

## To All Employees

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We are pleased to present you with this updated guide. It describes the benefits currently available to you and your family from the Health Benefits Fund (the Fund/the Plan). This Fund was originally established as a result of an Industry-Wide Collective Bargaining Agreement between the New York Hotel and Motel Trades Council, AFL-CIO and the Hotel Association of New York City, Inc.

Before the Fund could begin operations and provide comprehensive medical benefits, a special New York State law was required to create the New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Center, Inc. That law was enacted through the joint efforts of the Hotel Trades Council and the Hotel Association. Those efforts resulted in the necessary legislation being introduced and passed in the New York State Assembly and Senate, then being signed into law by Governor Thomas Dewey in 1949.

The Fund's health benefits program, which is self-insured and, for the most part, self-administered, has since served as a model for many programs. Even today, more than 50 years after the Health Center was established and the Fund was set up to collect employer contributions to finance the Health Center's operations, other organizations are adopting the concept of "in-house" delivery and administration of comprehensive health care benefits. As of January 1, 1999, the New York Hotel Trades Council and Hotel Association of New York City, Inc. Union Family Medical Fund, Insurance Fund and Dental Fund were combined to form a single fund, renamed the "Health Benefits Fund."

The benefits described on the following pages are designed to protect you and your family from the increasingly high costs of medical care and are paid for entirely by contributions made to the Fund by employers. You are not required to contribute to the cost of this Plan. You will find in this guide a description of the eligibility rules and regulations, the benefits to which you are entitled and the procedures you should follow to obtain benefits provided by the Fund. We urge you to become familiar with the Plan and the contents of this guide.

We believe that you will be as proud as we are of the progress that has been achieved over the years in providing a measure of security and well being for the employees in our industry and their dependents.

Keep this guide in a safe, easy-to-find place so that you can refer to it if you have any questions about the Plan, its benefits, or your coverage. The Fund Office will be pleased to help you at any time if you need assistance or information.

Sincerely,

THE BOARD OF TRUSTEES

This guide, or summary plan description (SPD), contains highlights of the health benefits provided by the New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund. If there is any difference between the language contained in this guide and the actual documents that make up the plan, those documents will always govern.

The Board of Trustees intends to continue the benefit programs described in this guide indefinitely. Nevertheless, it reserves the right, subject to the terms of a collective bargaining agreement, to terminate or amend any or all of the Fund's benefit programs, including benefits for retirees, in whole or in part at any time in the future. If any questions concerning eligibility for benefits arise, the Trustees have sole and exclusive authority to resolve the issue. The Trustees' decisions are final and binding.

The Plan may be terminated by the Board of Trustees when there is no longer in effect an agreement between any employer and the New York Hotel Trades Council requiring payment to the Fund. Upon termination of the Fund's benefit programs, the Board of Trustees will apply the monies of the Fund to provide benefits or otherwise to carry out the purposes of the Fund until all of the remaining assets of the Fund have been disbursed.

**Note: This guide does not contain the summary plan information for the Empire BlueChoice Preferred Provider Organization ("Empire PPO"), which provides medical benefits to employees who live outside Brooklyn, Queens, Manhattan and the Bronx. The provisions of the Empire PPO are described in a separate summary plan description that you should refer to for benefit information.**

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# Overview of the Plans

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## ***Lists of benefits provided by the Fund, and important phone numbers.***

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Your benefits under the New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund include:

- Medical benefits through two programs:
  - Health Center Program -- required for members who live “in-area” (Brooklyn, Queens, Manhattan or the Bronx) and
  - Empire Preferred Provider Organization (Empire PPO) -- available only to members who live “out-of-area” (outside of Brooklyn, Queens, Manhattan or the Bronx).
- Hospitalization benefits.
- Prescription Drug Program benefits.
- Vision benefits.
- Dental benefits.
- Members’ Health Assistance Program benefits.
- Life Insurance benefits (employees only).
- Accidental Death & Dismemberment (AD&D) benefits (employees only).
- Accident and Sickness Weekly (Short-Term Disability) benefits (employees only).

**The goal of the Health Benefits Fund is to make it as easy as possible for you and your family to get the health care you need. The Health Centers provide the majority of your care – *all under one roof!* When you visit and coordinate your care through a Health Center, there are usually:**

- **No deductibles.**
- **No co-pays.**
- **No claim forms to file.**

## **About This Guide**

This guide has been prepared to explain your benefits. You may want to glance through it now to become familiar with these benefits. Remember, if you live outside Brooklyn, Queens, Manhattan or the Bronx, you are also eligible for medical benefits coverage under the Empire PPO. Those medical benefits are described in a separate summary.

**If you have any questions about your benefits under the Plan, please call the Fund Office at 212-586-6400.**

We tried to describe your benefits as completely as possible and in everyday language. We’ve also organized this guide in a way that will be most useful to you, starting with a chart highlighting when you and your family can participate in the Plan and your coverage under each benefit program.

The ***Life Events*** section that follows is designed to show you how your benefits work at different stages of your life, such as getting married, having a child or retiring. It describes what you need to do to *make sure* your benefits continue during a life event.

Information about each benefit comes next. After that, there’s information on filing claims, the review and appeal process, and your rights under the Employee Retirement Income Security Act of 1974 (ERISA).

The following charts show key features of the Plan and provide important phone numbers. Please refer to the full descriptions in this guide for details and limits that may apply to benefits.

## Health Benefit Highlights

Benefit	Coverage Summary
Hospital (In-Patient), <i>Participating</i> with Blue Cross Plan	100% for covered services. First one hundred twenty (120) days (semi-private room) covered in full. Next one hundred eighty (180) days covered at 50% of semi-private room rates.
Hospital (In-Patient ) <i>Non-Participating</i> with Blue Cross Plan	100% for covered services. First one hundred twenty (120) days covered at thirty dollars (\$30) a day for room + eighty percent (80%) allowed charges. Next one hundred eighty (180) days covered at \$15 a day for room + 40% allowed charges.
Emergency Room: <ul style="list-style-type: none"> <li>• Accidental Injury</li> <li>• Sudden and Serious Illnesses</li> </ul>	<ul style="list-style-type: none"> <li>• You must go within seventy-two (72) hours of injury to be covered.</li> <li>• You must go within twelve (12) hours of onset of illness to be covered.</li> </ul>
Hospital (Out-patient Department) Ambulatory Surgery	100% for covered services
Home Health Care	<p><b>With prior hospital stay:</b> Plan pays for up to a maximum of two hundred (200) visits per calendar year.</p> <p><b>With no prior hospital stay:</b> \$50 deductible, then Plan pays 75% of allowed charges up to maximum of forty (40) visits per calendar year. See page 26-27.</p>
Hospice Care	Up to 210 days in-patient care, when certified life expectancy is (six) 6 months or less. See page 27-28.
Skilled Nursing Facility	Provided as substitute for all or part of a hospital stay. See page 28.
Office Fee	\$0 at Health Centers.
Health Center	100%. Providers in Manhattan, Brooklyn, Queens.
Providers	<p><b>In area:</b> Health Center providers only.</p> <p><b>Out-of-area:</b> Health Centers or Empire PPO providers. (only)</p> <p>There is no coverage when a non-Health Center or non-Empire PPO provider is used.</p> <p><b>Emergency:</b> See page 26.</p>
Maternity Care	Covered in full. See page 23-24.
Preventive Care	Covered in full.
Mental Health <ul style="list-style-type: none"> <li>• In-patient</li> <li>• Out-patient</li> </ul>	<ul style="list-style-type: none"> <li>• Not covered.</li> <li>• Covered through Members' Health Assistance Program only. See page 33.</li> </ul>
Alcohol & Substance Abuse	Covered through Members' Health Assistance Program. See page 33.
Prescription Drug	Formulary: \$5 for generic, \$15 for brand name, where generic is not available. Benefits available from pharmacy department at Health Centers* only. See page 29.
Vision Services	Coverage is provided through General Vision Services. See page 30.
Dental	Covered in full at the Health Centers, 14 Penn Plaza Dental Office, or approved facilities on Long Island or in Westchester. See page 31-32.
Life Insurance	Employees only. Life insurance of up to \$10,000 provided through ULLICO. See page 35-36.
Accidental Death & Dismemberment (AD&D)	Employees only. Up to \$10,000 provided through ULLICO. See page 37.
Accident & Sickness Weekly (Short-Term Disability)	Employees only. 50% of salary (\$300 maximum) per week for a maximum of twenty-six (26) weeks. See page 38.
Durable Medical Equipment (DME)	Covered through Health Centers.
Hearing Aids	Covered for one (1) per lifetime through Health Centers

\*Waiting periods may apply to some benefits.



