30755  
Salt Lake City, UT 84130-0755

### **Prescription drug claims**

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

**UNITE HERE HEALTH**  
**Attn: Hospitality Rx**  
P.O. Box 6020  
Aurora, IL 60598-0020

### **Dental claims**

BeneCare network dentists will generally file dental claims for you. However, if you need to file a claim, for example because you used a non-network provider, you should send the claim to BeneCare.

**BeneCare**  
615 Chestnut Street, Suite 1001  
Philadelphia, PA 19106

### **Vision claims**

Davis Vision network providers will generally file vision claims for you. However, if you need to file an out-of-area vision claim, the claim should be sent to Davis Vision. You can get a claim form at [www.davisvision.com](http://www.davisvision.com) or by calling **(800) 999-5431**.

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

H

H-3

## Claim filing and appeal provisions

### Life and AD&D insurance claims

Call the Fund at (888) 437-3480 for help filing life and AD&D claims. After the Fund helps you initiate the claim, Dearborn National will contact you (or your beneficiary) to complete the claim filing process. A claim for life insurance benefits must include a copy of the certified death certificate.

UNITE HERE HEALTH

P.O. Box 6680

Aurora, IL 60598-0020

### All other benefit claims

All claims for any services or supplies denied because you are not eligible should be mailed to

UNITE HERE HEALTH

P.O. Box 6680

Aurora, IL 60598-0020

### Deadlines for filing a benefit claim

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

- **Life** claims: within a reasonable amount of time.
- **AD&D** dismemberment claims: written *notice* must be received within 31 days of loss (or as soon as reasonably possible). Written *proof* of loss must be received within 90 days of loss (or as soon as reasonably possible). If you are legally incapacitated this time frame may be extended. Other deadlines may apply to your additional AD&D insurance benefits — read your insurance certificate for more information.
- **Dental** claims: no later than 11 months (335 days) after the date the services were received.
- **Vision** claims: no later than 365 days following the date the claim was incurred.
- **All other** claims, including medical, mental health/substance abuse claims, and prescription drug claims: no later than 18 months after the date the claim was incurred.

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

### Individuals who may file a benefit claim

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

### Who is an authorized representative?

You may delegate authority to an individual to act on your behalf in regard to a claim for benefits or review of a denial of your claim. If you would like to designate an authorized representative, you and the person whom you wish to designate as an authorized representative must complete and sign a form acceptable to the Fund and submit it to:

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

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

If UNITE HERE HEALTH determines that you are incompetent or incapable of naming an authorized representative to act on your behalf, any of the following individuals may be recognized as your authorized representative without the appropriate form:

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

Your authorized representative may act on your behalf until the earlier of the following dates:

- The date you inform UNITE HERE HEALTH, either verbally or in writing, that you revoke the individual's authority to act on your behalf.
- The date a final decision on your appeal is issued.

## Determination of claims

### Post-service healthcare claims not involving concurrent care decisions

You will be notified of the decision within a reasonable period of time appropriate to your medical circumstances, but no later than 30 days after your claim is received. In general, benefits for medical/surgical services will be paid to the provider of those services.

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

### Concurrent care decisions

If an ongoing course of treatment has been approved, any decision to reduce or terminate benefits payable for the course of treatment (other than by amendment or Plan termination) is considered

## Claim filing and appeal provisions

a denial of your claim. In the event of such a denial of benefits, you will be notified of the decision in time to allow you to appeal before the benefit is reduced or terminated.

If you request that an approved course of treatment be extended, and the request is an urgent care/emergency treatment claim, a decision regarding your request will be made as soon as possible, taking into account the medical circumstances of your situation. You will be notified of the decision (whether adverse or not) no later than 24 hours after receipt of your claim, provided you submit the claim at least 24 hours prior to the expiration of the initial treatment period.

### Life and AD&D benefit claims

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

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

## Rules for prior authorization of benefits

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

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

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

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

### Special rules for decisions involving concurrent care

Concurrent care decisions are decisions about courses of treatment authorized for a definite or indefinite period of time.

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



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

### **If a request for prior authorization is denied**

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

### **Appealing a benefit prior authorization denial**

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

## **If a benefit claim is denied**

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

### **Life and AD&D claims**

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

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

### **Dental claims**

You can file an appeal within 60 days of BeneCare's decision. No special form is necessary, but the appeal must be made in writing. If you still disagree with BeneCare's decision after your appeal is decided by BeneCare, you can request a second level of appeal that will be reviewed by the Atlantic Southern Dental Foundation Review Committee. You will receive more information about how to file an appeal when your claim or first level of appeal is denied. Call BeneCare at **(800) 843-4727** if you have any questions. At any time, you may file a consumer complaint with

## Claim filing and appeal provisions

the New Jersey Department of Banking and Insurance by calling (609) 292-5316 or by visiting [www.state.nj.us/dobi/enfcon.html](http://www.state.nj.us/dobi/enfcon.html).

