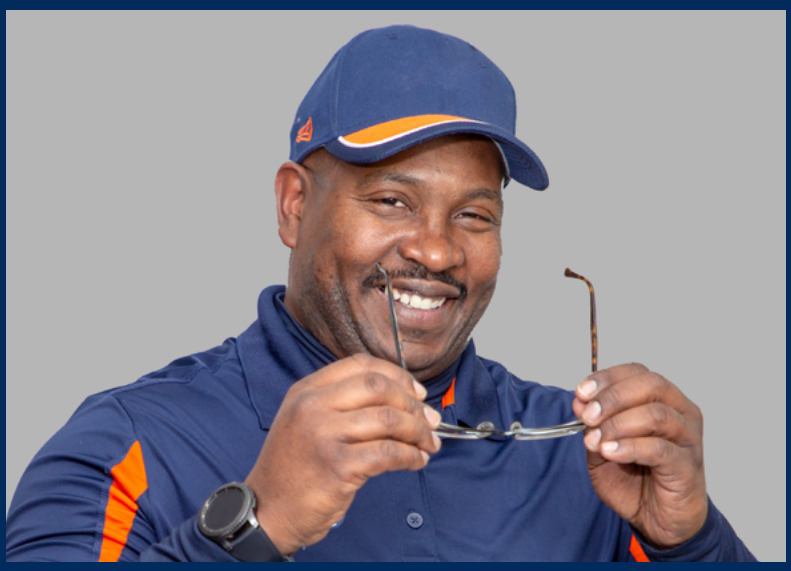
UNITE HERE HEALTH

Atlantic City Casinos

Plan Unit 102 (Actives)



Summary Plan Description

Your Health and Welfare Benefits

Your Fund is taking care of you during the national coronavirus emergency!

Until the end of the national coronavirus (COVID-19) emergency as declared by the Department of Health and Human Services (HHS), you will not pay any cost-sharing (copays, deductibles, or coinsurance) for:

- Medically appropriate COVID-19 testing ordered by a healthcare provider. ("Testing" includes both tests to determine if you currently have the virus, or if you have antibodies to the virus.) In addition, if the primary purpose is to get testing, you will not pay any cost-sharing for items and services related to the test, including, for example, in-person or telehealth office visits, urgent care center visits, and emergency room visits. However, your normal cost-sharing applies to visits, items, and services (other than the COVID-19 test), if the primary purpose of your visit isn't to get or determine if you need to get a COVID-19 test.
- Covered immunizations include ACIP-recommended coronavirus vaccines at network providers, and until the end of the public health emergency for the coronavirus pandemic, non-network providers.
- FDA-authorized over-the-counter COVID-19 tests that are self-administered and self-read:
  - You can buy tests from your local pharmacy or get them through the mail by calling WellDyne at **(844) 813-3860**. Visit www.uhh.org/covidtests for more information or to request reimbursement.
    - You can get up to 8 tests per person during a 30-day period (this limit does not apply to medically appropriate tests ordered by a healthcare professional).
    - Generally, you'll be reimbursed up to $12/test or $24/2-pack for eligible purchases.
    - The Fund will not pay for tests for employment purposes or purchased from a private person, online auction, or resale marketplace.
    - If you get your tests from your local pharmacy, you MUST go to the pharmacy (do NOT go to another check-out such as the cosmetics counter). Make sure you show your Hospitality Rx ID card. Otherwise, you'll have to pay for the tests and submit your receipt for reimbursement as described below.
    - If you buy your tests online or at a retailer other than a pharmacy (like a grocery store), submit your receipt for reimbursement. Print the form from www.uhh.org/covidtests and fill in ALL information. Complete a separate claim form for each family member. Include the receipt (it must show charges and purchase date). Mail form/receipt to: the address shown on the form.

When HHS declares the national emergency related to the coronavirus (COVID-19) has ended, the temporary special benefit changes made to support you and your family during the national emergency will also end and the regular Plan rules (including what cost-sharing you must pay, network requirements, and what's not covered) will again apply.

Because of the pandemic, you generally have more time to do certain things, like file or appeal a claim, enroll your new dependent, or elect COBRA and make COBRA payments. Call us at (888) 437-3480 for more information.

UNITE HERE HEALTH

Summary Plan Description

Atlantic City Casinos

Plan Unit 102 (Actives)

Effective September 1, 2022

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

This booklet contains a summary in English of your plan rights and benefits under UNITE HERE HEALTH. If you have difficulty understanding any part of this booklet, you can visit or contact the Atlantic City regional office at 1801 Atlantic Avenue, Suite 200, Atlantic City, NJ 08401. You may also call UNITE HERE HEALTH at (888) 437-3480 (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, NJ 08401. Usted también puede llamar a UNITE HERE HEALTH al (888) 437-3480 (TTY: (855) 386-3889 o (855) FUNDTTY) para asistencia.

本手冊以英文簡要介紹 UNITE HERE HEALTH 計畫的權利及福利。如果您無法了解本手冊的任何內容，請造訪或聯絡 Atlantic City 地區辦事處 1801 Atlantic Avenue, Suite 200, Atlantic City, NJ 08401。您可以致電 UNITE HERE HEALTH (888) 437-3480 (TTY（聽障專線）：(855) 386-3889 或 (855) FUNDTTY) 尋求協助。

Table of Contents

Using this book

Learn:

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

Please take some time to review this book.

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

What is UNITE HERE HEALTH?

UNITE HERE HEALTH (the Fund) was created to provide benefits for you and your covered dependents. UNITE HERE HEALTH serves participants working for employers in the hospitality industry and is governed by a Board of Trustees made up of an equal number of union and employer trustees. Each employer contributes to UNITE HERE HEALTH according to a specific contract, called a Collective Bargaining Agreement (CBA), between the employer and the union, or a Participation Agreement (PA) between the employer and UNITE HERE HEALTH.

Your coverage is being offered under 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 how your benefits work.

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

Some terms are defined for you in the section titled "Definitions" starting *on page I-2*. The SPD will also explain what some commonly used terms mean. When you have questions about what certain words or terms mean, contact the Fund at **(888) 437-3480**.

How can I get help?

UNITE HERE HEALTH
1801 Atlantic Avenue, Suite 200
Atlantic City, NJ 08401
(888) 437-3480 or **(855) 386-3889 (TTY)**
www.uhh.org

Call the Fund:

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

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

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

iPhone ***Android***

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How do I get the most from my benefits?

Learn:

- How to get free medical care.
- Why you should get a primary care provider.
- Why you should get preventive healthcare.
- How to reduce your costs for urgent care.
- How to get prior authorization for your care.
- How to use network providers to save time and money.

Get free medical care and prescription drugs

Use the UNITE HERE HEALTH—Health Center

UNITE HERE HEALTH—Health Center
1801 Atlantic Avenue, 3rd Floor
Atlantic City, NJ 08401
(609) 570-2400
(Located in the same building as the Fund office)

Free pharmacies	
UNITE HERE HEALTH—Health Center 1801 Atlantic Avenue, 3rd Floor Atlantic City, NJ 08401 **(609) 570-2400** *(Located in the same building as the Fund office)*	**Free CVS Pharmacies at** 3298 Edgemont Avenue Brookhaven, PA 19015 and 1306 W. MacDade Boulevard Woodlyn, PA 19094

Free lab work at these Quest Laboratory locations	
90 N. MacDade Blvd Glenolden, PA 19036	501 W. MacDade Blvd Folsom, PA 19033

Free primary care at these ChesPenn Health Services locations		
125 E. 9th Street Chester, PA 19013	744 E. Lincoln Highway, Suite 110 Coatesville, PA 19320	5 S. State Road Upper Darby, PA 19082

Free cancer care at these MD Anderson locations		
Two Cooper Plaza Camden, NJ 08103	303 Central Avenue Suite 4, Unit B Egg Harbor Township, NJ 08234	Other offices throughout the Philadelphia- South Jersey area

Use Shore Medical Center for free inpatient orthopedic surgery

Shore Medical Center
100 Medical Center Way
Somers Point, NJ 08244

See page D-2 for more information about free medical care. *See page D-18* for more information about free prescription drugs.

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-6*).

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

✓ You can 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-9*, *D-20*, and *I-7* for more information about preventive healthcare.

Re-think emergency room care

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

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

Get prior authorization for your care

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

To get prior authorization for	Call
Outpatient diagnostic imaging, cardiology, radiation therapy, and genetic testing	**eviCore** **(866) 496-6200**
Hospital pre-admission review (medical/surgical and behavioral health), emergency admission review, and certain outpatient services and supplies	**Horizon** **(866) 899-0626**

Use network providers

Reduce your costs with a network provider

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

How do I stay in the medical network?

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

If you have questions about your benefits or benefit options, call the Fund at **(888) 437-3480**.

Programs to help you

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

Summary of benefits

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

Medical Benefits

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

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

If you do not call Horizon at **(866) 899-0626** or eviCore at **(866) 496-6200**, as applicable, for prior authorization, a $150 penalty may apply or your claim could be denied entirely. *See page C-2* for more information.