# Participating in the Plan

*What you and your family need to know about eligibility for benefits and choosing a beneficiary.*

## Who Can Participate<sup>+</sup>

The following chart shows which individuals may be covered for Fund benefits:

If you are...	You're eligible for these benefits after any required waiting period....								
	Medical	Hospital	Rx Drugs	Vision	Dental	MHAP	Life Ins.	AD&D	A & S
<b>A hotel, concession or club employee in a job covered by a collective bargaining agreement between an employer and the New York Hotel and Motel Trades Council, AFL-CIO (or an affiliated Local Union).*</b>	√	√	√	√	√	√	√	√	√
Eligible dependents of employees in this category.	√	√	√	√	√	√			
Domestic partners of employees in this category.	√	√	√	√	√	√			
<b>A covered employee of the: New York Hotel and Motel Trades Council, AFL-CIO (or an affiliated Local Union). or Hotel Trades Council and Hotel Association of New York City, Inc. Employee Benefit Funds.*</b>	√	√	√	√	√	√	√	√	√
Eligible dependents of employees in this category.	√	√	√	√	√	√			
Domestic partners of employees in this category.	√	√	√	√	√	√			
<b>A covered employee of the Local Unions affiliated with the Hotel Trades Council (other than those above) who are not covered by other Local Union health programs.</b>	√	√	√	√	√	√	√	√	√
There is no dependent and domestic partner coverage in this category.									
<b>A retiree who leaves covered employment from a hotel, concession or club contributing to the Health Benefits Fund and who is <u>immediately</u>, upon termination of covered employment, eligible to receive a benefit from the Pension Fund.**</b>	Retirees who are not yet eligible for Medicare can maintain coverage for themselves and/or their eligible dependents by paying a subsidized rate to the Retiree Benefit Plan.			√	√	√			
Eligible dependents of retirees in this category.	Retirees who are or who become Medicare-eligible, who wish to maintain coverage for themselves and/or their eligible dependents, must sign an "Acknowledgement for Medical Benefits," assigning Part B of Medicare to the Funds.			Limited	√	√			
Domestic partners*** of retirees in this category are not eligible for health benefits.									

\*Any full time employee who works at least 14 hours per week is eligible for benefits coverage by the Fund.

\*\*The term "retiree" does not include persons who left covered employment with a vested right to receive a pension benefit at a future time, when they will reach early retirement or normal retirement age.

\*\*\*Domestic Partners are not eligible for COBRA.

+ Casual Employees are not eligible for benefits.

## Eligible Dependents

**Employees must appear personally at the Fund Office and complete all forms necessary to enroll for benefit coverage.** To enroll dependents for coverage, you must prove they are eligible by showing an original marriage certificate, original birth certificate or original adoption papers and proof of address. Eligible dependents of employees and retirees include:

- Your spouse.
- Unmarried children until the end of the calendar year in which they reach age nineteen (19).
- Stepchildren, foster children or adopted children up to age nineteen (19), if they depend on you for housing and a substantial amount (i.e., over 50%) of their financial support.
- Unmarried children, regardless of age, who are unable to support themselves due to mental illness, developmental disability or mental retardation, as defined in the NY mental hygiene law, or physical handicap, provided they are incapacitated before reaching nineteen (19).
- Children born to unmarried eligible dependents of a covered employee, eligible spouse, retiree, or domestic partner receive coverage for thirty (30) days from birth. Separate arrangements must be made to continue coverage for the newborn beyond that time.

## Domestic Partners

To enroll your domestic partner for coverage, you both must be at least eighteen (18) years old, and not be related by blood in a manner that would legally prohibit your marriage. A person may not be considered a domestic partner if he or she is married or has had another domestic partner within the last six (6) months.

## When Coverage Begins

You become eligible for certain benefits, provided you are working on a full-time basis, on the day your employer is obligated to make contributions for you. Other benefits become available after a waiting period. Coverage for your dependents becomes available when yours does, as long as you have enrolled them for coverage. Coverage for a domestic partner becomes available after a 3-month waiting period following enrollment.

The following chart shows when coverage for benefits begins, based on your date of hire:

Benefit	Immediately	After 4 weeks	After 30 days	After 60 days	After 6 Months	After 9 Months
Health Center medical	√					
Out of area medical				√		
Hospital				√		
Prescription drugs	√					
Vision						√
Dental			√			
Members' Health Assistance Program	√					
Life insurance					√	
AD&D					√	
Accident and Sickness		√				

## **Designating Your Beneficiary**

When you become eligible for life insurance and AD&D benefits, you'll be asked to name a person(s) who will receive the benefit if you should die. You may name more than one beneficiary and you may change your beneficiary at any time. If you name more than one beneficiary, you should indicate how your benefits should be divided.

The initial naming of your beneficiary or any change of beneficiary will take effect on the date you sign the *Beneficiary Designation* form.

It's important that you name a beneficiary. If you do not name a beneficiary, or if your beneficiary is not living at the time of your death, your benefit will be paid to your survivors as follows:

- Your spouse. If none,
- Your children, in equal shares. If none,
- Your parent(s), in equal shares. If none,
- Your brothers and sisters, in equal shares. If none,
- The executor or administrator of your estate.

## Life Events

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***Getting married – having a child – retiring – and more! All you need to know to keep your coverage going when these and other changes in your life take place.***

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Your benefits are designed to meet your needs at different stages of your life. This section describes how your coverage is affected when different lifestyle changes occur after you've enrolled.

### **If You Get Married or Have a Domestic Partner**

When you marry, your spouse is eligible for certain benefits as shown in the chart on page 4. Domestic partners are eligible for these benefits once you and your partner have lived together continuously for at least (six) 6 months.

To enroll your spouse for coverage you must visit the Fund Office within thirty (30) days after your marriage and provide your original marriage certificate for copying. Coverage will go into effect the date you visit the Fund Office. If you do not visit the Fund Office within the required thirty (30) days, coverage for your spouse will go into effect on the date you notify the Fund office, not the date of your marriage.

#### **To Do: Getting Married**

- Visit the Fund Office.
- Check your children's eligibility.
- Review your beneficiary designations.

To enroll your domestic partner for coverage, you and your partner must visit the Fund Office and provide identification and proof that you are living together and have shared financial responsibilities, which include: a valid driver's license, photo ID of both applicants, joint tenants on a lease or document of ownership of residence, joint bank account, joint credit or charge card or any other available document with both names indicating responsibility for maintaining a household together.

#### **To Do: Taking a Domestic Partner**

- Visit the Fund Office.
- Provide documentation.
- Enroll any children.
- Review your beneficiary designations.
- Get re-certified every 12 months.

