



## Plan Unit 102 (Retirees)



*Atlantic City Casinos — Retiree Drug Coverage*

# Summary Plan Description

*Your Health and Welfare Benefits*



# UNITE HERE HEALTH

## **Summary Plan Description**

### **Atlantic City Casinos—Retiree Drug Coverage Plan Unit 102 (Retirees)**

*Effective September 1, 2017*

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

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# ***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.

### What is UNITE HERE HEALTH?

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

Your coverage is being offered under Atlantic City Casinos—Retiree Drug Coverage Plan Unit 102 (Retirees), which has been adopted by the Trustees of UNITE HERE HEALTH to provide prescription drug benefits through the Fund. Other SPDs explain the benefits for other Plan Units, including the active employee benefits under Plan Unit 102 (Actives).

### 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.
- Limitations and exclusions.
- How to file claims.
- How to appeal denied claims.

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

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

### How do I use my SPD?

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

Read your SPD for important information about what your benefits are (*see page B-1*), 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 prescription drug benefits in the section titled "Prescription drug benefits." If you want to know more about how you become eligible, read the section titled "Eligibility for coverage."

Some terms are defined for you in the section titled "Definitions" starting *on page F-2*. The SPD

will also explain what some commonly used terms mean. When you have questions about what certain words or terms mean, contact the Fund.

# How can I get help?

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

Call the Fund:

- When you have questions about your benefits.
- When you have questions about your eligibility.
- To update your address.
- To request new ID cards.
- To get forms or a new SPD.
- To find out if you reached your benefit lifetime maximum.

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

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

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



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

## Learn:

- ▶ About the UNITE HERE HEALTH—Health Center.
- ▶ How to use network pharmacies to save time and money.
- ▶ Why you should choose generic prescription drugs.

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

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

The Health Center has pharmacy services available at no cost to you, including two extensions of the Health Center in the Philadelphia-area.

- ✓ Visit the Health Center pharmacy at:

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

CVS  
3298 Edgemont Avenue  
Brookhaven, PA 19015

CVS  
1306 W. MacDade Blvd  
Woodlyn, PA 19094

### How do I stay in the network?

- ✓ Benefits are only available when you use network pharmacies. You pay the entire cost when you use a non-network pharmacy.

#### Use network retail pharmacies

You have access to a select national network of participating pharmacies (called the True Choice network) that you must use in order to get benefits for prescription drugs. Not all pharmacies are in the network. For example, **CVS is in your network** while **Walgreens and Wal-Mart are not**.

In Network	Non-Network
CVS Rite Aid Parkway Pathmark Shoprite Jogi Discount Pharmacy	Walgreens Duane Reade USA Drugs Wal-Mart Certain independent local pharmacies

This list changes from time to time. Contact Hospitality Rx at **(844) 813-3860** or go to [www.hospitalityrx.org](http://www.hospitalityrx.org) to find a network pharmacy.

### Get prescriptions delivered to your home through the mail order pharmacy

- ✓ The mail order pharmacy program saves you time by sending medicine straight to your mailbox. No trips to the pharmacy or waiting in line!

If you regularly take prescription drugs, you can sign up to get your drugs in the mail. You can get a 60-day supply delivered to your home.

Call our mail order pharmacy partner, WellDyneRx, at **(844) 813-3860** to learn more.

### Use the specialty drug pharmacy

- ✓ Get specialty drugs at the Health Center or through the Walgreens Specialty Pharmacy.

Specialty drugs treat serious, chronic health conditions like: growth hormone deficiency, hepatitis C, immune deficiency, hemophilia, multiple sclerosis, and rheumatoid arthritis. If you need a specialty drug, you must use the Health Center pharmacy or the Walgreens Specialty Pharmacy. If you don't, no benefits will be paid. The only exception to this rule is for drugs to treat HIV/AIDs.

*The Walgreens Specialty Pharmacy is different from a Walgreens retail pharmacy, which isn't in the network.*

Call Walgreens Specialty Pharmacy at **(877) 647-5807**.

### **Choose generic drugs to save money**

- ✓ Choosing generic prescription drugs costs you and the Fund less!