### **Appealing the denial of a claim (other than life and AD&D claims, and dental claims)**

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

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

### **Two levels of appeal for medical prior authorization denials and all mental health/substance abuse denials**

#### **First level of appeal**

All appeals for medical/surgical claims denied under the prior authorization program (prior authorization denials, denials based on retrospective review, or extensions of treatment beyond limits previously approved) and all appeals for mental health/substance abuse benefit claims (including prior authorization denials, and post-service claim denials) must be sent within 12 months of your receipt of the claim denial to:

#### **For medical and surgical treatment:**

Horizon Blue Cross and Blue Shield of New  
P. O. Box 0199  
Newark, New NJ 07101-0199

#### **For certain diagnostic imaging services through eviCore:**

eviCore  
Attn: Clinical Appeals  
Mail Stop 600  
400 Buckwalter Place Boulevard  
Bluffton, SC 29910

#### **For mental health/substance abuse treatment:**

Optum  
P.O. Box 30512  
Salt Lake City, UT 84130-0512

## *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 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 claim denials made by Hospitality Rx**

#### **First level of appeal**

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

**UNITE HERE HEALTH**  
**Attn: Hospitality Rx**  
P.O. Box 6020  
Aurora, IL 60598-0020

#### **Second level of appeal**

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

**The Appeals Subcommittee**  
**UNITE HERE HEALTH**  
711 N. Commons Drive  
Aurora, Illinois 60504

### **One level of appeal for most other claims**

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

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

## Claim filing and appeal provisions

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

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

### Appeals involving urgent care claims

If you are appealing a denial of benefits that qualifies as a request for emergency treatment/urgent care, you can orally request an expedited (accelerated) appeal of the denial by calling **(630) 699-4372**. All necessary information may be sent by telephone, facsimile or any other available reasonably effective method.

### Appeals under the sole authority of the plan administrator

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

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

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

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

### Review of appeals

During review of your appeal, you or your Authorized Representative are entitled to:

- Examine and obtain copies, free of charge, of all Plan documents, records and other information that affect your claim.
- Submit written comments, documents, records, and other information relating to your claim.

## Claim filing and appeal provisions

- Information identifying the medical or vocational experts whose opinion was obtained on behalf of UNITE HERE HEALTH in connection with the denial of your claim. You are entitled to this information even if this information was not relied on when your appeal was denied.
- Designate someone to act as your authorized representative (*see page H-5* for details).

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

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

### Notice of the decision on your appeal

You will be notified of the decision on your appeal:

- As soon as possible, taking into account your medical circumstances, but not later than 72 hours (72 hours for both levels of appeal combined if the claim is subject to two levels of appeal) after the reviewing entity's receipt of an appeal that qualifies as a request involving emergency treatment/ urgent care.
- Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days for each level of appeal after the reviewing entity's receipt of an appeal regarding prior authorization of services other than those pertaining to concurrent care decisions.
- Within a reasonable period of time, but not later than 60 days (30 days for each level of appeal, if applicable) after the reviewing entity's receipt of an appeal of healthcare claims for services not requiring prior authorization.

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

If your appeal is denied, you will be provided with a written notice of the denial which includes

## Claim filing and appeal provisions

all of the information required by federal law, including a description of the Plan's external review procedures (where applicable), how to appeal for external review, and the time limits applicable to such procedures.

### Independent external review procedures

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

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

- You must have been eligible for benefits at the time you incurred the medical expense.
- Your claim denial must involve a medical judgment or rescission of coverage.
- The denial must not relate to your failure to meet the Plan's eligibility requirements (eligibility claims are not subject to external review).
- You must have exhausted your internal appeal rights.
- You must submit all the necessary information and forms.

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

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

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

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

### **Internal appeal exception**

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

### **Non-assignment of claims**

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

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

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

### **Commencement of legal action**

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

If you finish all internal appeals and decide to file a lawsuit against the Plan, that lawsuit must be commenced no more than 12 months after the date of the appeal denial letter. If you fail to com-

## *Claim filing and appeal provisions*

mence your lawsuit within this 12-month time frame, you will permanently and irrevocably lose your right to challenge the denial in court or in any other manner or forum. This 12-month rule applies to you and to your beneficiaries and any other person or entity making a claim on your behalf.