There is a three-month eligibility-waiting period for domestic partnership coverage once all your application paperwork is completed and filed. Domestic partners are required to be re-certified for Fund coverage once every twelve (12) months.

Stepchildren and children of covered domestic partners are also eligible for benefits under the Fund provided that your spouse or partner is identified as substantially responsible for the child. You will also need to decide whether to name your spouse or domestic partner as your beneficiary for life and AD&D insurance.

## If You Have a Baby or Adopt a Child

When you have or adopt a child or have a child placed with you for adoption, your child is eligible for certain benefits as shown in the chart on page 4.

You're required to furnish proof to the Fund Office of your child's birth, adoption, placement for adoption or dependency status within thirty (30) days after the birth, adoption, placement for adoption or dependency status in order for your child to be eligible for benefits.

If you already have family coverage, your newborn child or a proposed adopted child will be covered from the date of birth, adoption or placement for adoption, provided you bring appropriate papers to the Fund Office as soon as the event occurs.

If you have individual coverage, you must notify the Fund Office that you want to switch to family coverage within thirty (30) days from the date of birth or adoption or placement for adoption. If you notify the Fund Office after thirty (30) days, your family coverage begins on the date the Fund receives and accepts from you the appropriate papers and a completed enrollment form for your dependent.

### **To Do: Having a Baby or Adopting a Child**

- Notify the Fund Office immediately.
- Provide within 30 days the child's original birth certificate or adoption papers for copying.
- If proof is provided within 30 days, your child will be eligible for coverage on the date of birth, the date of adoption, or date of placement for adoption.
- You may be able to take an FMLA leave of absence.

## If You Take a Family or Medical Leave of Absence

Under the Family Medical Leave Act (FMLA) you may be entitled to take up to twelve (12) work weeks of unpaid leave per year for the birth of a child, placement of a child with you for adoption or foster care, or to care for a spouse, child, or parent with a severe health condition. In addition, you may be entitled to take an FMLA leave for your own serious health condition.

### **To Do: Taking a Leave of Absence**

- Notify your employer.
- Notify the Fund Office.

As required by this federal law, your coverage and any family medical coverage provided by the Fund will continue for the entire period of the leave. Your employer is required to make special contributions to the Fund to continue coverage for this period of time.

The Fund will maintain your eligibility status until the end of the leave, provided your employer properly grants the leave under the FMLA and makes the required notification and payment to the Fund.

Of course, any changes in this Plan's terms, rules or practices that go into effect while you are away on leave apply to you and your dependents, the same as to active employees and their dependents. Call your Employer to determine whether you are eligible for FMLA leave. Call the Fund Office regarding coverage during FMLA leave.

## If You Become Divorced

### **Your Spouse**

If you divorce, your spouse loses coverage under the Fund. However, he or she can continue coverage through COBRA for up to thirty-six (36) months. See the section on **Continuing Coverage (COBRA)** on page 15 for further information.

### **Your Children**

Your divorce settlement may name who will provide health care benefits for your children. Alternatively, you may be required to provide coverage for your children under federal law. A Qualified Medical Child Support Order (QMCSO) may require the Health Benefits Fund, under certain circumstances, to provide coverage for your children when you and your spouse divorce.

#### **To Do: Getting Divorced**

- Notify the Fund Office to remove your spouse from coverage.
- Review your beneficiary designations.
- Provide copy of settlement or court decree for coverage of your children.

The process begins when the Fund Office receives a QMCSO. This means any judgment, decree, or order, including approval of a settlement agreement, which:

- Is issued by or from a court under state domestic relations law.
- Requires an employee to provide the group health coverage available under the Fund for his or her children, even though he or she no longer has custody of them.
- Clearly specifies:
  - The employee's name and last known mailing address and the names and addresses of each child covered by the order.
  - A reasonable description of the coverage to be provided.
  - The length of time the order applies.
  - Each plan affected by the order.

*If you divorce, a QMCSO could have an effect on your benefit coverage or elections.*

*Notify the Fund Office if you become aware of this type of order as part of a divorce proceeding.*

Please note, a child's custodial parent, legal guardian or a state agency may apply for Fund coverage of an employee's children, even if you as the employee do not. The Fund Office or your Employer will provide written notification to you and each identified child that it has received a court order requiring coverage.

The Fund will comply with a QMCSO issued by a judge, or a National Medical Support Order (NMSO) issued by a state agency which meets the requirements of a QMCSO. These types of orders require the Fund to provide medical coverage for the child of a member who does not have custody of that child. If a QMCSO or a NMSO is received, the Fund Office or your Employer will provide written notification to you and each child of his or her eligibility for coverage and will permit immediate enrollment. This notice will include any required enrollment material, a description of the procedures to be followed and a form for designating the child's custodial parent or legal guardian as his or her representative for all purposes. Contact the Fund Office for more information.

## If Your Child Loses Eligibility

Coverage ends for dependent children when they marry. Your children also lose eligibility for benefits at the end of the calendar year in which they reach age nineteen (19), unless they're unable to support themselves as described on page 5.

If your children lose eligibility for benefits under the Plan, they can continue coverage through COBRA for thirty-six (36) months. See the section on **Continuing Coverage (COBRA)** on page 15.

## If You Become Disabled

If you become disabled by an off-the-job injury or illness and can't work, certain Plan programs are available to assist you. See, in particular, Accident and Sickness Weekly Benefits. Depending on the nature of your disability, you may also become eligible for Social Security disability benefits. In addition, you may want to apply for a disability pension through the Industry Pension Fund if you're eligible.

Your other benefits will be affected as described below. Your coverage will terminate for all benefits provided by the Health Benefits Fund when the payment of Accident and Sickness Weekly Benefit ends, that is, after up to twenty-six (26) weeks.

### **Disabled Under Age 60**

If you're unable to work because of a disability that begins while you're covered and before reaching age sixty (60), all benefits under the Plan will be continued while you remain disabled, up to a maximum of twenty-six (26) weeks from your last day worked. At the end of the 26-week period, if you have not returned to work, you may elect COBRA to continue your group health benefits or you may purchase continued hospital and possibly medical protection from Empire BlueChoice.

If you are completely disabled at the end of the 26-week period, life insurance benefits will be extended so that if you die within the following twelve (12) months, this benefit will be paid upon receipt of proof from the beneficiary that you remained totally disabled until death.

After your total disability has lasted for at least nine (9) months, you may arrange to continue life insurance benefits during your entire disability at no cost by submitting proof of your disability to the ULLICO claims administration office within the Fund Office. Proof must be submitted within twelve (12) months following termination of the 26-week period referred to above, and additional proof must be submitted from time to time as required by ULLICO.

### **Disabled Between Age 60 to 65**

If you are unable to work because of a disability which begins while you're covered and after reaching sixty (60) years old but before reaching age sixty-five (65), all benefits will be continued while you remain disabled, up to a maximum of twenty-six (26) weeks from the last day worked. At the end of the 26-week period, you may change your life insurance coverage provided by the Plan to an individual policy issued by ULLICO. At the end of the 26-week period, you may elect COBRA to continue your health benefits or you may purchase an individual policy for continued hospital and possibly medical protection from Empire BlueChoice.

#### **To Do: When Your Child Loses Eligibility**

- Notify the Fund Office when your child gets married.
- Notify the Fund Office when your child reaches age 19.

#### **To Do: If You're Disabled**

- Notify the Fund Office.
- Apply for Accident & Sickness Weekly benefits.
- After 26 weeks, apply for Social Security disability benefits and COBRA continuation, and conversion of life insurance.
- Consider applying for a disability pension.