You pay extra if you or your doctor choose a brand name prescription drug when a generic equivalent is available. *See page B-4* for more details.

Plus, generic prescription drugs usually cost less than brand name drugs, so you'll pay less co-insurance when you choose generic drugs.



# ***Prescription drug benefits***

## Learn:

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

## Prescription drug benefits

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

Hospitality Rx provides access to a select national network of participating pharmacies (called the True Choice network) that you must use in order to get benefits for prescription drugs. Not all pharmacies are in the network. For example, **CVS is in your network**. Walgreens, Duane Reade, Wal-Mart, USA Drugs, and certain independent local pharmacies are **not** in your network. Because this list changes from time to time, contact Hospitality Rx at **(844) 813-3860** or go to [www.hospitalityrx.org](http://www.hospitalityrx.org) to get the most current list of network pharmacies.

**Drugs and supplies are FREE at the UNITE HERE HEALTH—Health Center pharmacy in Atlantic City, New Jersey, including two locations in Pennsylvania!**

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

CVS  
3298 Edgemont Avenue  
Brookhaven, PA 19015

CVS  
1306 W. MacDade Blvd  
Woodlyn, PA 19094

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

Important Phone Numbers		
If you want to:	Call:	At:
Find a network pharmacy or ask questions about your benefits	The Fund	<b>(888) 437-3480</b>
Get prior authorization for prescription drugs or to ask which drugs require prior authorization	Hospitality Rx	<b>(844) 484-4726</b>
Get a free glucometer	TrueMetrix (by Trividia)	<b>(866) 788-9618</b>
	One Touch (by LifeScan) <i>use order code 739WDRX01</i>	<b>(888) 883-7091</b> <a href="http://www.OneTouch.orderpoints.com">www.OneTouch.orderpoints.com</a>
Order from the mail-order pharmacy	WellDyneRx Home Delivery (through Hospitality Rx)	<b>(844) 813-3860</b>
Order from the specialty pharmacy	Walgreens Specialty Pharmacy	<b>(877) 647-5807</b>

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

## What you pay

You must pay the applicable percent of allowable charges shown below for each fill of a prescription drug. You must also pay any expenses that are not considered covered expenses (*see page B-8* for information about excluded expenses).

Prescription Drugs (Network Pharmacies & Mail Order Only)	Your Cost for Each Fill or Refill
Drugs from the Health Center, including two locations in Pennsylvania ( <i>see page F-3</i> )	FREE!
Immunizations on the Formulary	FREE!
Generic Drugs on the Formulary	20%
Brand Name Drugs on the Formulary	20%
Specialty and Biosimilar Drugs on the Formulary	25%, up to a maximum of \$20
Drugs NOT on the Formulary	Not covered
<i>Lifetime Benefit Maximum—\$25,000</i>	

### 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.

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.

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

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 process 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.

You must use the UNITE HERE HEALTH—Health Center or the specialty pharmacy get spe-

cialty and biosimilar prescription drugs. *See page B-8* for more information about the specialty pharmacy.

### Lifetime Benefit Maximum

Your benefits are limited to a lifetime maximum of \$25,000. This means the total amount the Plan will pay in benefits is \$25,000 during your lifetime. Once you reach the lifetime maximum, your benefits under the Plan will end (see “Termination of coverage” on *page D-3*) and you will be responsible for all amounts the Plan does not pay.

### Generic prescription drug policy

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

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

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

### What’s covered

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

- Formulary FDA-approved prescription drugs which can legally be purchased only with a written prescription from a healthcare provider. This includes formulary oral and injectable contraceptives, and formulary drugs mixed to order by a pharmacist, as long as at least one part of the mixed-to-order drug is a formulary FDA-approved prescription drug.
- The following formulary diabetic supplies: insulin, diabetic test strips, control solution for glucometers, disposable syringes and needles, and lancets.
- The following formulary single-source vitamins: ferrous sulfate, vitamin D, cyanocobalamin, vitamin K, potassium chloride, bicarbonate, phosphate, calcium acetate, niacin, and Galzin (zinc).