# ***Definitions***

## Learn:

- ▶ A summary definition of some of the terms the Plan uses

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

### Allowable charges

An **allowable charge** is the amount of charges for covered treatments, services, or supplies that the Plan uses to calculate the benefits it pays for a claim. If you choose a non-network provider, the provider may charge more than the **allowable charge**. You must pay this difference between the actual charges and the **allowable charges**. Any charges that are more than the **allowable charge** are not covered. The Plan will not pay benefits for charges that are more than the **allowable charge**.

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

- **Allowable charges** for services furnished by network providers are based on the rates specified in the contract between UNITE HERE HEALTH and the provider network. Providers in the network usually offer discounted rates to you and your family. This means lower out-of-pocket costs for you and your family.
- Treatment by a non-network provider means you pay more out-of-pocket costs. Except where a different allowable charge is required by federal law for non-network emergency medical treatment, the Plan calculates benefits for non-network providers based on an independent metric, like the Medicare rate. The Plan will not pay the difference between what a non-network provider actually charges, and what the Plan considers an **allowable charge**. You pay this difference in cost. (This is sometimes called “balance billing.”)

### Copay or copayment

A fixed amount (for example, \$20) you pay for a covered health care service. You usually have to pay your **copay** to the provider at the time you get health care. The amount can vary by the type of covered health care service. Usually, once you have paid your **copay**, the Plan pays the rest of the covered expenses. However, sometimes you have to pay your deductible and coinsurance after the copay.

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

### Coinsurance

Your share of the costs of a covered expense, calculated as a percent (for example, 20%) of the allowable charge for the service. You pay your **coinsurance** plus any deductibles or copays. For example, if the allowable charge for network outpatient hospital services is \$1,000, and you already met your deductible, your 15% **coinsurance** equals \$150. The Fund pays the rest of the allowable charge.

### Cosmetic or reconstructive surgery

**Cosmetic or reconstructive surgery** is any surgery intended mainly to improve physical appearance or to change appearance or the form of the body without fixing a bodily malfunction. **Cosmetic or reconstructive surgery** includes surgery to prevent or treat a mental health or substance abuse disorder by changing the body.

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

### Covered expense

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

### Deductible

The amount you owe for covered medical expenses before the Fund begins paying benefits. For example, the Fund will not start paying certain medical benefits on your behalf until you meet your \$350 individual **deductible**.

Amounts you pay for medical care 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. You can get more information about your medical **deductibles** in the section titled “Medical benefits.”

### 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.
- Is approved for payment under Medicare.

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**.

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

**Experimental, investigational, or unproven** procedures or supplies are those procedures or supplies which are classified as such by agencies or subdivisions of the federal government, such as the Food and Drug Administration (FDA) or the Office of Health Technology Assessment of the Centers for Medicare & Medicaid Services (CMS); or according to CMS's Medicare Coverage Issues Manual. Procedures and supplies that are not provided in accordance with generally accepted medical practice, or that the medical community considers to be experimental or investigative will also meet the definition of **experimental, investigational, or unproven**.

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

### 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.

### Healthcare provider

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

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

- Family medicine.
- General practice.
- Geriatrics.
- Internal medicine.
- Pediatrics.
- Obstetrics and gynecology.

A **specialist** is a healthcare provider who specializes in a field other than those designated as primary care above.

A **dentist** is a healthcare provider licensed to practice dentistry or perform oral surgery in the state in which he or she is practicing, as long as he or she practices within the scope of that license. Another type of healthcare provider may be considered a dentist if the healthcare provider is performing a covered dental service and otherwise meets the definition of “healthcare provider.”

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

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

### Injuries and sicknesses

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

**Sickness** includes certain treatments and conditions, including: mental health conditions and substance abuse; pregnancy and pregnancy-related conditions, including abortion; voluntary sterilization for you, your spouse, and your female children.

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

### Medically necessary

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

- Consistent with and effective for the injury or sickness being treated;
- Considered good medical practice according to standards recognized by the organized medical community in the United States; and
- Not experimental or investigational (*see page I-4*), nor unproven as determined by appropriate governmental agencies, the organized medical community in the United States, or standards or procedures adopted from time-to-time by the Trustees.