### **Disabled When You Reach Age 65**

If you're unable to work because of a disability which begins while you're covered for Fund benefits and the disability continues after you reach age sixty-five (65), life insurance and AD & D benefits will be continued while you remain disabled, up to a maximum of twenty-six (26) weeks from the last day worked. At the end of the 26-week period, you may change your group life insurance coverage provided by the Fund to an individual policy issued by ULLICO. Health benefits for you and your eligible dependents will continue for up to twenty-six (26) weeks, or your 65<sup>th</sup> birthday, whichever happens first. At that time you will be eligible for Medicare, and your dependents will be offered COBRA.

### **If You're Injured on the Job**

If you're injured on the job, your medical expenses are covered by Workers' Compensation. The Fund does not provide or administer this coverage, as your employer is required to obtain workers compensation insurance under New York State Law. You may also be eligible for weekly income benefits under Workers' Compensation. If you receive Workers' Compensation, you will not be paid Accident and Sickness Weekly benefits by the Fund.

#### **To Do: If You Get Hurt On Your Job**

- Notify your employer immediately.

### **If You Lose Your Eligibility**

You and, where applicable, your eligible family members or domestic partner's coverage will terminate automatically under any one of the following conditions or events:

#### **To Do: If You Lose Your Eligibility for Benefits**

- Notify the Fund Office.
- If you're eligible to continue coverage under COBRA, make sure you enroll by the deadline.

### **If You Stop Working for a Contributing Employer**

If you stop working on a full-time basis (i.e., under fourteen (14) hours per week) for reasons other than disability, or go to work for an employer not required to contribute to the Fund, your coverage will end on the dates described in the following schedule:

<b>Benefit</b>	<b>Will end</b>
Accident and Sickness Weekly Benefit, Life Insurance and AD&D	After you stop being employed full-time for thirty-one (31) consecutive days.
Hospital, Dental, Health Center services, Members' Health Assistance Program, Vision and Out-of-Area Medical Benefits program	After you stop being employed full-time for thirty (30) consecutive days.

Coverage for your dependents ends when your coverage stops. You and your eligible dependents (not domestic partners) are eligible to continue health coverage under COBRA for eighteen (18) months.

### ***If You Enter Military Service***

If you enter military service, your coverage by the Fund will continue for the first thirty (30) days of your military leave. When your Fund coverage ends, you and your eligible family members may elect COBRA coverage for up to eighteen (18) months. Upon your return to active employment with a Contributing Employer after an honorable discharge from military service and within the time requirements of federal law, your Fund coverage will resume immediately.

### ***Other Losses of Eligibility***

- Your employer is no longer obligated to contribute to the Health Benefits Fund. However, in the event a covered hotel operation closes down, coverage may be continued for up to one hundred twenty (120) days after loss of employment due to the closing. This extended period is subject to verification of lay-off and continued unemployment through receipt of State Unemployment Insurance benefits.
- Termination of the Fund or of the group insurance or self-insured benefit programs provided through the Fund.
- If you have filed a Workers' Compensation claim, and you have medical expenses while your claim is pending, during the 26-week period following the date you left covered employment, you'll receive an allowance toward these expenses in accordance with the approved Fund fee schedule. However, a lien will be filed against any Workers' Compensation award that you receive for any amounts paid by the Fund which should have been paid under Workers' Compensation. The preceding sentence shall only apply when the injury has occurred while you were in Covered Employment, provided the treatment is for a claim-related injury and the treatment is received before the date that you begin work in non-covered employment.

### **Reinstatement of Coverage If You Return to Work**

If you begin work in a job covered by a collective bargaining agreement with the New York Hotel Trades Council, AFL-CIO (and its affiliated local unions), or for which an employer is required to contribute to the Fund after your coverage by the Fund has ended, your coverage will start again subject to the following rules:

- Coverage for Health Center services begins immediately.
- If you're re-employed within six (6) months from termination of coverage by the Fund, eligibility for all other benefits provided by the Fund starts again on the first of the month following the return to covered employment.
- If you're reemployed after six (6) months from termination of coverage by the Fund, eligibility for all other benefits provided by the Fund starts when you again satisfy the eligibility requirements described on page 5.
- Coverage for your eligible dependents starts again when yours does.

### **Health Benefits Provided by Medicare**

There are two parts to Medicare:

- **Medicare Part A** (hospitalization) is provided to people age sixty-five (65) and over, after registration at a Social Security Administration branch office. There is no premium charge for this coverage.
- **Medicare Part B** (physicians' services) is a voluntary program available to people age 65 and over, and requires premium payments. The Social Security Administration requires registration to receive benefits under Part B. Medicare Part B enrollees may use the services of a private physician, or, when eligible, the services of a Health Center. Persons enrolling in Medicare will receive a health insurance card from Social Security designating the type of coverage they have.

- **Medicare Alternatives** (Medicare Health Maintenance Organizations -- HMOs) are frequently offered by insurers as a replacement product for Medicare Parts A and B. These plans require no Medicare premiums and usually cover prescription drugs but limit the choice of providers. If you elect this type of program, coverage through the Plan is automatically terminated.

## Medicare at Retirement

When you retire, you're eligible to continue certain benefits as shown in the chart on page 4. Some of these benefits require payment on your part. To remain eligible for Health Center benefits after you reach age sixty-five (65), you must be enrolled in Medicare Part B and satisfy the requirements described below:

- You and your spouse must sign an "Acknowledgement for Medical Benefits" at the same time you sign your application to receive pension benefits from the Industry Pension Fund. This acknowledgement states that you understand that you must enroll in Part B of Medicare in order to continue to utilize the services of the Health Center.
- You and your spouse must also sign a card authorizing Medicare to reimburse the Fund for services provided by or through the Health Center.

## Medicare at Age 65 While Actively Employed

While you are working, the Fund remains your primary source of health coverage and you need not enroll in Medicare until retirement.

**(Medicare coverage for active employees age sixty-five (65) or older and the spouse of an active employee who is age sixty-five (65) or older is considered "secondary" or "supplementary" to the coverage provided under the Plan. If you are an active employee and you enroll in Medicare when you reach age sixty-five (65), the Fund will pay benefits first and Medicare will pay second.)**

### To Do: Prior to Retirement

- Enroll in Medicare Parts A and B **at least 3 months before** you retire.

## If Your Spouse, Partner or Dependent Dies

If a dependent dies, you should notify the Fund office as soon as possible. If your dependent was also your beneficiary, you'll need to change your beneficiary designation(s).

### To Do: If Your Dependent Dies

- Notify the Fund Office.
- Review your beneficiary designation(s).

## If You Die

If you die while working, in most instances your dependents lose eligibility for coverage. However, they may elect to continue coverage through COBRA for up to thirty-six (36) months. See the section on **Continuing Coverage (COBRA)** on page 15 for more information. Your dependents and/or beneficiaries should contact the Fund Office to report your death, and obtain information on submitting any claims for benefits payable because of your death and continuing Health Benefits Fund coverage through COBRA.

If you die after retirement, your spouse and dependent children remain eligible for benefits subject to the rules of the plan. However, should retiree benefits terminate or change, they will also terminate or change for the surviving spouse and dependent children.

# CONTINUING COVERAGE

## *Information on continuing your coverage when your benefits end.*

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and/or each of your covered dependents may continue health care coverage described in this booklet if coverage ends because of a “qualifying event” as shown in the chart below. To be eligible, you and/or your dependents must be enrolled in the Plan when coverage ends.

You and/or each of your dependents may continue health coverage by the Plan (not life, AD&D or Accident & Sickness benefit coverage) by paying the full cost of the health coverage for active employees, plus a 2% charge for administration. The Plan does not pay any of the cost of your continuation coverage. The time period for continuing coverage is determined by the reason coverage ended (called the “qualifying event”) and by whether you, the employee, or one of your dependents is continuing the coverage.