- Formulary drugs and supplies available at the Health Center.
- Certain immunizations (including the cost of administration by a pharmacist, if any) recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, such as flu, pneumonia, shingles, hepatitis, and tetanus.

### Free glucometers

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

**(866) 788-9618** for TrueMetrix (by Trividia)  
*no order code is needed*

**(888) 883-7091** for OneTouch (by LifeScan)  
or visit [www.OneTouch.orderpoints.com](http://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.

## Safety and cost containment programs for prescription drugs

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

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

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

*See page E-5* for information about appealing a request for prior authorization or appealing a denial of prescription drug benefits.

### Prior authorization

If you have a prescription for certain drugs, your healthcare provider will need to provide your medical records to show that the prescription drug is clinically appropriate for your medical sit-

## Prescription drug benefits

uation. The list of prescription drugs that require prior authorization changes from time to time. Call Hospitality Rx at (844) 484-4726 for a list of drugs on the prior authorization list, or to get prior authorization for a drug.

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

### Step therapy

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

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

The list of prescription drugs that require step therapy changes from time to time. Contact Hospitality Rx at (844) 484-4726 with questions about which prescription drugs require step therapy.

### Case management

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

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

## Fill and refill limits

### Quantity limits

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

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

You generally cannot refill a prescription earlier than allowed under any applicable guidelines, safety or cost containment programs, or other Plan rules. This usually means you must use at least 75% of the drug before it can be refilled. However, the Fund may have different requirements for certain drug types or categories. For example, you may need to use 90% of an opioid painkiller before you can get a refill.

However, in some cases, you may be able to refill a prescription sooner. 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.
- Your drug is lost or stolen.
- You run out of a drug too soon because you misunderstood the instructions or accidentally used too much (limited to one early refill per lifetime for that drug).

An early refill is subject to the quantity limits explained above, **plus** the refill quantity will not exceed the time for which you are eligible for benefits. The Fund may apply a surcharge after the first early refill of a drug each year. This surcharge can be up to \$50 (or the cost of the drug, if less) in addition to the applicable coinsurance, and you may be required to participate in the pharmacy case management program. However, the early refill surcharge will not apply at a participating Health Center.

Call Hospitality Rx if you need an early refill of a drug.

### **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, in these situations you may get a smaller supply of a prescription drug than as described in the previous section.

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

### **Mail-order pharmacy**

If you need a prescription drug to treat a chronic, long-term health condition, you can order these prescription drugs through the WellDyneRx Home Delivery mail-order pharmacy. You can get up to a 60-day supply of your prescription drug (sometimes called a “maintenance” prescription drug).

## Prescription drug benefits

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

### WellDyneRx Home Delivery

(844) 813-3860

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

## Specialty pharmacy

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

The specialty pharmacy provides prescription drugs for certain chronic or difficult to treat health conditions, such as multiple sclerosis (MS) or Hepatitis C. Specialty prescription drugs often need to be handled differently than other prescription drugs, or they may need special administration or monitoring. Using the specialty pharmacy gives you access to pharmacists and other health-care 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.

### UNITE HERE HEALTH—Health Center

1801 Atlantic Avenue, 3rd Floor

Atlantic City, NJ 08401

(609) 570-2400

### Walgreens Specialty Pharmacy

(877) 647-5807

*Walgreens Specialty Pharmacy is different than Walgreens retail pharmacies. Walgreens retail pharmacies (brick and mortar buildings) are still out of network.*

## What's not covered

See page C-1 for a list of the Plan's general exclusions and limitations. In addition to that list, the following types of prescription drug treatments, services, and supplies are not covered under the prescription drug benefit:

- Prescription drugs, vitamins, minerals, or supplies that are not included on the formulary. Your healthcare provider can ask for an exception. However, you must try all of the medically appropriate drugs on the formulary before Hospitality Rx will review a request for coverage of a non-formulary drug.
- Prescription drugs that have not been approved by the FDA. However, the Fund may cover

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prescription drugs not approved by the FDA in certain situations. You or your healthcare professional may ask for an exception through the prior authorization program.