For medical benefits, the Plan will use Horizon Blue Cross and Blue Shields medical policies and practices when determining what treatments, services, and supplies are considered medically necessary or experimental and investigational. If Horizon’s policies or practices do not address certain situations, are ambiguous, or are otherwise inapplicable to the Fund, the requirements above will apply.

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

## Definitions

However, the Board of Trustees has the sole authority to determine whether care and treatment is **medically necessary**, and whether care and treatment is experimental or investigational. In all cases, the Trustees' determination will be final and binding. Determinations of **medical necessity** and whether or not a procedure is experimental or investigative are solely for the purpose of establishing what services or courses of treatment are covered by the Plan. All decisions regarding medical treatment are between you and your healthcare provider and should be based on all appropriate factors, only one of which is what benefits the Plan will pay.

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

In order to protect you and your family, the Plan limits your cost-sharing for covered network services during a calendar year. Your Plan has two **out-of-pocket limits** — a **basic out-of-pocket limit** and a **safety net out-of-pocket limit**. Your **basic out-of-pocket limit** limits the amount of coinsurance you pay during one calendar year for network medical covered expenses. Your **safety net out-of-pocket limit** limits the amount of deductibles, coinsurance, and copays you pay during one calendar year for network medical and prescription drug covered expenses.

Amounts you pay out-of-pocket for services and supplies that are not covered, amounts over the allowable charges, or care or treatment you receive after the Plan's maximum benefit, do not count toward your **out-of-pocket limit**. In addition, amounts you pay in addition to your prescription drug copay when you choose a brand name drug when a generic equivalent is available or for early refill surcharges, do not count toward your **out-of-pocket limit**.

Out-of-pocket costs for non-network care or treatment do not count toward your **out-of-pocket limit**, except for emergency treatment, treatment provided by non-network healthcare providers who specialize in emergency medicine, radiology, anesthesiology, or pathology, inpatient consultations with non-network providers, and when the network doesn't have a provider in the required specialty. The Plan will not pay 100% for services or supplies that are not covered, or that are provided by a non-network provider, even if you have met your **out-of-pocket limit(s)** for the year.

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

### Participating Health Center

The UNITE HERE HEALTH—Health Center (Health Center) is located at **1801 Atlantic Avenue, Atlantic City, New Jersey 08401**. You and your covered dependents have access to the services at the Health Center. However, if the Plan pays secondary to your spouse's primary insurance (through the Plan's coordination of benefits rules), your spouse will not have access to the Health Center.

The services at the Health Center are available at no cost to you (for free). These free services currently include primary care, laboratory services, simple x-rays, physical therapy, and mental

health/substance abuse counseling services. The Health Center also includes a pharmacy where you can get free prescription drugs.

The services available at the Health Center may change from time to time. Be sure to call the Fund at **(888) 437-3480** to find out what services are currently available. Call the Health Center at **(609) 570-2400** for an appointment.

In addition, the following locations in the Philadelphia-area are extensions of the Health Center where you can get free services. Make sure you are eligible before you go and bring your medical ID card. If you aren't eligible when you receive services, you will be responsible for the entire bill.

**For free lab work,  
visit the Quest Laboratory locations:**

1001 Baltimore Pike, Suite 112  
Springfield, PA 19064

and

501 W. MacDade Blvd  
Folsom, PA 19033

**For free prescription medications,  
visit the CVS locations:**

3298 Edgemont Avenue  
Brookhaven, PA 19015

and

1306 W. MacDade Blvd  
Woodlyn, PA 19094

All other Quest Laboratory locations are NOT in the Horizon Direct Access network. Cost-sharing is required at all other CVS locations.

Remember, the Health Center, including any extensions of the Health Center, is not available to a dependent spouse if the Plan pays secondary to the spouse's other insurance (*see page F-1*). If you are not sure if the Plan pays secondary for your spouse, call the Fund at **(888) 437-3480**. If your spouse has other primary coverage and goes to one of the above Quest or CVS locations, the services will not be free.

## Plan Document

The rules and regulations governing the Plan of benefits provided to eligible employees and dependents participating in Plan Unit 102 (Atlantic City Casinos).

## Preventive healthcare

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

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

## Definitions

- 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.

The Plan may cover certain **preventive healthcare** more liberally (for example, more frequently or at earlier/later ages) than required. For example, routine mammograms are generally covered annually for all women. The Plan also considers routine PSA screening tests (prostate-specific antigen tests) to be preventive healthcare.

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

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

### Totally Disabled or Total Disability

You are considered to be totally disabled if you are prevented by injury or sickness from engaging in any occupation for wage or profit, for which you are reasonably qualified by education, training, or experience. A dependent is considered to be totally disabled if he or she suffers from any medically determinable physical or mental impairment of comparable severity.