The COBRA continuation periods are as follows:

Coverage may continue for *...	If this qualifying event occurs...	For a maximum duration of**...
You and your dependents	Your employment terminates (for reasons other than gross misconduct) or you retire.	18 months (29 months if you or your dependents are disabled at the time)
You and your dependents	Your hours are reduced so that you no longer meet eligibility requirements.	18 months (29 months if you or your dependents are disabled at the time)
Your dependents	You die.	36 months
Your dependents	You become entitled to Medicare.	36 months
Your dependents	You are divorced or legally separated from your spouse.	36 months
Your dependent children	Children no longer qualify as eligible dependents.	36 months

\*Domestic Partners are not eligible for COBRA continuation.

\*\*The COBRA Continuation Coverage period begins on the date you and/or your dependent lose Fund coverage, rather than on the date of the qualifying event.

## How to Elect COBRA Continuation Coverage

When your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Plan, or when the Fund Office is notified on a timely basis that you died, divorced, or were legally separated, became entitled to Medicare, or that a dependent child loses dependent status, the Fund Office will give you and/or your covered dependents notice of the date on which your coverage ends and the information and forms they need to elect COBRA Continuation Coverage. Under the law, you and/or your covered dependents will then have only 60 (sixty) days from the date you or they receive that notice to apply for COBRA Continuation Coverage.

**IF YOU AND/OR ANY OF YOUR COVERED DEPENDENTS DO NOT CHOOSE COBRA CONTINUATION COVERAGE WITHIN SIXTY (60) DAYS AFTER RECEIVING THAT NOTICE, YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDS.**

COBRA Continuation Coverage may be elected for some members of the family and not others. In addition, one or more dependents may elect COBRA even if the employee does not elect it. A parent may elect or reject COBRA Continuation Coverage on behalf of dependent children living with him or her.

The COBRA Continuation Coverage period begins on the date you and/or your dependents lose coverage (rather than on the date of the qualifying event).

You and your covered family members have an independent right to elect continuation coverage. You and your dependents do not have to prove you are in good health in order to continue health coverage under COBRA. If you decide to continue health coverage you will receive the same health benefits as active employees and their dependents. After you have elected continuation coverage, you have the same rights as similarly situated active employees to add dependents and make other changes in your benefits.

If you have a “dependent” qualifying event (such as divorce, legal separation or loss of dependent status), you or your eligible family members must notify the Fund Office within sixty (60) days of the event. You then will receive from the Fund Office a Continuation of Coverage Election Form and full details about continuing your coverage.

If you do not notify the Fund Office within this 60-day time period, your eligible family members *will not* be allowed to elect COBRA Continuation Coverage.

Under federal law, you or your covered family member have the responsibility to notify the Fund Office within sixty (60) days of a divorce, legal separation or a child losing dependent status, which may qualify for a COBRA election. Your Employer has the legal obligation to notify the Fund Office of your death, termination of employment, reduction in hours or Medicare entitlement. The time period in which your Employer must notify the Funds of the qualifying event will begin to run from the date of the loss of coverage and not the qualifying event date.

## **COBRA Coverage in Cases of Social Security Disability**

If you, your spouse, or any of your covered dependent child(ren) are entitled to COBRA coverage for an 18-month period, that period can be extended for the covered person who is determined to be entitled to Social Security Disability Income benefits, and for any other covered family members, for up to eleven (11) additional months (for a total of twenty-nine (29) months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage, or within the first sixty (60) days of COBRA coverage.
- The disabled covered person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.
- The Plan must be notified by you or by the disabled covered person or another family member that the determination was received no later than sixty (60) days after it was received, and before the 18-month COBRA continuation period ends.

This extended period of COBRA coverage will end at the **earliest** of:

- The last day of the month, thirty (30) days after Social Security has determined that you and/or your dependent(s) are no longer disabled.
- The end of twenty-nine (29) months from the date of the COBRA qualifying event.
- The date the disabled individual becomes entitled to Medicare.

## **Cost of COBRA Coverage in Cases of Social Security Disability**

If the 18-month period of COBRA Continuation Coverage is extended because of Social Security disability, the Plan will charge employees and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month extension period. Any family units that do not include the disabled person will be charged 102% of the cost of coverage.

## **Acquiring New Dependents While Covered by COBRA or Other Health Insurance**

If you or any of your dependents acquire a new dependent through marriage, birth, adoption, or placement for adoption while enrolled in COBRA Continuation Coverage, you or they may add that dependent to COBRA coverage for the balance of the COBRA coverage period. For example, if you have five (5) months of COBRA left and you get married, you can enroll your new spouse for five (5) months of COBRA coverage. In order for the dependent to be covered, you must notify the Fund Office within thirty (30) days of either the date of your marriage or the child's birth, adoption, or placement for adoption. The dependent will be covered immediately, for the balance of the COBRA continuation period, provided the required COBRA premiums are paid. There may be a change in your COBRA premium amount in order to cover the new dependent.

## **Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage**

If, while you are enrolled in COBRA Continuation Coverage, your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible for, but not enrolled for, coverage under the terms of this Plan. To enroll your spouse or dependent for COBRA coverage, you must notify the Fund Office. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

## **Multiple Qualifying Events While Covered by COBRA**

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, divorce or legally separate, become entitled to Medicare, or if a covered child ceases to be a dependent child under the Plan, the maximum COBRA continuation period for the affected spouse and/or child is extended to thirty-six (36) months from the date of your termination of employment or reduction in hours. For example, assume you lose your job (the first COBRA-qualifying event), and you enroll yourself and your covered eligible dependents for COBRA coverage. Three (3) months after your COBRA coverage begins, you divorce and your spouse is no longer eligible for Plan coverage. Your spouse then can continue COBRA coverage for an additional thirty-three (33) months, for a total of thirty-six (36) months of COBRA coverage.

## **Termination of Employment /Reduction in Hours Following Medicare Entitlement**

If you become entitled to (enrolled in) Medicare and you later have a reduction in hours or terminate employment, your spouse and/or dependent(s) are entitled to COBRA for a period of eighteen (18) months (or twenty-nine (29) months, if the 11-month Social Security Disability extension applies) from your termination of employment or reduction in hours, or thirty-six (36) months from the date you became entitled to Medicare, whichever is longer.

There is an initial grace period of forty-five (45) days to pay the first month's premium due starting with the date continuation coverage is elected. There will then be a grace period of thirty (30) days to pay any future monthly premiums due. If payment of the required premiums is not received by the Fund by the end of the applicable grace period, COBRA Continuation Coverage will terminate. The Fund Office will notify you of the cost of the coverage at the time you receive your notice of right to elect COBRA Continuation Coverage.

If you do not elect COBRA Continuation Coverage, all health benefits coverage provided by the Fund will end. You may be able to convert to an individual hospital insurance policy issued by Empire BlueChoice. Contact Empire BlueChoice directly for more information.

If you become covered by another group health plan after your Fund coverage ends, you may continue health benefits coverage by the Fund if the other plan has a pre-existing condition limitation that applies to you. You would be responsible for paying for this coverage.

COBRA Continuation Coverage by the Fund will end before the end of the maximum eighteen (18), twenty-nine (29) or thirty-six (36) month continuation period described above when the earliest of the following occurs:

- You fail to make any required COBRA premium payment before the end of the forty-five (45) day or thirty (30) day grace period, whichever applies.
- You or your dependents become enrolled in Medicare.
- You or your dependents become covered under another group health plan (unless that plan does not provide benefits for a pre-existing condition for which you are being treated).
- This Fund and its plan of health care benefits is terminated for all employees.