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

Medical Benefits—*What You Pay*		
	Network Provider	**Non-Network Provider**
Calendar Year Deductibles		
Calendar Year Deductibles	$350/person & $700/family	

Medical Benefits—*What You Pay*			
		Network Provider	**Non-Network Provider**
Office Visits			
All Services Available at the UNITE HERE HEALTH–Health Center are FREE!			Not applicable
Preventive Healthcare Services— *see page D-9 and page I-7*	***FREE** at the Health Center!*	$0	Not covered *(except for non-hospital grade breast pumps and related supplies)*
Primary Care Provider (PCP) Office Visit	***FREE** at the Health Center! (and at three ChesPenn Health Services locations in Pennsylvania)*	$20 copay/visit	50% after deductible
Specialist Visit: When your PCP provides a referral before your visit (*see page D-6*) When your PCP does not provide a referral before your visit		$40 copay/visit $75 copay/visit	50% after deductible
Mental Health Office Visit	***FREE** at the Health Center!*	$10 copay/visit	50% after deductible
Substance Abuse Office Visit		$0	50% after deductible
Acupuncture— *up to 12 visits per person each calendar year*		$20 copay/visit	50% after deductible
Chiropractic Care— *up to 24 visits per person each calendar year*		The Plan pays up to $25/visit	Not covered
Podiatry Office Visits—*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	50% after deductible
Emergency and Urgent Care			
Urgent Care Center		$30 copay/visit	50% after deductible
Emergency Room Treatment: Facility services Professional services Medical/surgical Mental health and substance abuse		$200 copay/visit and 15% after deductible *(copay waived if admitted)* 20% after deductible 15% after deductible	
Professional Ambulance Services		$130 copay/trip	

Medical Benefits—*What You Pay*			
		Network Provider	**Non-Network Provider**
Lab & Imaging Services			
Laboratory Services: Non-Hospital Hospital Outpatient	***FREE** at the Health Center! (and at two Quest locations in Pennsylvania)*	 15% after deductible 20% after deductible	50% after deductible
Radiology—*X-ray, including Chiropractic X-ray, and Ultrasound (including professional services):* Non-Hospital Hospital Outpatient	***FREE** at the Health Center!*	 $50 copay/visit $150 copay/visit	
Diagnostic Imaging—*CAT/CT, CTA, Cardiac CT, MRI, MRA, and PET scans, Nuclear Medicine, Nuclear Cardiac Imaging, Cardiac Catheterization, and Echocardiograms (including professional services):* Non-Hospital Hospital Outpatient		 $100 copay/visit $350 copay/visit	
Outpatient Surgery In a provider's office AtlantiCare Surgery Center Other Ambulatory Surgical Centers Hospital Outpatient		 *See applicable Office Visit above* $0 15% after deductible $200 copay/visit and 15% after deductible	50% after deductible
Physical, Speech, and Occupational Therapy	Physical therapy is ***FREE** at the Health Center!*	15% after deductible	50% after deductible
Habilitative Therapy for Children with Autism Spectrum Disorder—*certain limits apply* *(see page D-12)*		$10 copay/day	50% after deductible
Diabetes Education		$0 copay/visit	Not covered
Nutritional Counseling—*up to 4 visits per person each calendar year*		$0 copay/visit	Not covered
Other Outpatient Services at a Hospital *(facility services)*		15% after deductible	50% after deductible

Medical Benefits—*What You Pay*		
	Network Provider	**Non-Network Provider**
Inpatient Treatment *(Facility Services)*		
Inpatient Hospitalization: Hospice, Substance Abuse Treatment Hospital, Skilled Nursing Facility, Mental Health Treatment *(including residential treatment and professional services)*	$0 20% after deductible	50% after deductible
Shore Medical Center (in Somers Point, NJ) *Non-pediatric inpatient treatment for orthopedic knee, hip, and spine surgery only (including professional services)—see page D-4*	$0	Not applicable
Other Services and Supplies		
Prosthetics and Orthotics	20% after deductible	50% after deductible *(no coverage for podiatric orthotics)*
Sleep Studies	20% after deductible	50% after deductible
Home Healthcare Services	$0	50% after deductible
Hospice Care	$0	50% after deductible
Partial Hospitalization, Intensive Outpatient, or Ambulatory Detoxification Treatment *(including professional services):* Mental Health Substance Abuse	 15% after deductible $0	50% after deductible
Durable Medical Equipment	20% after deductible	Not covered
Travel and Lodging— *see page D-13 for information*	Plan pays 100% up to $10,000 per episode of care, including up to $250 per day for lodging and meals	
Medical Foods—*see page D-13 for information*	Plan reimburses you 100%	
MD Anderson Cancer Center at Cooper for Certain Covered Care for a Cancer Diagnosis— *see page D-3 for information*	$0	Not applicable
Healthcare Professional Services, Other Than Shown Above— *may be required in addition to cost-sharing shown for facility services*	20% after deductible Mental Health: 15% after deductible Substance Abuse: $0	50% after deductible
All Other Covered Expenses	20% after deductible	50% after deductible

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.

<table>
<tr><th colspan="4">Prescription Drug Benefits—What You Pay</th></tr>
<tr><th></th><th colspan="3">Per Prescription</th></tr>
<tr><td colspan="4">Formulary Prescription Drug Benefits at the UNITE HERE HEALTH - Health Center and free pharmacy locations (up to a 60-day supply)</td></tr>
<tr><td>Prescription Drugs—excluding select specialty, select biosimilar, and select brand drugs</td><td colspan="3">FREE!</td></tr>
<tr><td>Select Specialty and Select Biosimilar Drugs*</td><td colspan="3">25%</td></tr>
<tr><td>Select Brand Drugs*</td><td colspan="3">50%</td></tr>
<tr><td>Formulary Prescription Drug Benefits at Network Retail Pharmacies and Mail Order</td><td>Retail Pharmacy
up to a 34-day supply</td><td colspan="2">Mail Order Pharmacy
up to a 60-day supply</td></tr>
<tr><td>Preventive Healthcare Services Drugs—
See page I-7</td><td colspan="3">$0</td></tr>
<tr><td>Generic and Some Brand Drugs</td><td colspan="3">$5</td></tr>
<tr><td>Preferred Drugs</td><td colspan="3">$15</td></tr>
<tr><td>Non-Preferred Drugs</td><td colspan="3">$30</td></tr>
<tr><td rowspan="2">Select Specialty and Select Biosimilar Drugs*</td><td rowspan="2">Not covered</td><td>Generic</td><td>Brand</td></tr>
<tr><td>$5</td><td>25%</td></tr>
<tr><td>Non-Formulary Prescription Drugs and Supplies</td><td colspan="3">Not covered, unless an exception is approved</td></tr>
<tr><td colspan="4">*Current pharmacy benefit provider will actively manage and determine drugs in tier. Specialty drugs are only available through the specialty mail order pharmacy or the Atlantic City Health Center. However, if you take specialty medications as part of your HIV treatment plan, you may be able to receive an exception to use your network retail pharmacy instead.</td></tr>
</table>

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

Hearing Aid Benefit—*What the Plan Pays*	
	Benefit Maximum
Maximum benefit per 24-month benefit period The benefit period begins with the date a hearing aid is first delivered.	$500

Dental Benefits—*What You Pay*		
	BeneCare Network Providers	**Non-Network Providers**
Deductible	$0	
Maximum Benefit for Dental Treatment *(non-orthodontic)*	$1,500 per person every benefit year *(includes up to $500 for non-network services)*	
Lifetime Maximum Benefit for Orthodontic Treatment	$1,000 per child	
Description of Services	**What You Pay for Covered Dental Care**	
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 *Covered once every 12 months, except as noted below*	**Davis Vision Providers**	**Non-Network Providers**
Eye Exam	$10 copay	Plan benefits limited to persons residing outside the network coverage area and to $100 for any combination of routine services, including materials *(maximum benefit does not apply to exams for children under age 5)*
Frames—*covered every 24 months*	$0 for Davis Collection Fashion or Designer frames $0 for Non-Davis Collection frames; Plan benefits are limited to $30	
Lenses	$0	
Elective Contacts *(instead of glasses)*	$45 copay for Davis Collection contacts $0 for Non-Davis Collection contacts; Plan benefits are limited to $100 *(including exam and fitting)*	
Medically Necessary Contacts for Keratoconus	Plan pays up to $100 with prior approval	

Life and AD&D Benefit — *What the Plan Pays*	
Life Insurance	
Employees	$20,000
Dependents	
Spouse	$5,000
Child – live birth up to age 6 months	$3,000
Child – 6 months and older	$5,000
Accidental Death and Dismemberment (AD&D) Insurance	
Employees Only	$20,000

Prior authorization program

Learn:

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

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

To get prior authorization for	Call
Outpatient diagnostic imaging, cardiology, radiation therapy, and genetic testing	**eviCore** (866) 496-6200
Hospital pre-admission review (medical/surgical and behavioral health), emergency admission review, and certain outpatient services and supplies	**Horizon** (866) 899-0626

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

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, 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 BlueCard network provider (a network provider located outside of New Jersey) or a non-network provider, you are responsible for getting prior authorization. If you don't get prior authorization before getting 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.**

EviCore may reach out to you to help you schedule your appointment at the best-value imaging location nearest you. You can also call eviCore and get help scheduling basic radiology services that do not require prior authorization.

- ✓ 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 must contact Horizon or eviCore, as applicable, before getting any of the following 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.

Horizon (866) 899-0626	eviCore (866) 496-6200

• Any inpatient admission, regardless of the type of facility or care, including but not limited to skilled nursing facility care, hospice, and residential treatment
• Non-emergent air ambulance transportation
• Bariatric/gastric bypass and morbid obesity procedures
• Clinical trials
• Cosmetic or potentially cosmetic procedures, including dermatology and varicose vein services
• Durable medical equipment over $500 (including breast pumps costing over $500)
• Gender reassignment surgical services and certain hormone therapy
• Habilitative therapy for children with autism spectrum disorder
• Home health care services, including all skilled services in the home
• Home hospice services
• Home infusion services
• Hyperbaric oxygen therapy
• Medical foods
• The following behavioral health services:
  ▸ Electroconvulsive therapy (ECT)
  ▸ In-home services
  ▸ Partial hospitalization (PHP) & intensive outpatient treatment (IOP)
  ▸ Psychological testing
  ▸ Transcranial magnetic stimulation (TMS)
• Prosthetics and orthotics over $500
• Specialty pharmaceuticals (certain medical injectables)
• Transplant services, except for corneal transplants
• Travel and lodging
	• Radiology services:
	  ▸ CT and CTA scans (computed tomography and computed tomography angiography)
	  ▸ MRA and MRI (magnetic resonance imaging or magnetic resonance angiography)
	  ▸ PET and PET-CT (positron emission tomography)
	  ▸ Nuclear medicine
	  ▸ Nuclear cardiac imaging
	• Cardiology services:
	  ▸ Diagnostic heart catheterization
	  ▸ Cardiac CT and MRI
	  ▸ Echocardiography: transthoracic and transesophageal
	  ▸ Myocardial perfusion imaging (SPECT and PET)
	  ▸ Stress testing
	  ▸ Stress echocardiography
	• Radiation therapy
	• Genetic testing (molecular and genomic testing)

For emergency admissions, be sure to call no later than the first business day following the admission. No prior authorization is required for emergency medical treatment, including observation or admissions following an emergency visit, or for care you get through the UNITE HERE HEALTH — Health Center.

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

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 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 provides case management services.

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

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

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

Medical benefits

Learn:

- How to get free medical care.
- 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 are covered.
- What types of medical healthcare are not covered.

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

Get free medical care

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

UNITE HERE HEALTH—Health Center
1801 Atlantic Avenue, 3rd Floor
Atlantic City, NJ 08401
(609) 570-2400
(Located in the same building as the Fund office)

The services at the UNITE HERE HEALTH—Health Center (Health Center) are available at no cost to you. These free services currently include primary care, laboratory services, pharmacy services, counseling services through video or in-person, physical therapy, ultrasounds, and x-rays. The Health Center also includes a pharmacy where you can get free prescription drugs (*see page D-18* for more information about 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.