- Specialty prescription drugs, other than those used to treat HIV/AIDS, if you do not use the specialty pharmacy.
- Experimental or investigational drugs.
- Fertility drugs.
- Birth control devices.
- Prescriptions or refills in amounts over the quantity limits (*see page B-6*).
- Non-sedating antihistamines.
- Over-the-counter proton pump inhibitors, except as may be covered at a participating health center.
- Vitamins, dietary supplements, or dietary aids, except those specifically listed as a covered expense.
- New-to-market prescription drugs until the Fund or its representative has reviewed and approved the prescription drug.
- High-cost “me too” drugs, unless the Fund or its representative approves an exception through the prior authorization program. “Me-too” drugs usually have only very small differences in how they work, but are considered “new” drugs with no generic equivalent. Often, the manufacturer charges high prices for these drugs even though there are other drugs available that work just as well for a lower cost.
- Drugs that require review under a safety or cost containment program (such as a drug that requires prior authorization, or a drug subject to the step therapy program) if that safety or cost containment program is not followed, or does not approve the drug.
- Drugs, medications, or supplies that are not for an FDA-approved indication, that are not covered under the Plan’s or Plan’s designee’s claims processing guidelines or any other internal rule, including but not limited to any national guidelines used by the medical community.
- Glucometers, other than those the Fund gives to you for free.
- Drugs or medications used, consumed, or administered at the place where it is dispensed, other than immunizations.
- Diagnostics or biologicals.
- Drugs used for cosmetic reasons, including Rogaine and other drugs to prevent hair loss.
- Weight control drugs, unless approved through the prior authorization program.

## *Prescription drug benefits*

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- Human growth hormone, except to treat emaciation due to AIDS.
- Drugs or other covered supplies not purchased from a network pharmacy.
- Medical foods.

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# ***General exclusions and limitations***

Learn:

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

## General exclusions and limitations

The Prescription drug benefits section has a list of the types of treatment, services, and supplies that are not covered. In addition to that list, the following types of treatment, services and supplies are also excluded for all prescription drug benefits. 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 recommended or approved by the attending physician, or not medically necessary in treating the injury or sickness as defined by UNITE HERE HEALTH (*see page F-3*).
- Any bodily injury or sickness for which the person for whom a claim is made is not under the care of a doctor.
- Any injury, sickness, or dental or vision treatment which arises out of or in the course of any occupation or employment, or for which you have gotten or are entitled to get benefits under a workers' compensation or occupational disease law, whether or not you have applied or been approved for such benefits.
- Any treatment, services, or supplies:
  - For which no charge is made.
  - For which a person is not required to pay.
  - Which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish, or municipal hospital when there is no legal requirement to pay for such treatment, services, or supplies.
  - Which are provided by an individual who is related by blood or marriage to you, your spouse, or your child, or who normally lives in your home.
- Any charge which is more than the Plan's allowable charge (*see page F-2*).
- Experimental treatment (*see page F-2*), or treatment that is not in accordance with generally accepted professional medical or dental standards as defined by UNITE HERE HEALTH.
- Any treatment, services, or supplies purchased or provided outside of the United States (or its Territories), unless for the treatment of a medical emergency. The decision of the Trustees in determining whether an emergency existed will be final.
- Any expense or charge incurred by a Person confined in an institution that is primarily a place of rest, a place for the aged 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.
- Infertility drugs or medications of any kind.



## *General exclusions and limitations*

- Any smoking cessation treatment, program, drug, or device to help you stop smoking or using tobacco, except as specifically provided by the Plan.
- 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.
- Education or training.
- 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.
- Prescription drugs not purchased from a network provider, unless otherwise provided or allowed by the Plan.
- Charges or claims incurred as a result, in whole or in part, of fraud, false information, or misrepresentation.



# ***Subrogation***

## Learn:

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

### The Plan's right to recover payments

#### When injury is caused by someone else

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

Typical examples include injuries sustained:

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

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

#### Statement of facts and repayment agreement

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

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

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

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

### **Settling your claim**

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

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

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

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



# ***Eligibility for coverage***

## Learn:

- ▶ Who is eligible for coverage.
- ▶ When and how you become eligible for coverage.