## **The Health Insurance Portability and Accountability Act (HIPAA)**

When your health coverage or COBRA Continuation Coverage by the Fund ends, you and/or your covered dependents are entitled by law to, and will be provided with, a "Certificate of Creditable Coverage" (HIPAA Certificate), that indicates the period of time you and/or they were covered by the Fund. This certificate will be provided to you shortly after the Fund knows or has reason to know that health benefit coverage for you and/or your covered dependent(s) has ended.

If, within sixty-three (63) days after your health benefit coverage under the Fund ends, you and/or your covered dependents become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered dependents a health insurance policy, this HIPAA Certificate may be necessary to reduce or eliminate any exclusion for pre-existing conditions that may apply to you and/or your covered dependents in that group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered by the Fund, and certain additional information that is required by law.

The HIPAA Certificate will be sent to you (or to any of your covered dependents) by first class mail shortly after your or their coverage by the Fund ends. If you (or any of your covered dependents) elect COBRA Continuation Coverage, another certificate will be sent to you (or them, if COBRA Continuation Coverage is provided only to them) by first class mail shortly after the COBRA Continuation Coverage ends for any reason.

In addition, a HIPAA Certificate will be provided to you and/or any covered dependent on receipt of a request for such a certificate if that request is received by the Fund Office within two (2) years after the later of the date your coverage by the Fund ended or the date COBRA Continuation Coverage ended. You should address all requests for a HIPAA Certificate to: Plan Administration-HIPAA Certifications, NY Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund, 305 West 44<sup>th</sup> Street, 3<sup>rd</sup> Floor, New York, NY 10036.

## Medical Benefits

**Health Center benefits, how to make an appointment, what to do if you're away from home.**

### The In-Area Plan: Health Center Program

If you live in Manhattan, the Bronx, Brooklyn or Queens, you are considered an "in-area" Plan participant, and will be assigned to a Health Center near your home for your medical care. The following chart lists the locations of each of the Health Centers:

If you live in...	You'll be assigned to*...	Telephone number
Manhattan or the Bronx	52 <sup>nd</sup> Street Health Center 773-779 9th Avenue New York, NY 10019 Or Harlem Health Center 133 Morningside Avenue New York, NY 10027	212-586-1550  212-923-2525
Brooklyn	Brooklyn Health Center 68-80 Schermerhorn Street Brooklyn, NY 11202	718-858-7200
Queens	Queens Health Center 37-11 Queens Boulevard Long Island City, NY 11101	718-361-5100

\*Employees may request assignment to the 52<sup>nd</sup> Street Health Center.

### Covered Medical Services

When you use the Health Center, there are no deductibles, no co-pays (except for prescription drugs) and no claims to file. The Health Centers provide a complete range of medical, diagnostic and screening services, including:

- General medicine (including physical exams and routine check-ups)
- Internal medicine
- Pediatrics
- Pre-surgical testing, pre- and post-surgical care as well as post-surgical follow-up
- Obstetrics/Gynecology
- Laboratory services and Pathology
- Mammography
- Radiology; Ultrasound
- Cardiology
- Dermatology
- Allergy
- Neurology
- Pulmonology
- Orthopedics
- Chiropractic
- Physical therapy
- Urology
- Podiatry

- Ophthalmology
- Otolaryngology (ENT)
- Gastroenterology
- Endocrinology
- Urgent Care
- Medically necessary ambulance or ambulance services.

***You must obtain surgical care through the panel of Health Center referral providers. Your Health Center will coordinate all your medical and hospital care.***

## **Making an Appointment**

If you or your eligible family member need medical care, call your assigned Health Center to make an appointment. If you need to cancel your appointment, call the Health Center as soon as possible so that your reserved time can be given to someone else.

If you need to see a specialist outside the Health Center, or when you need to be hospitalized, the Health Center will make all the necessary arrangements for the appointment or the admission.

**As long as the Health Center arranges for the outside consultation or care, there is no cost to you. If you choose to use your own physician and are not referred through the Health Center, there is no coverage for services.**

**Whenever the Health Centers are closed, you can reach a nurse at Empire HealthLine at 1-877-825-5276 (1-877-TALK-2-RN) for advice.**

## **In Case of an Emergency**

If there is a medical emergency at home or at work when the Health Centers are closed, call the Empire HealthLine at **1-877-825-5276 (1-877-TALK-2-RN)** for advice on what to do. Empire HealthLine personnel are trained to assess your condition and refer you to the appropriate source for care. Remember to show your Empire BlueChoice ID card to the admitting clerk when going to a hospital for emergency services. If you are billed for the emergency service, you must bring a bill or receipt to the Fund Office for reimbursement or payment.

## **If You Are Away From Home**

If you have a medical emergency while you are away from home and are outside the Health Center service area, it's your responsibility to pay all fees. When you return, submit an itemized bill to the Fund Office, and your claim for benefits will be processed according to the rules of the Plan. If the claims are payable, bills are reimbursed based on the Fund's fee schedule.

## **If You Live Out of the Area: Empire PPO**

If you live outside of the operating areas of the Health Centers (Bronx, Brooklyn, Manhattan, and Queens), your major medical benefits (physicians' services and diagnostic tests) are provided through the Empire PPO and your hospital benefits are provided by the Fund under an administrative services contract between the Fund and Empire BlueChoice. *Refer to the separate Summary Plan Description for the Empire PPO for specific information on your major medical benefits.*

# Hospital Benefits

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## ***A list of benefits and information on getting the most from your hospital care.***

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The following information applies whether you live in the service area of a Health Center or participate in the out-of-area Empire PPO program.

If you use the Health Center and require hospitalization, your Health Center physician will coordinate your care and arrange for your hospital admission. Empire's Medical Management Program will help make sure you get care in the most appropriate setting. Upon admission to the hospital, you must call the Empire Medical Management Program number on the back of your Empire BlueChoice ID card.

Hospital benefits cover 100% of charges for semi-private care for the first 120 days. The next 180 days are paid at 50%.

### **Where to Obtain Care**

Benefits are provided in any participating hospital in Empire's operating area (twenty-eight (28) counties of eastern New York, including New York City).

***Please be aware that benefits will not be paid for care provided at a non-participating hospital within Empire's service area, except for emergency care for illness or injury. However, most hospitals in the service area are participating.***

If you need hospital care when you're away from home, you are covered in the US by the BlueCard program of which Empire BlueChoice is a member.

### **Maximizing Your Benefits: The Medical Management Program**

The Fund provides comprehensive hospital benefits, and encourages you and your family to get the most out of these benefits by coordinating your care through Empire's Medical Management Program. This program helps you receive health care in the most appropriate setting, reduce unnecessary hospitalizations and encourage the use of safe, cost-effective hospital alternatives.

Program physicians, nurses, and health care professionals will work with you and your doctor to:

- Choose the most appropriate health care setting (hospital, ambulatory surgery unit) or service (home care).
- Explain the different health care choices available, particularly alternate care settings.
- Assure that your stay lasts only as long as is medically necessary.
- Help arrange for any covered services needed after discharge.

The following sections describe in detail how the Medical Management Program works.

#### ***Notification***

You are required to call the Medical Management Program for certain services and situations outlined below. Either you or a representative, such as a family member, can reach a program representative by calling **1-800-841-2530**. This telephone

#### **If You Have Questions**

- Notify the Medical Management Program by telephone before a non-emergency admission. Have your Empire BlueChoice ID card available when you call.
- Make sure that a family member or friend knows that the program must be called within two business days after an emergency hospital admission.

number also appears on the back of your ID card. Business hours are 8:30 a.m. to 5:00 p.m., Monday through Friday.