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. 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 these locations, the services will not be free.

Extensions of the Health Center in Pennsylvania

If you're eligible to use the Health Center, you can also get free primary care services and free lab work at the following locations. 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. Cost-sharing is required at all other Quest Laboratory locations.

Free primary care at these ChesPenn Health Services locations:

- 125 E. 9th Street
  Chester, PA 19013
- 744 E. Lincoln Highway, Suite 110,
  Coatesville, PA 19320
- 5 S. State Road
  Upper Darby, PA 19082

Free lab work at these Quest Laboratory locations:

- 90 N. MacDade Boulevard
  Glenolden, PA 19036
- 501 W. MacDade Boulevard
  Folsom, PA 19033

Use MD Anderson at Cooper for your cancer care and save!

MD Anderson Cancer Center at Cooper (MD Anderson at Cooper) is the preferred provider for cancer care services. Covered care from MD Anderson at Cooper for a cancer diagnosis is free to you. You pay $0 (no deductible, coinsurance, or copay).

Together, UNITE HERE HEALTH and MD Anderson at Cooper will help you get the broad range of services you need. When you join this cancer care program, you get care coordination and dedicated resources to help you manage your healthcare during this challenging time.

You may even be able to get free rides to certain MD Anderson at Cooper locations.

Which services aren't free at MD Anderson at Cooper?

The $0 copay doesn't apply to the following:

- Ambulance transportation.
- Services you get from MD Anderson at Cooper that aren't for your cancer diagnosis. For example, if you go to the emergency room at MD Anderson at Cooper for treatment for a broken leg (unrelated to cancer), you will pay the Plan's usual copayment, deductible, and coinsurance required for emergency room services.

Which MD Anderson at Cooper locations can I go to?

MD Anderson at Cooper has several locations. You can get complete cancer care services in Camden, New Jersey and many services in Egg Harbor Township. Services are also available in Voorhees, Willingboro, and other local offices.

MD Anderson at Cooper locations:

- Two Cooper Plaza, Camden NJ 08103
- 303 Central Ave., Suite 4, Unit B, Egg Harbor Township, NJ 08234
- Other offices throughout the Philadelphia-South Jersey area

What other important information should I know?

The Plan's rules about what's covered, what's not covered, and any prior authorization requirements still apply to services you get from MD Anderson at Cooper.

At this time, MD Anderson at Cooper doesn't treat pediatric patients, or certain cancers like ocular cancer or bone marrow cancer.

To find out more and join the program, call the Fund at **(888) 437-3480**.

Use Shore Medical Center for your inpatient orthopedic surgery!

You pay no cost-sharing (copays, deductibles, or coinsurance) for non-pediatric inpatient orthopedic surgery at Shore Medical Center in Somers Point, NJ. This means you pay $0 for inpatient admissions (including facility services and professional services) for knee, hip, and spine surgery. Your normal cost-sharing applies to all other services at Shore Medical Center. The Plan's rules about what's covered, what's not covered, and any prior authorization requirements still apply.

Shore Medical Center
100 Medical Center Way
Somers Point, NJ

Network providers

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

Horizon Blue Cross and Blue Shield of New Jersey (Horizon) (800) 810-2583 www.horizonblue.com	
Your network for care INSIDE New Jersey	Horizon Direct Access
Your network for care OUTSIDE New Jersey	BlueCard PPO

✓ *See page A-8* for more information about how staying in the network can help you save money.

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

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

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

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

- *Emergency medical treatment*
  You get emergency medical treatment from a non-network provider. The non-network provider cannot balance bill you for your emergency medical treatment. (*See page I-4* for the definition of "emergency medical treatment").

- *You use a network hospital or network ambulatory surgical center*
  You get services and supplies from non-network providers in connection with a visit to a network hospital (including the outpatient department) or a network ambulatory surgical center. The non-network provider cannot balance bill you. However, this does not apply if you give informed consent to your healthcare professional agreeing to give up your protections from balance billing (you do not have to give consent if you don't want to).
- *Non-network providers who provide inpatient consultations or specialize in anesthesiology, emergency medicine, pathology, or radiology*
  You use non-network providers who provide inpatient consultations or who specialize in anesthesiology, emergency medicine, pathology, or radiology. You pay the network cost-sharing. Unless the rules above about emergency medical treatment or visits to a network hospital or network ambulatory surgical center apply, the provider may also balance bill you.
- *Ambulance services*
  You use a non-network ambulance service (ground, air, water). Non-network air ambulance providers cannot balance bill you. Non-network ground and water ambulance providers can balance bill you.
- *The provider directory is wrong*
  You rely on the Plan's provider directory, or the Fund or Horizon tells you a provider is in the network when the provider really is not in your network. Contact the Fund if you think this rule applies to your claim. The provider may balance bill you.

  Make sure you always ask if the provider is in your network.
- *Your provider leaves the network*
  You are getting a course of treatment with a provider who leaves the network and you are a "continuing care patient" as defined by federal law because:
  - You are pregnant and getting care for your pregnancy.
  - You are getting treatment for a serious and complex condition requiring specialized medical care.
  - You are getting inpatient care.
  - You have scheduled a non-elective surgery (including post-operative care).
  - You are terminally ill (expected to live for 6 months or less).

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

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

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

- *There is no network provider in the required specialty*
  The network does not have a provider in the required specialty. You pay the network cost-sharing, but the provider may also balance bill you.

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

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, 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 copays, coinsurance, or deductibles) for your share of covered expenses. You must also pay any expenses that are not considered covered expenses (*see page D-14* for information about what's not covered), including 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 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 $700 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 will pay $0 if you use the UNITE HERE HEALTH—Health Center. *See page D-2* for more information.

You pay copays for certain types of care (see your *"Summary of benefits"*). Your copay is your only cost sharing for all of the healthcare you receive during a network office visit or urgent care center visit. For example, you only pay one office visit copay for all healthcare you receive during the office visit, even if you received other services at the same time. 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 may 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. If, during that same visit, you also had another service that requires coinsurance, you would pay the diagnostic imaging copay, plus the coinsurance.

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. 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.

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 care is 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. Certain limits or rules may apply to when and how you get preventive healthcare based on your gender, age, and health status.
  - PSA tests for men are covered once each calendar year.
  - Cervical cancer screenings (pap smear and human papillomavirus screening) are covered once each calendar year for women, regardless of age.
  - Routine mammogram screenings are covered once each calendar year for women age 35 and older, and are covered once each calendar year for women under age 35 who are at high risk for breast cancer.

- **Professional services** of a healthcare provider.
- Services provided at or by the **UNITE HERE HEALTH - Health Center (Atlantic City)**, except for certain spouses with other primary coverage that the Plan pays secondary to under the Plan's coordination of benefits rules (*see page F-1* for details about coordination of benefits).
- **Administration of injectable medications**, including immunizations, provided by a healthcare provider.
- Treatment of **mental health conditions and substance abuse**, including inpatient and residential treatment, outpatient care, partial hospitalization, intensive outpatient care, and ambulatory detoxification.
- **Acupuncture services**, up to a total of 12 visits per person each calendar year.
- **Podiatric services**, including routine and non-routine podiatry, and office surgery, provided by a network provider. Non-network services are not covered.
- **Chiropractic care**, provided by a network provider, limited to a maximum benefit of $25 per visit, and up to 24 visits per person each calendar year. Non-network services are not covered. The Plan covers x-rays performed by a chiropractor with the cost-sharing required for radiology services.
- 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 whether the ambulance was called, for example when the ambulance is called by a healthcare professional, employer, law enforcement, school, etc., the ambulance will be considered medically necessary. Contact the Fund if you had no control over an ambulance being called.
- **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.
- **Radiology services**, including x-rays and ultrasounds.
- **Diagnostic imaging**, including MRIs, MRAs, CAT/CT scans, CTA scans, cardiac CT scans, PET scans, cardiac catheterizations, echocardiograms, nuclear cardiac imaging, and nuclear medicine.
- **Laboratory services**.
- **Radiation therapy.**
- **Dialysis services**.

- **Chemotherapy and infusion 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 employees and covered dependents.
- **Nursery services** and well-baby care, but not for a newborn child born to a covered dependent child.
- **Mastectomies**, including all stages of surgery to rebuild the removed breast (reconstruction) surgery and reconstruction on the other breast so the breasts look even, breast implants and prostheses, and treatment of physical health problems from a mastectomy, including swollen lymph glands (lymphedema).
- **Medical services for organ transplants** if the following rules are all met:
  - The transplant must be covered by Medicare, including meeting Medicare's clinical, facility, and provider requirements.
  - You must use any case management program recommended by the Fund or its representative.
  - You must get prior authorization for the transplant.
  - Donor expenses for your transplant are only covered if the donor has no other coverage.
  - Transplant coverage does not include your expenses if you are giving an organ instead of getting an organ.
- **Facility charges,** including anesthesia and other ancillary services, and charges for the administration of anesthesia by an anesthesiologist, for dental procedures requiring an institutional setting to safely administer the care, including for treatment if you are suffering from medical or behavioral conditions, such as autism or Alzheimer's, that severely limit your ability to cooperate with the necessary care. This covered expense only applies to the extent the treatment would otherwise be covered under a dental benefit.
- **Jaw reduction**, open or closed, for a fractured or dislocated jaw.
- **LeFort type operations** when intended 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.
- **Skilled nursing facility care**.
- **Blood and blood plasma,** and their administration.
- **Home healthcare services.**
- Inpatient and outpatient **hospice** services and supplies if you are terminally ill.
- **Anesthesia**, and its administration.

- **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. Non-network podiatric orthotics are not covered.
- **Habilitative therapy** for children with autism spectrum disorder. *You must get prior authorization for habilitative therapy before the Plan pays benefits.* Benefits are limited to 30 hours per person each week, and to a total of 36 months. "Habilitative therapy" includes applied behavioral analysis (ABA) therapy and similar types of treatment. It does not include physical, speech, or occupational therapy.
  - Your child must be at least 2 years old, but no more than 8 years old.
  - Your child must have a diagnosis of autism spectrum disorder, and have a prorated mental age of at least 11 months.
  - The provider supervising the habilitative therapy must be certified by the Behavioral Analyst Certification Board (BACB) as a Board Certified Behavior Analyst or Board Certified Behavior Analyst Doctorate (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).
  - Benefits will only be paid for services supplemental to any therapy for which your child is eligible through his or her school or school district. No benefits will be paid for therapy provided through the school or school district.
  - The habilitative therapy and treatment plan must get prior authorization from the Fund before treatment begins. The treatment notes and treatment plan must be reviewed by the Fund at least twice a year, and must show that:
    - Your child is demonstrating improvement.
    - You are trained to, and do, participate in the habilitative therapy.
    - You follow the treatment plan.