### Who is eligible for coverage

You are eligible for coverage if, on or after January 1, 2000, you meet all of the following requirements.

- You are age 65 or older.
- You are entitled to enroll for benefits under Medicare.
- You are not covered under any other UNITE HERE HEALTH Plan Unit when you incur allowable charges for covered expenses under this Plan Unit.
  - This means you are not eligible for benefits under this Plan Unit while you are covered as an employee or dependent under Plan Unit 102 Actives (Atlantic City Casinos).
- You were covered under Plan Unit 102 Actives (Atlantic City Casinos) for at least 168 months out of the 180-month period immediately preceding the later of:
  - January 1, 2000; or
  - the later of the first day of the month during which
    - you attain age 65, or
    - you fail to meet the hours requirements necessary to maintain eligibility under Plan Unit 102 Actives (Atlantic City Casinos).

The length of coverage requirement (coverage for at least 168 out of the 180 months immediately preceding the month during which the individual becomes age 65) is waived for former Sands Casino Hotel participants who were, at the time of the closing of the Sands Casino Hotel, age 60 or older and were within 48 months of otherwise qualifying for the retiree benefits under this Plan Unit.

*No benefits of any kind are provided for dependents.*

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

### Enrollment requirements

Once you become eligible, coverage is automatic.



# ***Termination of coverage***

Learn:

- ▶ When your coverage ends.

## Termination of coverage

Your coverage continues as long as you maintain your eligibility as described *on page D-2*. However, your coverage ends if one of the events described below happens.

### When coverage ends

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

- The date you reach the Plan's lifetime benefit maximum amount (\$25,000).
- The date you reestablish eligibility under any other UNITE HERE HEALTH Plan Unit.
- The date of your death.
- The date the Plan is terminated.

### Certificate of creditable coverage

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

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

Learn how you file claims and appeal a denied claim:

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

## Claim filing and appeal provisions

### Filing a benefit claim

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

- Your name.
- Your Social Security number.
- Dates of service(s).
- Charges incurred for each service(s).
- Name and address of the provider.
- The original receipt with prescription details from your pharmacy.

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

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

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

### Deadlines for filing a benefit claim

Only those benefit claims that are filed in a timely manner will be considered for payment. The deadline for filing a claim is no later than 18 months after the date the claim was incurred.

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

### Individuals who may file a benefit claim

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

### Who is an authorized representative?

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

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

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

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

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

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

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

## Determination of claims

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

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

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

### Concurrent care decisions

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

## Claim filing and appeal provisions

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

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

### Rules for prior authorization of benefits

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

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

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

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

### Special rules for decisions involving concurrent care

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

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

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

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

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

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

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

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

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

### **Appealing the denial of a claim**

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.

#### **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:

## Claim filing and appeal provisions

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

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

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

### Appeals involving urgent care claims

If you are appealing a denial of benefits that qualifies as a request for emergency treatment/urgent care, you can orally request an expedited (accelerated) appeal of the denial by calling **(844) 813-3860**. All necessary information may be sent by telephone, facsimile or any other available reasonably effective method.

### Review of appeals

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

- Examine and obtain copies, free of charge, of all Plan documents, records and other information that affect your claim.
- Submit written comments, documents, records, and other information relating to your claim.
- 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 E-3* for details).

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

- UNITE HERE HEALTH may not defer to the initial denial of your claim.
- Review of your appeal must be conducted by a named fiduciary of UNITE HERE HEALTH who is neither the individual who initially denied your claim, nor a subordinate of such individual.



- If the denial of your initial claim was based, in whole or in part, on a medical judgment (including decisions as to whether a drug, treatment, or other item is experimental, investigational, or not medically necessary or appropriate), a named fiduciary of UNITE HERE HEALTH must consult with a healthcare provider who has appropriate training and experience in the field of medicine involved in the medical judgment. This healthcare provider cannot be an individual who was consulted in connection with the initial determination on your claim, nor the subordinate of such individual.