After business hours and on weekends, please leave a message on the program's answering machine and be sure to include:

- Your name, birthday and sex.
- Your Empire identification number.
- Reason for admission and nature of the services to be performed.
- Name and telephone number of the admitting doctor.
- Your address, area code and telephone number where you can be reached between 8:30 a.m. and 5:00 p.m. on the next business day.
- Name and address of hospital/facility.

If more information is needed, you will be contacted on the next business day.

### ***When to Notify the Medical Management Program***

In order for you to receive the maximum available benefits, you or someone on your behalf must call the Medical Management Program in the following instances:

- At least two weeks prior to any planned surgery or hospital admission. This applies to ambulatory surgery as well as in-patient surgery.
- Within 24 – 48 hours of an emergency hospital admission. (You do not have to call if the emergency room sends you home.)
- Within the first three months of a pregnancy and no more than one business day after the actual delivery.
- Before receiving home health care or home infusion therapy services.
- Before admission to a skilled nursing facility.
- When needing hospice care.

Upon receiving all necessary medical records and information, Medical Management will discuss the treatment with you, your attending doctor, and any other providers. Within four (4) business days, they will send you, your doctor, and the hospital a written statement of approval or denial.

You do **not** have to call the program if:

- You or your dependent(s) are admitted to a hospital outside the continental United States  
or
- Your primary health coverage is Medicare.

**You must also call the Health Center to obtain prosthetics, orthotics and durable medical equipment supplies.**

### ***After you have Notified the Medical Management Program***

#### **Pre-admission Review**

Except in the case of an admission for maternity care, the Medical Management Program will conduct a pre-admission review after notification, but before you enter the hospital for a scheduled non-emergency admission. The pre-admission review will include:

- Reviewing the reason for admission.
- Helping you get a second surgical opinion, if requested.
- Discussing out-patient surgery with you and your physician, if appropriate.

The Program will send you, your physician and the hospital written confirmation when the pre-admission review has been completed.

### **Medical Necessity Review**

Most of the time, Medical Management Program staff can certify your admission to a hospital or continued hospital stay without having to talk with your physician. On occasion, it may be necessary for a Program physician to review your case and discuss it with your physician. Usually, the physicians reach an agreement during this discussion about the necessity of the admission or continued stay in the hospital. Either the Program's physician will agree on the in-patient setting, or your physician will agree that an alternative setting (such as an out-patient surgery unit) is appropriate.

In the rare event that the physicians cannot agree, the Medical Management Program will notify you, your physician and the hospital, in writing, that your admission or stay has not been approved on an in-patient basis.

### **During Your Hospitalization**

While you are in the hospital, the Medical Management Program staff will conduct a continued stay review, which includes:

- Working with the hospital and your physician to help make sure your stay lasts only as long as is medically necessary.
- Assisting in arranging for other covered services, such as home care, following hospital discharge when needed.
- Working with you and your family to identify and arrange continuing health care services in the case of a prolonged illness.

### **Out-Patient Surgery**

Some surgical procedures can be done without having to stay overnight in the hospital. Out-patient surgery offers a safe alternative to in-patient hospitalization, allows you to recuperate at home, and saves health care dollars.

If your physician wants you to stay overnight in the hospital for one of these surgical procedures, you must contact the Medical Management Program before admission. If you schedule an operation on an out-patient basis, and during or following surgery you develop complications that require admission to the hospital, you **must** call the Medical Management Program within one business day of the admission. You or your representative **must** call the Program even if you are discharged the following day.

### **Individual Case Management**

If you and your family face a catastrophic illness or injury, the Medical Management Program individual case management staff can provide assistance and support. You will have access to social workers and nurses who can help you and your family plan for post-hospital care.

Examples of such situations include:

- Cancer.
- Stroke.
- AIDS.
- Chronic illness.
- Spinal cord and other traumatic injuries.

### **Newborn Infants Requiring Specialized Care**

The birth of a new baby is usually a happy time. Hospitals typically discharge you and your baby within a few days, but this is not always the case. Because of a complicated or premature delivery or an illness discovered shortly after birth, your baby may remain in the hospital after

you return home. You must call the Medical Management Program within twenty-four to forty-eight (24-48) hours if your baby must remain hospitalized for any reason after your discharge. Program case managers are available to help you arrange for the often highly technical care that may enable your baby to go home sooner than would otherwise be possible.

## **In-patient Stays**

Semi-private room and board are covered in full for one hundred twenty (120) days of care, for one or several stays. After you have used all of your paid-in-full days of care, you are eligible for an additional one hundred eighty (180) days of care at the rate of 50% of the average semi-private charge. Another one hundred twenty (120) full days and one hundred eighty (180) partial days at 50% become available to you or your covered dependents each time there are ninety (90) days or more between hospital stays.

If you occupy a private room, you will receive a daily allowance equal to the hospital's average semi-private room charge toward the cost of bed, board and general nursing care. You are responsible for paying the difference.

If you are admitted to a hospital **outside** Empire's twenty-eight (28) county plan area that is not participating with a Blue Cross and/or Blue Shield plan, you will receive, for up to one hundred twenty (120) days, an allowance of thirty dollars (\$30) a day for room, board and general nursing services plus eighty percent (80%) of the hospital's allowed charges for other hospital services. You must pay the balance. For up to an additional one hundred eighty (180) days, the allowance is fifteen dollars (\$15) a day for room, board and general nursing services, plus 40% of the hospital's allowed charges for other hospital services.

## **Covered Hospital Services**

The following services are covered, regardless of the type of room occupied, if they are necessary for the diagnosis and treatment of the condition for which you are hospitalized:

- Use of operating rooms, cystoscopic rooms, recovery rooms and equipment.
- Use of intensive care or special care units and equipment.
- X-ray, laboratory and pathological examinations.
- Drugs and medicines for use in the hospital, which are commercially available for purchase and readily obtainable by the hospital.
- Blood, use of blood transfusion equipment and administration of blood or blood derivatives when given by a hospital employee.
- Sera, biologicals, vaccines and intravenous preparations.
- Anesthesia supplies and use of anesthesia equipment.
- Oxygen and other inhalation therapeutic services and supplies.
- Dressings and plaster casts.
- Radiation and nuclear therapy in a facility approved by the appropriate governmental authorities.
- Any additional medical services and supplies customarily provided by participating hospitals unless specifically excluded from the contract.

## **Maternity Care**

Your benefits cover pregnancy and any pregnancy-related treatment. It is important to notify the Health Center as soon as you are aware that you are pregnant. Your maternity care benefits include, at a minimum, coverage for a hospital stay of at least forty-eight (48) hours after childbirth for any delivery other than a cesarean section. Following a cesarean section delivery, the plan provides, at a minimum, coverage for a hospital stay of at least ninety-six (96) hours. You or your

spouse are automatically eligible for the above hospital lengths of stay following childbirth. If you or your spouse requires an extended hospital stay, you must call the Medical Management Program at 1-800-841-2530 immediately. See page 23 for specific information about medical necessity reviews.

If you or your spouse decide to be discharged earlier than either forty-eight (48) hours after childbirth for any delivery other than a cesarean section, or ninety-six (96) hours following a cesarean section, you or your spouse are entitled, upon request made within that time period, to one home care visit. This visit will be made within twenty-four (24) hours after discharge or of the time of the request, whichever is later. This home care visit is in addition to other home care benefits provided by the Plan. It is not subject to the deductible or coinsurance.

Maternity care coverage also includes, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal and newborn clinical assessments.