- **Physical, speech, and occupational therapy**.
- **Hearing examinations**.
- Professional services for **diabetes education** and training for the care, monitoring, or treatment of diabetes provided by a network provider. Non-network services are not covered.
- Professional services for **nutrition counseling** provided by a network provider, up to a total of 4 visits per person each calendar year. Non-network services are not covered.
- **Repair of sound natural teeth** and their supporting structures, if the covered expenses are the result of an injury. Treatment must be received while you are covered under the Fund.
- **Sterilization procedures** for employees and spouses. For female dependent children, FDA-approved sterilization procedures considered preventive healthcare (*see page I-7*) are also covered.
- **Surgical supplies, surgical dressings**, casts, splints, and trusses.
- Treatment of **tumors, cysts and lesions** not considered a dental procedure.
- **Medical foods** if you have an inborn error of metabolism (IEM). *You must get prior authorization for your medical food costs before the Plan will reimburse you.* The Plan will reimburse 100% of your costs for medical foods. To be reimbursed, the medical food must be: (1) ordered by and used under the supervision of a healthcare provider; (2) the primary source of your nutrition; and (3) labeled and used for dietary management of your IEM.
- Reimbursement for **travel, lodging, and meal costs** 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 instead of requiring you to pay yourself and then file for reimbursement.

More details about the benefit are available upon request.

- **Gender reassignment surgery** for individuals with a diagnosis of gender dysphoria and related charges (e.g., laboratory work, x-rays, office visits, etc.). The Plan will cover surgical procedures, including medically necessary corrective surgeries, to change your gender once (for example, if the Plan covers procedures changing your gender from male to female, the Plan will not then pay to change your gender back to male). You must be at least 18 years of age and obtain prior authorization for surgical services.

What's not covered

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

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

- Ambulatory surgical facility fees for procedures normally performed in a provider's office.
- Prescription drugs and medications, other than those used where they are dispensed. Prescription drugs may be covered under the prescription drug benefit starting *on page D-18*.
- 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-18* for information about the prescription drug benefit).
- Cosmetic services.
- 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.
- Unless specifically listed as covered, dental services for or in connection with:
  - 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).

  - Routine care of the teeth and supporting oral tissues, or replacement of natural teeth lost as a result of injury.

- Treatment of temporomandibular joint (TMJ) disorders, craniofacial disorders or orthognathic disorders, unless UNITE HERE HEALTH or its representative provides 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.
- 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.
- Home construction for any reason.
- Private duty nursing care.
- Hearing aids. Hearing aids are covered under the hearing aid benefit shown *on page D-29*.
- 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.
- Except as specifically covered under the Plan, non-healthcare items or services, including but not limited to oral nutrition or supplements, and disposable supplies, such as bandages, antiseptics, and diapers.

Prescription drug benefits

Learn:

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

Hospitality Rx (a subsidiary of UNITE HERE HEALTH) provides pharmacy benefit management services. Hospitality Rx contracts with several organizations to provide specialized administrative services. Benefits are only paid if you buy your prescription drugs at a pharmacy that participates in the network, like CVS. *Not all retail pharmacies are in your pharmacy network.* **Drugs and supplies are FREE at the Health Center pharmacy, including two locations in Pennsylvania!**

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

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

Important Phone Numbers		
If you want to:	**Call:**	**At:**
Find a network pharmacy or ask questions about your benefits	UNITE HERE HEALTH	**(888) 437-3480** www.hospitalityrx.com
Get prior authorization for prescription drugs or to ask which drugs require prior authorization	Hospitality Rx	**(844) 813-3860** www.hospitalityrx.com
Get a free glucometer	FreeStyle *(by Abbott)* *use order code U2L65MBU*	**(866) 224-8892** www.ChooseFreeStyle.com
	One Touch *(by LifeScan)* *use order code 739WDRX01*	**(888) 883-7091** www.OneTouch.orderpoints.com
Order from the mail-order pharmacy	WellDyneRx Home Delivery *(through Hospitality Rx)*	**(844) 813-3860** wellview.welldyne.com
Order from the specialty pharmacy	WellDyne Specialty Pharmacy	**(800) 373-1879** welldynespecialty.com

Free pharmacies

You can get FREE focus formulary prescription drugs and certain over-the-counter (OTC) drugs (with a prescription), up to a 60-day supply, at the UNITE HERE HEALTH—Health Center in Atlantic City and at the free CVS pharmacy locations in Pennsylvania.

UNITE HERE HEALTH—Health Center	**Free CVS Pharmacies at**
1801 Atlantic Avenue, 3rd Floor Atlantic City, NJ 08401 **(609) 570-2400** *(Located in the same building as the Fund office)*	3298 Edgemont Avenue Brookhaven, PA 19015 and 1306 W. MacDade Boulevard Woodlyn, PA 19094

The Health Center and free pharmacy locations are not available to a dependent spouse if the Plan pays secondary to the spouse's other insurance. 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 these CVS locations, the services will not be free.

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-26* for information about what's not covered).

Prescription Drug Benefits—*What You Pay*			
	Per Prescription		
Formulary Prescription Drug Benefits at the UNITE HERE HEALTH - Health Center and free pharmacy locations ***(up to a 60-day supply)***			
Prescription Drugs—*excluding select specialty, select biosimilar, and select brand drugs*	***FREE!***		
Select Specialty and Select Biosimilar Drugs*	25%		
Select Brand Drugs*	50%		
Formulary Prescription Drug Benefits at Network Retail Pharmacies and Mail Order	**Retail Pharmacy** *up to a 34-day supply*	**Mail Order Pharmacy** *up to a 60-day supply*	
Preventive Healthcare Services Drugs—*See page I-7*	$0		
Generic and Some Brand Drugs	$5		
Preferred Drugs	$15		
Non-Preferred Drugs	$30		
Select Specialty and Select Biosimilar Drugs*	Not covered	**Generic**	**Brand**
		$5	25%
Non-Formulary Prescription Drugs and Supplies	Not covered, unless an exception is approved		

**Current pharmacy benefit provider will actively manage and determine drugs in tier. Specialty drugs are only available through the specialty mail order pharmacy or the Atlantic City Health Center. However, if you take specialty medications as part of your HIV treatment plan, you may be able to receive an exception to use your network retail pharmacy instead.*

Drugs and supplies on the formulary are safe, effective, and high-quality. No benefits are paid for drugs not on the formulary unless the Fund approves the drug. Prescription drugs and supplies may be added to or removed from the formulary from time to time.

Use the formulary lookup tool at www.hospitalityrx.org or call Hospitality Rx at **(844) 813-3860** if you or your healthcare provider have questions about which prescription drugs and supplies are on the formulary.

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

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 safety net 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). 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-9*.

What's covered

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

- FDA-approved medications and supplies which can legally be purchased only with a written prescription from a healthcare provider. This includes oral and injectable contraceptives, and drugs mixed to order by a pharmacist, as long as at least one part of the mixed-to-order drug is an FDA-approved prescription drug.
- The following diabetic supplies: insulin, diabetic test strips, control solution for glucometers, disposable syringes and needles, lancets, and lancet devices.
- Prescription and certain over-the-counter preventive healthcare services and supplies, including routine immunizations (*see page I-7*). You must have a prescription for over-the-counter preventive healthcare services and supplies in order for the Fund to pay for these services.

- Vitamins.
- Hormone therapy as long as the hormones are FDA approved and only available by prescription. Prior authorization is required for certain hormone therapy. Hormone therapy for individuals with gender dysphoria is not subject to an age restriction; however, the prior authorization process for individuals under age 18 will include an additional requirement that the treating physician have documentation showing sexual maturity of Tanner stage 2 or more.
- Certain over-the-counter (OTC) drugs, as long as you have a prescription, and as long as you get the drug at the UNITE HERE HEALTH – Health Center or the two free locations in Pennsylvania.

Free glucometers

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

(866) 224-8892 for FreeStyle (by Abbott)
or visit www.ChooseFreeStyle.com
use order code ***U2L65MBU***

(888) 883-7091 for One Touch (by LifeScan)
or visit www.OneTouch.orderpoints.com
use order code 739WDRX01

If you don't want to use one of the Fund's free glucometers, you have to pay the full cost of the glucometer up front. 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-5*).

Safety and cost containment programs for prescription drugs

The Fund provides extra protection through several safety and cost containment programs. These programs may change from time to time, and the prescription drugs or types of prescription drugs that are part of these programs may also change from time to time. You and your healthcare provider can always get the most current information by contacting Hospitality Rx at **(844) 813-3860**, or visiting www.hospitalityrx.org.

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

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

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

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

Pain Management Safety Program

The Fund created the Pain Management Safety Program for you and your dependents to make sure you get care that's safe and effective.

The following special rules apply to you if you've filled a prescription for opioids 3 months in a row:

- You can only fill opioid prescriptions at the Health Center or one of the two free pharmacy locations in Pennsylvania (*see page D-18)*.
- Each time you fill an opioid prescription, you must use the same pharmacy. Hospitality Rx will contact you to help pick your pharmacy.

You only have to fill opioid prescriptions at one of these locations. You can get non-opioid prescriptions at any network pharmacy.

Remember, if you are a spouse with other primary coverage, and the Plan pays secondary to that coverage, you don't have access to the Health Center or free CVS locations in Pennsylvania. This means you won't be able to fill an opioid prescription under this Plan if you are impacted by these rules.

Depending on your prescription, you may also need to get prior authorization before your opioid prescription will be filled. Your doctor must call Hospitality Rx at **(844) 813-3860** for prior authorization.

If you meet one of the exceptions listed below, then you don't have to follow these rules. You can get your opioid prescriptions at any network pharmacy.

- You have a cancer diagnosis, and your opioid prescription is written by your oncologist or oncology provider, or by a Health Center provider.
- You are getting opioids as part of end-of-life care.
- You are getting opioids as part of palliative care treatment or you are in a palliative-care treatment program, and your opioid prescription is written by a board-certified palliative care provider, or by a Health Center provider.

If you have problems filling your opioid prescriptions, please call Hospitality Rx at **(844) 484-4726**.