### Notice of the decision on your appeal

You will be notified of the decision on your appeal:

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

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

If your appeal is denied, you will be provided with a written notice of the denial which includes all of the information required by federal law.

### 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.

## *Claim filing and appeal provisions*

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.

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.*

## Definitions

### Allowable charges

An **allowable charge** is the amount of charges for covered treatments, services, or supplies that the Plan uses to calculate the benefits it pays for a claim. The 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. This means lower out-of-pocket costs for you.
- Treatment by a non-network provider means you pay more out-of-pocket costs. The Plan will not pay benefits if you use a non-network provider.

### Coinsurance

Your share of the costs of a covered expense, calculated as a percent (for example, 20%) of the allowable charge for the prescription drug.

### Covered expense

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

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

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

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

### Injuries and sicknesses

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

### 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 F-2*), nor unproven as determined by appropriate governmental agencies, the organized medical community in the United States, or standards or procedures adopted from time-to-time by the Trustees.

However, 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.

### Participating Health Center

The UNITE HERE HEALTH—Health Center (Health Center) is located at **1801 Atlantic Avenue, Atlantic City, New Jersey 08401**. The pharmacy services at the Health Center are available at no cost to you (for free). You are not eligible to receive other services at the Health Center.

In addition, the following locations in the Philadelphia-area are extensions of the Health Center where you can get free prescription medications: 3298 Edgemont Avenue, Brookhaven, PA 19015 and 1306 W. MacDade Boulevard, Woodlyn, PA 19094.

### Plan Document

The rules and regulations governing the Plan of benefits provided to eligible retirees participating in Plan Unit 102 Retirees (Atlantic City Casinos —Retiree Drug Coverage).



***Other important information***



## Other important information

### Who pays for your benefits?

In general, Plan benefits are provided by the money (contributions) employers participating in the Plan must contribute on behalf of eligible employees under the terms of the Collective Bargaining Agreements (CBAs) negotiated by your union.

### What benefits are provided through insurance companies?

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

The Plan contracts with other Hospitality Rx, LLC, a wholly owned subsidiary of UNITE HERE HEALTH, to administer prescription drug benefits.

### Interpretation of Plan provisions

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 if the Board of Trustees of UNITE HERE HEALTH, in their sole and exclusive discretion, decide that the applicant is entitled to them.

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



on all those dealing with or claiming benefits under the Plan, and if challenged in court, the Plan intends for the Trustees' decision to be upheld unless it is determined to be arbitrary and capricious.

### Amendment or termination of the Plan

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

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

If UNITE HERE HEALTH is terminated, in whole or in part, or if your Plan, any other Plan Unit or any schedule of benefits is terminated or suspended, no employer, participant, beneficiary or other employee benefit plan will have any rights to any part of UNITE HERE HEALTH's assets. This means that no employer, plan or other person shall be entitled to a transfer of any of UNITE HERE HEALTH's assets on such termination or suspension. The Trustees may continue paying 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 providers is voluntary, and the Plan makes no recommendation as to which specific provider you should use, even when benefits may only be available for services furnished by providers designated by the Plan. You should select a provider or treatment based on all appropriate factors, only one of which is coverage under the Plan.

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

## *Other important information*

### **Workers' compensation**

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

### **Type of Plan**

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

### **Employer and employee organizations**

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

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

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

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

### **Employer identification number**

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

### **Plan number**

The Plan Number is 501.

### **Plan year**

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

### **Remedies for fraud**

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



# ***Your rights under ERISA***



## *Your rights under ERISA*

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

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

### **Receive information about your Plan and benefits**

ERISA provides that all Plan participants shall be entitled to:

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

### **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

**Hospitality Rx**  
P.O. Box 6020  
Aurora, IL 60598-0020  
**(844) 484-4726**

**UNITE HERE HEALTH**  
1801 Atlantic Avenue, Suite 200  
Atlantic City, NJ 08401  
**(888) 437-3480**



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



## Union Trustees

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*President*

UNITE HERE  
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UNITE HERE Local 54  
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