Determination of total disability requires written certification by the attending doctor and approval of UNITE HERE HEALTH.

*See page D-42* for the definition of total disability applicable to the extension of the life insurance benefit.



***Other important information***



## 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, the prescription drug benefits, the vision care benefits, the hearing aid benefits, and the member assistance program (MAP) benefits on a self-funded basis. Self-funded means that none of these benefits are funded through insurance contracts. Benefits and associated administrative expenses are paid directly from UNITE HERE HEALTH.

The Plan provides the dental benefits and the life and accidental death & dismemberment (AD&D) benefits on a fully insured basis. The dental benefits are funded and guaranteed under a group policy underwritten by The Atlantic Southern Dental Foundation (BeneCare Dental Plans). The life and AD&D benefits are funded and guaranteed under a group policy underwritten by Dearborn National.

The Plan also contracts with other organizations to help administer certain benefits. Prescription drug benefits are administered by Hospitality Rx, LLC, a wholly owned subsidiary of UNITE HERE HEALTH. Davis Vision administers the vision benefit. Optum administers the mental health and substance abuse benefits, including prior authorization. Prior authorization and other utilization review services for the Plan's medical and surgical benefits are provided by Horizon Blue Cross and Blue Shield of New Jersey (Horizon). Horizon contracts with eviCore to manage prior authorization for certain diagnostic imaging services and with Magellan Rx Management for prior authorization of medical injectables.

### Interpretation of Plan provisions

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

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

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

- Make the final decisions about applications for or entitlement to Plan benefits, including:
  - ▶ The exclusive discretion to increase, decrease, or otherwise change Plan provisions for

## Other important information

the efficient administration of the Plan or to further the purposes of UNITE HERE HEALTH,

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

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

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

### Amendment or termination of the Plan

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

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

If UNITE HERE HEALTH is terminated, in whole or in part, or if your Plan, any other Plan Unit or any schedule of benefits is terminated or suspended, no employer, participant, beneficiary or other employee benefit plan will have any rights to any part of UNITE HERE HEALTH's assets. This means that no employer, plan or other person shall be entitled to a transfer of any of UNITE HERE HEALTH's assets on such termination or suspension. The Trustees may continue paying

## *Other important information*

claims incurred before the termination of UNITE HERE HEALTH or any Plan Unit, as applicable, or take any other actions as authorized by the Trust Agreement. Payment of benefits for claims incurred before the termination of UNITE HERE HEALTH, any Plan Unit, or any schedule of benefits will depend on the financial condition of UNITE HERE HEALTH.

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

### **Free choice of provider**

The decision to use the services of particular hospitals, clinics, doctors, dentists, or other health-care 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 insurance. 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.

### **Employer and employee organizations**

You can get a complete list of employers and employee organizations participating in the Plan by writing to the Plan Administrator. Copies are also available for review at the Aurora, Illinois, Office and, within 10 days of a request for review, at the following locations: regional offices, the

main offices of employers at which at least 50 participants are working, or the main offices or meeting halls of local unions.

### **Plan administrator and agent for service of legal process**

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

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

### **Employer identification number**

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

### **Plan number**

The Plan Number is 501.

### **Plan year**

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

### **Remedies for fraud**

If you or a dependent submit information that you know is false 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.

### **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. You have the right to file an appeal if your coverage is rescinded.

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. 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.

# ***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.

# Important phone numbers and addresses

## **BeneCare**

BeneCare Dental Plans  
615 Chestnut Street, Suite 1001  
Philadelphia, PA 19106  
**(800) 843-4727**

## **Davis Vision**

175 East Hudson Street  
San Antonio, TX 78205  
**(800) 999-5431**

## **Dearborn National**

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

## **eviCore**

400 Buckwalter Place Boulevard  
Bluffton, SC 29910  
**(866) 496-6200**

## **Horizon Blue Cross and Blue Shield of New Jersey**

3 Penn Plaza East  
Newark, NJ 07105  
**(866) 899-0626**

## **Hospitality Rx**

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

## **Optum**

11000 Optum Circle  
Eden Prairie, MN 55344  
**(866) 248-4094**

***UNITE HERE HEALTH***  
***Board of Trustees***



# UNITE HERE HEALTH Board of Trustees

## Union Trustees

### Chairman of the Board

#### **D. Taylor**

*President*

UNITE HERE  
1630 S. Commerce Street  
Las Vegas, NV 89102

#### **Geoconda Arguello-Kline**

*Secretary/Treasurer*

Culinary Union Local 226  
1630 S. Commerce Street  
Las Vegas, NV 89102

#### **William Biggerstaff**

*UNITE HERE International Executive Vice President/Financial Secretary-Treasurer*