Call the Fund at **(888) 437-3480** if you have questions or need more information about the pain management safety program. We'll work with you to provide more information about this program, including other non-opioid ways to manage your pain. Some of these options might even work better and have fewer risks and side effects.

Generic prescription drug policy

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

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

The generic prescription drug policy does not apply to certain prescription drugs that need to be closely monitored, or if very small changes in the dose could be harmful. The prescription drugs that are not subject to the generic prescription drug policy change from time to time. You can get up-to-date information by calling Hospitality Rx at **(844) 813-3860**. This rule will also not apply if you get an exception through a safety or cost containment program. Your healthcare provider will need to get prior approval for this exception to apply to your prescription drugs.

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

Prior authorization

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

Step therapy

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

For example, if you need an ARB (angiotensin receptor blocker) to treat high blood pressure, you may first be asked to try a generic version. If the generic version does not work or causes serious side effects, you may be asked to try a brand name version.

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

Case management

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

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

Quantity limits

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

- The amount prescribed by your healthcare professional.
- If you use a retail pharmacy, up to a 34-day supply.
- If you use the UNITE HERE HEALTH—Health Center or one of the free pharmacy locations in Pennsylvania, up to a 60-day supply of your drug.
- If you use the non-specialty mail-order pharmacy, up to a 60-day supply.
- The amount allowed under any safety or cost containment program. For example, most prescriptions filled through the specialty mail-order pharmacy will be limited to less than a 34-day or 60-day supply.

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

Exceptions to the standard quantity limits

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

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

Early refills

You generally cannot refill a prescription earlier than allowed under any applicable guidelines, safety or cost containment programs, or other Plan rules. In some cases, you may be able to refill a prescription sooner than is usually allowed. For example, you may get an early refill if:

- You show you will be out of the country when you will run out of a prescription drug. If your early refill is approved, you can get up to a 60-day supply for the applicable retail drug copay.

- Your drug is lost or stolen.
- You run out of a drug too soon because you misunderstood the instructions or accidentally used too much. You will be able to get one such early refill per lifetime for that drug.

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

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

Mail-order pharmacy

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

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

WellDyneRx Home Delivery
(844) 813-3860
wellview.welldyne.com

Specialty pharmacy

You must use the specialty pharmacy to purchase all specialty prescription drugs or visit the on-site pharmacy at the UNITE HERE HEALTH—Health Center. The specialty pharmacy provides prescription drugs for certain chronic or difficult-to-treat health conditions, such as multiple sclerosis (MS) or Hepatitis C. Specialty prescription drugs often need to be handled differently than other prescription drugs, or they may need special administration or monitoring. However, if you take specialty medications as part of your HIV treatment plan, you may be able to receive an exception to use your network retail pharmacy instead. The specialty drug copays will apply, even if you get an exception. You can get a copy of the form you must fill out to request this exemption by calling HospitalityRx at **(844) 484-4726**.

Using the specialty pharmacy gives you access to pharmacists and other healthcare providers who specialize in helping people with your condition. The specialty pharmacy staff can help make sure your prescription gets refilled on time, and can answer questions about your prescription drugs and your condition.

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

What's not covered

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

- Prescription drugs that have not been approved by the FDA. However, the Fund or its designee may cover prescription drugs not approved by the FDA in certain situations. You or your healthcare professional may ask for an exception through the prior authorization program.
- Drugs or supplies that are not listed on the formulary, unless the Fund or its designee gives prior approval for the drug or supply. You must try all medically appropriate formulary alternatives before you can get a formulary exception.
- Drugs or medications used, consumed or administered at the place where dispensed, other than immunizations. (These drugs may be covered under your medical benefits. *See page D-9*)
- Prescriptions or refills in amounts over the quantity limits *(see page D-24).*
- Vitamins, dietary supplements, or dietary aids, except those specifically included on the formulary.
- Drugs used for cosmetic reasons, including Rogaine and other drugs to prevent hair loss.
- Human growth hormone, except to treat emaciation due to AIDS.
- Drugs or covered supplies not purchased from a network pharmacy.
- Birth control devices and implants other than over-the-counter FDA-approved female contraceptive drugs, devices, or supplies for which you have a prescription.
- Non-sedating antihistamines or histamine receptor blockers, except as covered at the UNITE HERE HEALTH – Health Center or at one of the free pharmacy locations.
- Fertility drugs.
- Glucometers, other than those the Fund gives you for free. You may be able to get a glucometer through the medical benefits if you do not want one of the free ones, but you will usually have to pay part or all of the cost.
- Weight control drugs, unless for the treatment of morbid obesity under the direct supervision of a healthcare provider, and authorized in writing by the Fund or its designee.
- Preventive healthcare services and supplies that you must get through the medical benefits.

- Drugs that require review under a safety or cost containment program (such as a drug that requires prior authorization, or a drug subject to the step therapy program) if that safety or cost containment program is not followed, or does not approve the drug.
- New-to-market prescription drugs until the Fund or its designee has reviewed and approved the prescription drug.
- Specialty prescription drugs if you do not use the specialty pharmacy or the UNITE HERE HEALTH-Health Center. This exclusion does not apply to HIV/AIDS drugs if you are approved to use a network retail pharmacy for these drugs.
- Over-the-counter drugs not specifically listed on the formulary, or received through the UNITE HERE HEALTH-Health Center or one of the free pharmacies.
- High-cost "me too" drugs, unless the Fund or its designee approves the drug for purchase. "Me-too" drugs usually have only very small differences in how they work, but are considered "new" drugs with no generic equivalent. Often, the manufacturer charges high prices for these drugs even though there are other drugs available that work just as well for a lower cost. You can find out if a "me too" drug is covered by contacting Hospitality Rx.
- Diagnostics (drugs used to help in the process of diagnosing certain medical conditions).
- Drugs, medications, or supplies that are not covered under the Fund's or Fund's designee's claims processing guidelines or any other internal rule, including, but not limited to any national guidelines used by the medical community.
- Medical foods (medical foods may be covered under the medical benefit—*see page D-9*).

Hearing aid benefit

Learn:

- What the Plan pays.
- What types of services and supplies are not covered.

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
Maximum benefit per 24-month benefit period 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-9*).
- 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 are covered.
- What types of dental care are not covered.

UNITE HERE HEALTH (the Fund) 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 the Fund at **(888) 437-3480** if you want to enroll other dependents in your dental plan.

Dental Benefits—*What You Pay*		
	BeneCare Network Providers	**Non-Network Providers**
Deductible	$0	
Maximum Benefit for Dental Treatment *(non-orthodontic)*	$1,500 per person every benefit year *(includes up to $500 for non-network services)*	
Lifetime Maximum Benefit for Orthodontic Treatment	$1,000 per child	
Description of Services	**What You Pay for Covered Dental Care**	
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-37 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**
members.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-34* for more 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.

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.
- Recognized by most dentists to be appropriate based on current national 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, crowns, 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-37*.
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.

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.

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	BeneCare Network Providers	Non-Network Providers
Description of Services	**What You Pay**	**Maximum the Plan Pays** *(You pay amounts over the maximum benefit)*
Diagnostic & Preventive Services		
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

Dental Benefits	BeneCare Network Providers	Non-Network Providers
Description of Services	**What You Pay**	**Maximum the Plan Pays** *(You pay amounts over the maximum benefit)*
Restorative Services		
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
Recement Crown	$0	$16
Endodontics		
Root Canal Therapy *(excluding final restorations)*		
Two Canals	$110	$181
Three Canals	$150	$209
Oral Surgery		
Simple Extraction, single tooth	$0	$25
Surgical Extraction		
Removal of erupted tooth	$0	$29
Removal of impacted tooth, partially bony	$60	$72
Prosthodontics		
Removable Dentures, complete upper or lower	$105	$170
Fixed Bridgework *(bridge pontics)*		
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.

UNITE HERE HEALTH (the Fund) has contracted with Davis Vision to administer the vision benefits to you and your dependents. This part of the Summary Plan Description (SPD) summarizes your vision benefits.

Vision Benefits — What You Pay		
Description of Services *Covered once every 12 months, except as noted below*	**Davis Vision Providers**	**Non-Network Providers**
Eye Exam	$10 copay	Plan benefits limited to persons residing outside the network coverage area and to $100 for any combination of routine services, including materials *(maximum benefit does not apply to exams for children under age 5)*
Frames—*covered every 24 months*	$0 for Davis Collection Fashion or Designer frames $0 for Non-Davis Collection frames; Plan benefits are limited to $30	
Lenses	$0	
Elective Contacts *(instead of glasses)*	$45 copay for Davis Collection contacts $0 for Non-Davis Collection contacts; Plan benefits are limited to $100 *(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
(Register for detailed information)

At your appointment, tell them you have Davis Vision. You don't need an ID card. If you'd like a card, you can request one at www.davisvision.com. (You must register for an account.)

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).

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, 2022, the next time the Plan would cover your exam and lenses would be July 1, 2023, and frames would be covered again starting July 1, 2024.

- Exams (including dilation when professionally indicated).
- Lenses, including single vision, bifocal lenses, trifocal lenses, or lenticular lenses.
- Frames.
- Standard contact lenses (soft, daily-wear, disposable, or planned replacement) in lieu of glasses.
  - Disposable and planned replacement contacts will be supplied in quantities determined by Davis Vision.
- Medically necessary contacts, with prior authorization from Davis Vision.

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.

Life and AD&D benefits

Learn:

- What your and your dependents' 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 these benefits if you die.
- Additional benefits under the life and AD&D benefit.

AD&D benefits are for employees only. Dependents are not eligible for AD&D benefits.

Life and AD&D Benefit — What the Plan Pays	
Life Insurance	
Employees	$20,000
Dependents	
Spouse	$5,000
Child — live birth up to age 6 months	$3,000
Child — age 6 months and older	$5,000
Accidental Death and Dismemberment (AD&D) Insurance	
Employees Only	$20,000

Life insurance and AD&D insurance benefits are provided under an insured group insurance policy issued to UNITE HERE HEALTH by Dearborn Life Insurance Company, branded as Blue Cross and Blue Shield of Illinois (BCBSIL). The terms and conditions of your and your dependents' life and AD&D insurance coverage are contained in a certificate of insurance. The certificate describes, among other things:

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

The terms of the certificate are summarized below. If there is a conflict between this summary and the certificate of insurance, the certificate governs. You may request a copy of the certificate of insurance free of charge by contacting UNITE HERE HEALTH.

Life insurance benefit

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

In addition, a life insurance benefit is available for your enrolled dependents. The amount of the benefit is shown in the table above. If your dependent dies while he or she is eligible for coverage (or within the 31-day period immediately following the date coverage ends), the amount of the life insurance will be paid to you. Dependents do not get AD&D benefits or the terminal illness benefit.

Continuation if you become totally disabled

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

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

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

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

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

Converting to individual life insurance coverage

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

Premiums for converted coverage are based on your age and the amount of insurance you select. Conversion coverage becomes effective on the day following the 31-day period during which you could apply for conversion if you pay the required premium before then. If you think you might want to convert your group life insurance to an individual policy you pay for yourself, go to www.uhh.org/conversion to get the "Application to Convert Group Life Insurance" form. You can also get the form by calling Member Services. For more information about conversion coverage, contact BCBSIL.

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

Terminal illness benefit

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

Accidental death & dismemberment insurance benefit

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

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

AD&D exclusions

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

- Any disease, or infirmity of mind or body, and any medical or surgical treatment thereof.
- Any infection, except an infection of an accidental injury.
- Any intentionally self-inflicted injury.
- Suicide or attempted suicide while sane or insane.

- While you are under the influence of narcotics or other controlled substances, gas or fumes.
- A direct result of your intoxication.
- Your active participation in a riot.
- War or an act of war while serving in the military, if you die while in the military or within 6 months after your service in the military.

See your certificate for complete details.

Additional accidental death & dismemberment insurance benefits

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

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

Naming a beneficiary

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

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

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

Additional services

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

Travel Resource Services

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

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

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

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

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

Beneficiary Resource Services

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

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

John Wilhelm Scholarship

Learn:

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

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

Who is eligible

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

You must meet the following requirements:

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

How to apply

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

Scholarship decisions

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

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

Other important information

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

Appeal rights

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

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

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

General exclusions and limitations

Learn:

- The types of care not covered by the Plan.

General exclusions and limitations

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

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

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

- 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 you, your spouse or child is not required to pay.
  - Which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish, or municipal hospital when there is no legal requirement to pay for such treatment, services, or supplies.
- Any charge which is more than the Plan's allowable charge *(see page I-2)*.
- Experimental treatment *(see page I-4)*, or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH.
- Any expense or charge for failure to appear for an appointment as scheduled, or charge for completion of claim forms, or finance charges.
- Any treatment, services, or supplies provided by an individual who is related by blood or marriage to you, your spouse, or your child, or who normally lives in your home.
- Any treatment, services, or supplies purchased or provided outside of the United States (or its Territories), unless for a medical emergency. The decision of the Trustees in determining whether an emergency existed will be final.

- Any charges incurred for treatment, services, or supplies as a result of a declared or undeclared war or any act thereof; or any loss, expense or charge incurred while a person is on active duty or in training in the Armed Forces, National Guard, or Reserves of any state or any country.
- Any injury or sickness resulting from participation in an insurrection or riot, or participation in the commission of a felonious act or assault.
- Any expense greater than the Plan's maximum benefits, or any expense incurred before eligibility for coverage begins or after eligibility terminates, unless specifically provided for under the Plan.
- Preventive medicine, unless specifically included as covered services.
- Any charges incurred for education or training, unless specifically included as covered services.
- Any charges denied for any treatment, services, or supplies requiring prior authorization, when this mandatory program is not used as required.
- Any elective procedure (other than sterilization or abortion, or as otherwise specifically stated as covered) that is not for the correction or cure of a bodily injury or sickness.
- Treatment for or in connection with infertility, other than for diagnostic services.
- Any expense or charge by a rest home, old age home, or a nursing home.
- Any charges incurred while you are confined in a hospital, nursing home, or other facility or institution (or a part of such facility) which are primarily for education, training, or custodial care.
- Weight loss programs or treatment, except to treat morbid obesity if the program is under the direct supervision of a healthcare provider, or as specifically stated as covered (for example, diabetes education, nutrition counseling, or preventive healthcare services).
- Any smoking cessation treatment, drug, or device to help you stop smoking or using tobacco, other than preventive healthcare services or as otherwise stated as covered.
- Massage therapy, rolfing, acupressure, or biofeedback training.
- Naturopathy or naprapathy.
- Athletic training.
- 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.
- Services, treatment, or supplies for Christian Science.
- 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, unless federal surprise billing protections apply (*see page I-2)*.
- A service or item that is not covered under the Plan's claims processing guidelines or any other internal rule, guideline, protocol or similar criterion that the Plan relies upon.
- Charges or claims incurred as a result, in whole or in part, of fraud, false information, or misrepresentation.

Coordination of benefits

Learn:

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

These coordination of benefit provisions only apply to the medical benefits. 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 trusteed plans, employee organization benefit plans, or employer organization benefit plans.
- Any coverage under governmental programs or provided by any statute, except Medicaid.
- Any automobile insurance policies (including but not limited to "no fault" coverage containing personal injury protection (PIP)).

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

Which plan pays first

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

Order of payment

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

- 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 that covers a person (or dependent of such person) who is laid off, retired, or enrolled in continuation coverage offered in accordance with federal or state law will be secondary to active coverage, including self-paid coverage.
- Continuation coverage offered in accordance with federal or state law, such as COBRA, will be secondary to any non-continuation coverage, subject to the rule for military or government plans, below.
- Generally, military or government coverage will be secondary to all other coverage.
- With respect to plans that have COB and cover dependent children under age 18 whose parents are not separated, plans that cover the parent whose birthday falls earlier in a year pay before plans covering the parent whose birthday falls later in that year.
- With respect to plans that have COB and cover dependent children under age 18 whose parents are separated or divorced:
  - Plans covering the parent whose financial responsibility for the child's healthcare expenses is established by court order pay first.
  - If there is no court order establishing financial responsibility, the plan covering the parent with custody pays first.
  - If the parent with custody has remarried and the child is covered as a dependent under the plan of the stepparent, the order of payment is as follows:
    - The plan of the parent with custody.
    - The plan of the stepparent with custody.
    - The plan of the parent without custody.
- With respect to plans that have COB and cover adult dependent children age 18 and older under both parents' plans, regardless of whether these parents are separated or divorced, or not separated or divorced, the plan that covers the parent whose birthday falls earlier in a year pays before the plan covering the parent whose birthday falls later in the year, unless a court order requires a different order.
- With respect to plans that have COB and cover adult dependent children age 18 and older under one or more parents' plan and also under the dependent child's spouse's plan, the plan that has covered the dependent child the longest will pay first. In the event the dependent child's coverage under the spouse's plan began on the same date as either or both parents' plans, the order of benefits shall be determined by applying the birthday rule to the dependent child's parent(s) and spouse.

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

COB, prior authorization, and referrals

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

I am an active employee

Generally, the Plan pays primary to Medicare for you and your dependents. However, there is an exception if you or your dependent has end-stage renal disease (see below).

If you are also enrolled in Medicare, Medicare will pay secondary. This means Medicare may pay for some of your expenses after the Plan pays its benefits.

I am an active employee, but I have, or my dependent has, end-stage renal disease (ESRD)

For the first 30 months you (or your dependent) are eligible for Medicare because of ESRD, the Plan pays primary, and Medicare pays secondary.

Medicare will pay primary for people with ESRD, regardless of their age, beginning 30 months after you become eligible for Medicare because of ESRD. The Plan pays secondary, whether or not you (or your dependent) have enrolled in Medicare.

Your ESRD Medicare coverage will usually end, and the Plan's normal coordination rules will apply again:

- 12 months after the month you stop dialysis treatments; or
- 36 months after the month you have a kidney transplant.

If you (or your dependent) have ESRD, you should enroll in Medicare to avoid getting billed for things Medicare will cover.

I have COBRA coverage or retiree coverage

If you and your dependents have COBRA coverage or retiree coverage, and you (or your dependent) are eligible for Medicare, the Plan pays secondary to Medicare whether or not you (or your dependent) enroll in Medicare. The Plan won't pay amounts that can be paid by Medicare.

If you have retiree or COBRA coverage, and you do not enroll in both Medicare Part A (Hospital Benefits) and Part B (Doctor's Benefits) when you are 65, you will have to pay 100% of the costs that Medicare would have paid.

How to get help with Medicare

Get help enrolling in Medicare, or get answers about Medicare, by:

- Calling **(800) 772-1213**.
- Going online to www.SocialSecurity.gov.
- Contacting your local Social Security office.

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.
- Services of a non-network healthcare provider when the network doesn't have a provider in the required specialty.

Subrogation

Learn:

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

The Plan's right to recover payments

When injury is caused by someone else

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

Typical examples include injuries sustained:

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

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

Statement of facts and repayment agreement

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

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

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

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

Settling your claim

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

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

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

Although UNITE HERE HEALTH expects full reimbursement, there may be times when full recovery is not possible. The Trustees may reduce the amount you must repay if special circumstances exist, such as the need to replace lost wages, ongoing disability, or similar considerations.

When your claim settles, if you believe the amount UNITE HERE HEALTH is entitled to should be reduced, send your written request to:

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

Eligibility for coverage

Learn:

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

You establish and maintain eligibility by working for an employer required to make contributions to UNITE HERE HEALTH on your behalf. There may be a waiting period before your employer is required to begin making those contributions. You may also have to satisfy other rules or eligibility requirements before your employer is required to contribute on your behalf. Any hours you work during a waiting period or before you meet all of the eligibility criteria before your employer is required to begin making contributions for you do not count toward establishing your eligibility under UNITE HERE HEALTH.

Generally, the rules shown in this SPD assume you are not required to contribute toward the cost of coverage for yourself or your dependents. However, depending on the terms of your Collective Bargaining Agreement (CBA), you may be required to pay a portion of the insurance premium, and you or your dependents may have additional special enrollment rights.

If you have any questions about when your employer will begin making contributions for you or if you are required to contribute toward the cost of coverage, talk to your employer or union representative.

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

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

Who is eligible for coverage

Employees

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

- You work for an employer who is required by a Collective Bargaining Agreement (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. Your dependents' coverage cannot start before your coverage starts. You cannot decline coverage for yourself and sign up your dependents.

You can add dependents after your coverage starts. See *"When dependent coverage starts"* starting *on page G-10* for more information.

You must sign up any dependent you want covered by the Plan. 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.

If you don't sign up your dependent, the Plan will not pay benefits for that person.

Who your dependents are

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

- Your legal spouse who meets the Plan's additional requirements.
- 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 any of the following:
  - Biological children.
  - Step-children.
  - Adopted children or children placed with you for adoption, if you are legally responsible for supporting the children until the adoption is finalized.
  - Children for whom you are the legal guardian or for whom you have sole custody under a state domestic relations law.