UNITE HERE Local 450  
7238 West Roosevelt Road  
Forest Park IL 60130

#### **Donna DeCaprio**

*Financial Secretary Treasurer*

UNITE HERE Local 54  
1014 Atlantic Avenue  
Atlantic City, NJ 08401

#### **Jim DuPont**

*Local Union Support Director*

UNITE HERE  
c/o UNITE HERE HEALTH  
711 N. Commons Drive  
Aurora, IL 60504

#### **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

#### **Connie Holt**

*Connecticut Director*

UNITE HERE Local 217  
425 College Street  
New Haven, CT 06511

#### **Karen Kent**

*President*

UNITE HERE Local 1  
218 S. Wabash Avenue, 7th floor  
Chicago, IL 60604

#### **Rev. Clete Kiley**

*UNITE HERE International Union*

218 S. Wabash Avenue, 7th Floor  
Chicago, IL 60604

#### **Brian Lang**

*President*

UNITE HERE Local 26  
33 Harrison Avenue, 4th floor  
Boston, MA 02111

#### **C. Robert McDevitt**

*President*

UNITE HERE Local 54  
1014 Atlantic Avenue  
Atlantic City, NJ 08401

#### **Leonard O'Neill**

UNITE HERE Local 483  
702C Forest Avenue  
Pacific Grove, CA 93950

#### **Tom Walsh**

*President*

UNITE HERE Local 11  
464 S. Lucas Avenue, Suite 201  
Los Angeles, CA 90017

# UNITE HERE HEALTH Board of Trustees

## Employer Trustees

### Secretary of the Board

#### **Arnold F. Karr**

*President*

Karr & Associates  
c/o UNITE HERE HEALTH  
711 N. Commons Drive  
Aurora, IL 60504

#### **Paul Ades**

*Senior Vice President Labor Relations*

Hilton Worldwide  
7930 Jones Branch Drive  
McLean, VA 22102

#### **James L. Claus**

*Executive Vice President*

Tishman Hotel Corporation  
100 Park Avenue, 18th Floor  
New York, NY 10017

#### **Richard Ellis**

*Vice President/Labor Relations*  
ARAMARK

1101 Market Street, 6th Floor  
Philadelphia, PA 19107

#### **George Greene**

*Vice President Labor Relations*

Starwood Hotels and Resorts  
715 W. Park Avenue, Unit 354  
Oakhurst, NJ 07755

#### **Cynthia Kiser Murphey**

*President & Chief Operating Officer*

New York-New York  
3790 Las Vegas Blvd. South  
Las Vegas, NV 89109

#### **Robert Kovacs**

*VP Total Rewards North America*

Compass Group  
2400 Yorkmont Road  
Charlotte, NC 28217

#### **Russ Melaragni**

*Vice President of Associate & Labor Relations*

Hyatt Hotels & Resorts  
71 S. Wacker Drive  
Chicago, IL 60606

#### **Cynthia Moehring**

*Vice President of Human Resources*

The Mirage  
3400 Las Vegas Blvd, South  
Las Vegas, NV 89109

#### **Frank Muscolina**

*Vice President Corporate Labor Relations*

Caesars Palace  
c/o UNITE HERE HEALTH  
711 N. Commons Drive  
Aurora, IL 60504

#### **William Noonan**

*Senior Vice President - Administration*

Boyd Gaming  
3883 Howard Hughes Parkway  
9th Floor  
Las Vegas, NV 89118

#### **Michael O'Brien**

*Vice President Corporate HR Services*

Caesars Palace  
1 Caesars Palace Drive  
Las Vegas, NV 89109

#### **James Stamas**

*Dean Emeritus*

Boston University School of Hospitality  
c/o UNITE HERE HEALTH  
711 N. Commons Drive  
Aurora, IL 60504

#### **Harold Taegel**

*Senior Director Labor Relations*  
Sodexo

c/o UNITE HERE HEALTH  
711 N. Commons Drive  
Aurora, IL 60504

#### **George Wright**

c/o UNITE HERE HEALTH  
711 N. Commons Drive  
Aurora, IL 60504





**UNITE HERE HEALTH**

P.O. Box 6020

Aurora, IL 60598-0020

**(630) 236-5100**