- Children entitled to coverage under a Qualified Medical Child Support Order.

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

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

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

You must provide proof of the mental or physical handicap within 30 days after the date coverage would end because the child becomes age 26. The Fund may also require you to provide proof of the handicap periodically. Contact the Fund for more information on how to continue coverage for a child with a serious handicap.

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Enrollment requirements

Employees

Once you become eligible, your coverage is automatic. However, you and your employer must provide the Fund with any required information before benefits will be paid on your behalf.

Dependents

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

In order to enroll your dependents, you must provide any requested information about them to UNITE HERE HEALTH. You can enroll your dependents at any time, but the date your dependent's coverage begins will be determined by the date you enroll your dependent 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 for each of your dependents:

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

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

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

Eligibility

When your coverage begins (initial eligibility)

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

- **Work period** means a 6-calendar month period 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 in each month and a total of at least 720 hours.
- **Lag period** means the 2-calendar month period between the end of a work period and the beginning of the corresponding coverage period.
- **Coverage period** means the calendar month you get coverage for benefits (based on the related work period).

Example: Establishing Initial Eligibility		
Work Period	**Lag Period**	**Coverage Period**
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 continues through the entire month of February.

Continuing eligibility

Once you establish eligibility, you continue to be eligible as long as you are credited with the required number of hours during the corresponding work period and contributions continue to be required on your behalf.

For purposes of continuing eligibility:

- **Work period** means a calendar month for which you are credited with at least 120 hours 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 you get coverage for benefits (based on the related 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 for December, your coverage continues during March. A contribution and credit for 120 hours 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 or by calling the Fund. Follow the instructions on the form to give the completed form to UNITE HERE HEALTH by mail, fax, or in-person. You can also submit your request through the member portal at www.uhh.org/member. When you submit your request 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.

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 or for which you made a COBRA payment. 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/PTO hours and hours for New Jersey sick leave reported by the employer, but does not include self-pay, FMLA, or disability credit hours. However, this 300-hour requirement won't apply during:

- the first 12 months from the date you first become eligible under this Plan Unit, or
- the 12 months from the date you reestablish eligibility by again satisfying the initial eligibility rules (see the *"Reestablishing eligibility"* section),

The amount of self-payment required is the difference between 125 hours and the actual hours you were credited with for the 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 reestablish eligibility.

If you meet certain requirements, you may also be able to make a self-payment for a work period during which you lose health coverage under your spouse's plan because of divorce or because your spouse loses his or her coverage. If you think this applies to you, call the Fund to see if you qualify.

Self-payments can be made on the member portal at www.uhh.org/member or by calling the Fund at **(888) 437-3480.** You can also mail your self-payment. Contact the Fund for more details.

Self-payments during remodeling or restoration

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

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

Self-payments during a strike

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

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

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

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-7*) 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 provide acceptable proof of your total disability to the Fund.

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, the maximum number of disability credit hours allowed during any one 12-month period is 375 hours (3 months).

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

The Plan does not provide benefits for disabilities that are job-related or for which you are entitled to benefits under workers' compensation (*see page I-12*). Disability credit hours are only used to continue your eligibility. Contact the Fund if you become disabled and might be eligible to get disability credit hours.

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 your dependents before the Plan will pay benefits *(see page G-4)*.

If you enroll dependents when you become initially eligible

Coverage for your dependents begins the same time yours does, as long as you satisfactorily enroll your dependents within 60 days of the date your coverage initially 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:

- Termination of other health coverage you (or your dependent) had when you previously became eligible for coverage (or your dependent first became eligible for coverage). If your (or your dependent's) other coverage was COBRA, you have a special enrollment right only if you (or your dependent) have exhausted the COBRA maximum continuation period.
- Your marriage.
- The birth of your child.
- The adoption or placement for adoption of a child under age 26.

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

Termination of coverage

Learn:

- When your coverage and your dependents' coverage ends.

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

If you (the employee) are absent from covered employment because of uniformed service, you may elect to continue healthcare coverage under the Plan for yourself and your dependents for up to 24 months from the date on which your absence due to uniformed service begins. For more information, including the effect of this election on your COBRA rights, contact UNITE HERE HEALTH at **(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 corresponding to the last work period for which your employer was required to make a contribution on your behalf, and you were credited with the minimum number of hours required to maintain eligibility.
- 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.

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

When dependent coverage ends

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

- The date the Plan is terminated.
- Your (the employee's) coverage ends.
- The dependent enters any branch of the uniformed services.
- The last day of the month in which your dependent no longer meets the Plan's definition of a dependent (*see page G-3*).
- The date your (the employee's) eligibility would have terminated had you not died.

You may also ask the Fund to stop covering your dependent (or dependents). Contact the Fund at **(888) 437-3480** for more information about how to stop covering a dependent, or how to re-enroll a dependent if you change your mind.

The effect of severely delinquent employer contributions

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

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

Special termination rules

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

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

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

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

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

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

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

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

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

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

Certificate of creditable coverage

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

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

Reestablishing eligibility

Learn:

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

Portability

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

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

If you are covered by an Atlantic City Plan Unit (Plan Unit 102A or 202), and go to work for an employer participating in the other Atlantic City Plan Unit, you will become eligible under the new Plan Unit as follows:

- If you start working for the new employer less than 12 consecutive month after your termination of employment with your original employer, you will become eligible under the new Plan Unit according to that Plan Unit's continuing eligibility rules.
- If you start working for the new employer 12 or more consecutive months after your termination of employment with your original employer, you will become eligible under the new Plan Unit according to that Plan Unit's initial eligibility rules.

Family and Medical Leave Act (FMLA)

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

The effect of uniformed service

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

Reestablishing eligibility lost for other reasons

Reestablishing eligibility for employees

If you lose eligibility, and your loss of eligibility is 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 *(see page G-5).*

However, if you are reestablishing eligibility during the period of January 1, 2021 through December 31, 2022, you can use the Plan's continuing eligibility rules to reestablish eligibility as long as your loss of eligibility is less than 24 months. If your loss of eligibility lasts for 24 months or more you must again satisfy the Plan's initial eligibility rules.

Reestablishing eligibility for dependents

If dependent coverage terminates because you lose eligibility for reasons other than termination of employment, dependent coverage will be reestablished when your coverage is reestablished.

COBRA continuation coverage

Learn:

- How you can make payments to continue your coverage.

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

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

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

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

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, it will determine if you or your dependents are entitled to COBRA continuation coverage.

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

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

You must complete a COBRA continuation coverage election form and submit it within 60 days from the later of the following dates:

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

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

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

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

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To qualify for this special extended COBRA Coverage, the individual must send (or bring) to the Fund Office the Social Security disability determination before the initial 18 months of continuation coverage expires. After the Plan receives a copy of the disability determination, you will be notified of any increase in cost required to continue the COBRA Coverage for the extended period (the period between 18 and 29 months).

Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

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

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

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

When will COBRA continuation coverage end?

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

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

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

Are there other coverage options besides COBRA continuation coverage?

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

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period,

you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information:

UNITE HERE HEALTH
Attn: COBRA Department
P. O. Box 6557
Aurora, IL 60589-0557
(888) 437-3480

Claim filing and appeal provisions

Learn:

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

Filing a benefit claim

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

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

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

- Diagnoses.
- Dates of service(s).
- Identification of the specific service(s) furnished, 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 benefits may require a certified copy of the death certificate. All claims for benefits must be made as shown below. If you need help filing a claim, contact the Fund at **(888) 437-3480**.

Medical/surgical (including hearing aids) and mental health/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 Blue Cross and Blue Shield of New Jersey
P. O. Box 1219
Newark, NJ 07101-1219

All claims for treatment furnished outside of New Jersey must be mailed to the local Blue Cross Blue Shield plan where you were treated.

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. If you need help filing a claim, contact the Fund at **(888) 437-3480**.

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

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

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

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 or by calling **(800) 999-5431**.

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

All other claims
All life or AD&D claims should be mailed to UNITE HERE HEALTH. All claims, including health care claims, dental claims, vision claims, or prescription drug claims, denied because you are not eligible, should also be mailed to UNITE HERE HEALTH.

UNITE HERE HEALTH
P.O. Box 6020
Aurora, IL 60598-0020
(888) 437-3480

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

Deadlines for filing a benefit claim

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

Deadline for filing a claim	
Type of claim	**Deadline to file**
Dental claims	No later than 11 months (335 days) after the date the services were received
Vision claims	365 days following the date the claim was incurred
Life insurance	Within a reasonable amount of time
AD&D insurance	• Written *notice* must be received within 31 days of loss (or as soon as possible). • Written *proof* of loss must be received within 90 days of loss (or as soon as possible). Other deadlines may apply to your additional AD&D insurance benefits—your insurance certificate provides more information.
All other claims—Including healthcare, mental health/ substance abuse, and prescription drug claims	18 months following the date the claim was incurred

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

Individuals who may file a benefit claim

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

Who is an authorized representative?
You may give someone else the authority to act for you to file a claim for benefits or appeal a claim denial. If you would like someone else (called an "authorized representative") to act for you, you and the person you want to be your authorized representative must complete and sign a form acceptable to the Fund. Call UNITE HERE HEALTH to obtain a form and submit it to:

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

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

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

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

Your authorized representative may act for you until the earlier of the following dates:

- The date you tell UNITE HERE HEALTH, either verbally or in writing, that you no longer want the authorized representative to act for you.
- The date a final decision on your appeal is issued.

Determination of claims

Post-service healthcare claims not involving concurrent care decisions
You will be notified of the decision within a reasonable period of time appropriate to your medical circumstances, but no later than 30 days after getting your claim. In general, benefits for medical/surgical services will be paid to the provider of those services.

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

Concurrent care decisions
If your ongoing course of treatment has been approved, any decision to reduce or terminate the benefits payable for that course of treatment is considered a denial of your claim. (If the Plan is amended or terminated, the reduction or termination of benefits is not a denial).

For example, if you are approved for a 30-day stay in a skilled nursing facility, but your clinical records on day 20 of your stay show that you only need to stay a total of 25 days, the approval for your skilled nursing facility stay may be changed from 30 days to 25 days. The final 5 days of your original 30-day stay will not be covered, and are considered a denial of your claim.

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

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

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

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

Rules for prior authorization of benefits

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

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

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

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

If you don't follow the rules for requesting prior authorization, you will be given notice how to file such a request. This notice will be provided within 5 days (24 hours in case of an urgent care claim) of the failure.

Special rules for decisions involving urgent concurrent care

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

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

If a request for prior authorization is denied

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

Appealing a benefit prior authorization denial

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

If a benefit claim is denied

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

Life and AD&D claims

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

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

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. You also have the right to file a consumer complaint with the New Jersey Department of Banking and Insurance by calling **(609) 292-5316** or by visiting www.state.nj.us/dobi/enfcon.html.

Appealing claim denials (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 prior authorization denials and continuity of care application denials

First level of appeal

All appeals for claims denied under the prior authorization program (prior authorization denials, denials based on retrospective review, or extensions of treatment beyond limits previously approved) or denials of continuity of care applications (*see page D-5*) must be sent within 12 months of your receipt of the claim denial to:

For denials issued through eviCore:

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

For all other denials:

Horizon Blue Cross and Blue Shield of New Jersey
P.O. Box 317
Newark, NJ 07101-1219

Second level of appeal

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

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

Two levels of appeals for prescription drug claim denials

First level of appeal

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

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

Second level of appeal

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

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

John Wilhelm Scholarship benefits: one level of appeal

If you or your dependent(s) do not get the scholarship benefit because you do not meet the Fund eligibility requirement as described *on page D-52*, you may appeal the denial within 60 days of receiving the denial notice to:

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

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

All other claims: one level of appeal

If you disagree with all or any part of a claim denial under the vision benefit, or post-service healthcare claims, 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 date you receive notice of the claim denial to:

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

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

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

Appeals involving urgent care claims

If you are appealing a denial of benefits that qualifies as a request for emergency treatment/urgent care, you can orally request an expedited (accelerated) appeal of the denial by calling:

- **(630) 699-4372** for urgent medical appeals.
- **(844) 813-3860** for urgent prescription drug appeals.

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

Appeals under the sole authority of the plan administrator

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

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

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

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

Review of appeals

During review of your appeal, you or your authorized representative are entitled to:

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

- Information identifying the medical or vocational experts whose opinion was obtained on behalf of UNITE HERE HEALTH in connection with the denial of your claim. You are entitled to this information even if this information was not relied on when your appeal was denied.
- Designate someone to act as your authorized representative (*see page H-4* for details).

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

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

Notice of the decision on your appeal

You will be notified of the decision on your appeal within the following time frames, counted from the reviewing entity's receipt of your appeal:

	Emergency Treatment/ Urgent Care	Prior Authorization	All Other Healthcare Claims
Subject to one level of appeal	As soon as possible not later than 72 hours	Within a reasonable time period, but not later than 15 days	Within a reasonable time period, but not later than 60 days
Subject to two levels of appeal	As soon as possible but not later than 72 hours for both levels of appeal combined	Within a reasonable time period, but not later than 15 days for each level of appeal	Within a reasonable time period, but not later than 30 days for each level of appeal

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

If your appeal is denied, you will be provided with a written notice of the denial which includes all of the information required by federal law, including a description of the Plan's external review procedures (where applicable), how to appeal for external review, and the time limits applicable to such procedures.

Independent external review procedures

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

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

- You must have been eligible for benefits at the time you incurred the medical expense.
- Your claim denial must involve a medical judgment, claims subject to federal no surprises billing protections, 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 commence your lawsuit within this 12-month time frame, you will permanently and irrevocably lose your right to challenge the denial in court or in any other manner or forum. This 12-month rule applies to you and to your beneficiaries and any other person or entity making a claim on your behalf.

Definitions

Learn:

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

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

Allowable charges

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

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

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

Copay or copayment

A fixed amount (for example, $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.)

Your medical copays and your prescription drug copays apply toward your safety net out-of-pocket limit (*see page D-9 and D-20*).

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.

Your medical coinsurance and your prescription drug coinsurance applies toward your out-of-pocket limits (*see page D-9 and D-20*).

Cosmetic services

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

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

Medically necessary gender reassignment services are not cosmetic services *(see page D-14)*.

Covered expense

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

Deductible

The amount you owe for covered expenses before benefits are payable on your claims, if applicable.

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

Durable medical equipment (DME)

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

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

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

Emergency medical treatment

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

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

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

Experimental, investigational, or unproven (experimental or investigational)

Experimental, investigational, or unproven procedures or supplies are those procedures or supplies which are classified as such by agencies or subdivisions of the federal government, such as the Food and Drug Administration (FDA) or the Office of Health Technology Assessment of the Centers for Medicare & Medicaid Services (CMS); or according to CMS's Medicare Coverage Issues Manual. Procedures and supplies that are not provided in accordance with generally accepted medical practice, or that the medical community considers to be experimental or investigative will also meet the definition of **experimental, investigational, or unproven,** as does any treatment, service, and supply which does not constitute an effective treatment for the nature of the illness, injury, or condition being treated as determined by the Trustees or their designee.

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

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

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

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

Injuries and sicknesses

Benefits are only paid for the treatment of **injuries** or **sicknesses** that are not related to employment (non-occupational **injuries** or **sicknesses**).

Sickness also includes mental health conditions and substance abuse, pregnancy and pregnancy-related conditions, including abortion, and 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 Shield's 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-10*.

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. These limits are called out-of-pocket limits. Once your out-of-pocket costs for covered expenses meets the out-of-pocket limit, this Plan will usually pay 100% for your (or your family's) covered expenses during the rest of that 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.

The following amounts do not count toward your basic or safety net out-of-pocket limits and will not be paid at 100%, even if you have met your out-of-pocket limit(s) for the year:

- Amounts you pay for services and supplies that are not covered.
- Amounts over the allowable charge.
- Care or treatment you receive after the Plan's maximum benefit.
- Amounts you pay in addition to your prescription drug copay when you choose a brand name drug when a generic equivalent is available
- Non-network care or treatment, except for situations in which the non-network provider is considered a network provider (*see page D-4*).

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.)

Plan Document

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

Preventive healthcare

Under the medical and prescription drug benefits, **preventive healthcare** is covered 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).
- Routine immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention.
- 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.

Certain **preventive healthcare** may be covered more liberally (for example, more frequently or at earlier/later ages) than required. The Plan also considers routine PSA screening tests (prostate-specific antigen tests) and preventive vitamin D 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 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-45 for the definition of total disability applicable to the extension of the life insurance benefit.

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 dependent's coverage.

What benefits are provided through insurance companies?

This Plan provides the following benefits on a self-funded basis; however the Plan may contract with other organizations to help administer certain benefits. Self-funded means that none of these benefits are funded through insurance contracts. Benefits and associated administrative expenses are paid directly from UNITE HERE HEALTH.

- Medical benefits. Horizon Blue Cross Blue Shield (Horizon) provides prior authorization and other utilization review services, case management, and chronic condition management. Horizon contracts with eviCore to manage prior authorization for certain diagnostic imaging, cardiology, radiation therapy, and genetic testing services, with Magellan Rx Management for prior authorization of medical injectables, and with CareCentrix for prior authorization of durable medical equipment and home infusion services.
- Prescription drug benefits. These benefits are administered by Hospitality Rx, LLC, a wholly owned subsidiary of UNITE HERE HEALTH.
- Vision benefits. Vision benefits are administered by Davis Vision.
- Hearing aid benefits.

The following benefits are provided on a fully insured basis. This means that the benefits are funded and guaranteed under group policies underwritten by an entity other than UNITE HERE HEALTH.

- Dental benefits through The Atlantic Southern Dental Foundation (BeneCare Dental Plans).
- Life insurance and AD&D benefits through Dearborn National (branded as BCBSIL).

Interpretation of Plan provisions

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

For claims subject to the independent dispute resolution process under the federal surprise billing protections, the independent dispute resolution entity has the sole authority to determine the allowable charges for purposes of provider payment. However, the independent dispute resolution

entity has no authority over any other aspect of the Fund's administration, including but not limited to the determination of what benefits are payable and what expenses are covered.

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

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

- Make the final decisions about applications for or entitlement to Plan benefits, including:
  - The exclusive discretion to increase, decrease, or otherwise change Plan provisions for the efficient administration of the Plan or to further the purposes of UNITE HERE HEALTH,
  - The right to obtain or provide information needed to coordinate benefit payments with other plans,
  - The right to obtain second medical or dental opinions or to have an autopsy performed when not forbidden by law;
- Interpret all Plan provisions and associated administrative rules and procedures;
- Authorize all payments under the Plan or recover any amounts in excess of the total amounts required by the Plan.

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

The Plan gives the Trustees full discretion and sole authority to make the final decision in all areas of Plan interpretation and administration, including eligibility for benefits, the level of benefits provided, and the meaning of all Plan language (including this Summary Plan Description). In the event of a conflict between this Summary Plan Description and the Plan Document governing the Plan, the Plan Document will govern.

Restriction of venue

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

Amendment or termination of the Plan

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

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

If UNITE HERE HEALTH is terminated, in whole or in part, or if your Plan, any other Plan Unit or any schedule of benefits is terminated or suspended, no employer, participant, beneficiary or other employee benefit plan will have any rights to any part of UNITE HERE HEALTH's assets. This means that no employer, plan or other person shall be entitled to a transfer of any of UNITE HERE HEALTH's assets on such termination or suspension. The Trustees may continue paying claims incurred before the termination of UNITE HERE HEALTH or any Plan Unit, as applicable, or take any other actions as authorized by the Trust Agreement. Payment of benefits for claims incurred before the termination of UNITE HERE HEALTH, any Plan Unit, or any schedule of benefits will depend on the financial condition of UNITE HERE HEALTH.

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

Free choice of provider

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

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

Workers' compensation

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

Type of Plan

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

Employer and employee organizations

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

Plan administrator and agent for service of legal process

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

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

Employer identification number

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

Plan number

The Plan Number is 501.

Plan year

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

Remedies for fraud

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

Limited retroactive terminations of coverage allowed

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

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

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

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
members.benecare.com

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

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

Horizon Blue Cross and Blue Shield of New Jersey
3 Penn Plaza East
Newark, NJ 07105
(866) 899-0626
www.horizon.com

Hospitality Rx
P.O. Box 6020
Aurora, IL 60598-0020
(866) 686-0003
www.hospitalityrx.org

UNITE HERE HEALTH
711 North Commons Drive
Aurora, IL 60504-4197
(630) 236-5100
www.uhh.org

UNITE HERE HEALTH – Health Center
1801 Atlantic Avenue, 3rd Floor
Atlantic City, NJ 08401
(609) 570-2400
www.uhh.org

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New Orleans, LA 70119

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