## Newborn Children

Hospital benefits are available from birth for:

- The treatment of illness or injury.
- Nursery care in an approved premature unit for an infant weighing less than 2,500 grams (5.5 pounds).
- Incubator care, regardless of your baby's weight.
- Circumcision.

Benefits for your newborn child also include, at a minimum, coverage for at least forty-eight (48) hours in a hospital following birth for any delivery other than a cesarean section. Following a cesarean section delivery, the plan provides, at a minimum, coverage for at least ninety-six (96) hours.

If your newborn requires an extended hospital stay, you must call the Medical Management Program at 1-800-841-2530 immediately to avoid any loss of benefits. See page 23 for specific information about medical necessity reviews for newborns.

## Out-patient Services

Out-patient services must be performed by an Empire BlueChoice participating provider.

**Services performed by non-participating providers are not covered by the Fund.**

However, emergency room services will be covered at eighty percent (80%) of the allowed amount.

You are covered for the same services on an out-patient basis in an Empire BlueChoice participating hospital that you would receive as a hospital in-patient. This includes all services, supplies and equipment given by the hospital as part of its regular in-patient care. The out-patient services described in this section are covered in full for up to thirty (30) visits or treatments per calendar year when provided in the emergency room or out-patient department of a participating hospital.

## Pre-Surgical Testing

You are covered for diagnostic tests performed in a participating hospital if the tests are prescribed by your doctor and are preliminary to scheduled surgery in the same hospital within seven (7) days.

## Chemotherapy

Benefits are available for unlimited cancer chemotherapy treatments (including medications) when provided in a participating hospital on an out-patient basis.

## Mammography Screening

Mammography screenings are covered if requested by a doctor and indicated by the patient's health history. In addition, annual mammography screenings are covered for women thirty-five (35) years of age and older.

## Mastectomy

### ***Breast Reconstruction Surgery Benefits Following Mastectomy***

Under the Women's Health and Cancer Rights Act of 1998, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery effective January 1, 1999 for this Plan. Therefore, members and dependents who receive benefits under this Plan in connection with a mastectomy, and who elect breast reconstruction, will be covered, in a manner determined in consultation with the attending physician and the patient, for:

- Reconstruction of the breast on which the mastectomy is performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Protheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

## Cervical Cytology Screening

Cytology screening benefits are provided for women eighteen (18) years of age and older for one routine pelvic examination per calendar year, including Pap smear and diagnostic evaluation of the Pap smear. These services must be given by a participating hospital employee and billed by the participating hospital.

## Dialysis for Kidney Failure

Your health plan covers hemodialysis or peritoneal dialysis while you are a registered in-patient in a participating hospital. Out-patient dialysis benefits are also available, as follows:

- **In your home** – The Fund will pay the cost of all appropriate and necessary supplies required for home dialysis treatment, as well as the reasonable rental cost of the required equipment.
- **In a participating hospital or freestanding facility** – The Fund will pay the cost of necessary treatment if the facility's dialysis program is approved by the appropriate governmental authorities.

These dialysis benefits will be available until you become covered by Medicare. After your Medicare coverage begins, the Fund becomes secondary.

## Emergency

An emergency is defined as the sudden beginning of a medical condition with symptoms of such severity, including severe pain, that a “prudent” layperson with an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention would result in any of the following:

- Placing the health of the affected person or others in serious jeopardy.
- Causing serious impairment to the affected person's bodily functions.
- Causing serious dysfunction of any bodily organ or part.
- Causing serious disfigurement of the affected person.

Your benefits cover the **first** visit for treatment of an emergency condition delivered in a participating hospital's emergency or operating room. To prevent having to pay unnecessary charges for using a hospital's emergency room when it is not medically necessary to do so and at the same time to get the care you need when you need it, just observe the following instructions:

### Emergency Room Tips:

- Emergency room care is for medical emergencies **only**, not for routine medical care. Emergency Room care is the most expensive way to treat a routine ailment.
- The Fund covers emergency room care **only** when medically necessary.
- The Fund will **not** cover emergency room care if it's late at night and the need for treatment is not sudden and serious.

### What to do in an emergency

1. If you have questions about health situations and/or emergencies, you should call your personal physician for advice. Your personal physician will direct you to the appropriate care setting. Or you may call Empire HEALTHLINE<sup>SM</sup> at **1-877-TALK-2RN (825-5276)**. This toll-free 24-hour service links you to professional nurses who can give you medical information.
2. Call an ambulance or go directly to an emergency room if you cannot call your personal physician in advance. Emergency care does not require your provider's prior approval. If possible, go to the emergency room of the hospital where your personal physician is affiliated.
3. When you arrive at the emergency room, show your member identification card. If you are admitted, you or your representative must contact Medical Management within 24 – 48 hours (or as soon as reasonably possible).

### Emergency care outside the Plan's service area

If you have a medical emergency while you are away from home and outside Empire's service area (twenty-eight (28) counties in New York State), follow Steps 1 and 2 above.

If you must go to an emergency room, show your Empire BlueChoice ID card at the hospital. If the hospital participates with another Blue Cross and Blue Shield plan, that plan will submit your claim to Empire. Otherwise, you will have to pay the bill and submit it to the Fund for reimbursement according to the Plan's fee schedule.

## Home Health Care Benefits

Home Care benefits are available under a physician-approved plan of treatment when the necessary services are provided by a New York State-certified home health agency. Benefits will be provided only if hospitalization or confinement in a skilled nursing facility would otherwise have been required.

When care is provided with prior hospitalization, the Plan pays for up to a maximum of two hundred (200) visits per calendar year.

When care is provided without prior hospitalization or through a non-participating agency, you must pay a fifty dollar (\$50) deductible. You will receive an allowance

**Home care must be approved in advance by calling the Medical Management Program at 1-800-841-2530.**

equal to 75% of the agency's allowed charges for up to a maximum of forty (40) home care visits per calendar year.

Covered services include:

- Part-time professional nursing.
- Part-time home health aide services (up to four (4) hours of such care is equal to one (1) home care visit).
- Physical, occupational or speech therapy.
- Medical supplies, drugs and medicines prescribed by a physician.
- Necessary laboratory services.

Additional services are available when home care is provided by an agency that participates in an agreement with Empire BlueChoice to provide home care if care begins within seven (7) days of discharge from a hospital:

- Medical social work visits.
- X-ray and EKG services.
- Ambulance or ambulette services between the patient's home and hospital.

## Hospice Benefits

The Fund provides a lifetime maximum of up to two hundred ten (210) days of the following:

- In-patient hospice care in a hospice.
- Hospital, home care and out-patient services delivered by the hospice.

**Hospice care must be approved in advance by calling the Medical Management Program at 1-800-841-2530.**

The following conditions apply:

- The patient must be certified by his or her primary attending physician as having a life expectancy of six (6) months or less.
- The hospice is both located in New York State and is certified under Article 40 of the New York Public Health Law.
- The hospice is located outside of New York State and is certified by the state in which the hospice organization is located.

When care is provided by a facility that has an agreement with Empire or any other Blue Cross Plan in New York State, the patient will receive full benefits for covered services. When the facility does not have such an agreement with Empire, coverage is limited to eighty percent (80%) of the facility's charges for services, but in no case will payment to such a facility exceed eighty percent (80%) of the average payment the Fund would make for a like service to a participating facility.

Typically, covered hospice and out-patient services include:

- Bed patient care, either in a designated hospice unit or in a regular hospital bed.
- Day care services provided by the hospice organization.
- Home care and out-patient services provided by the hospice and billed by the hospice, such as:
  - Intermittent care by an RN, LPN or Home Health Aide.
  - Physical therapy.
  - Speech and occupational therapy.
  - Respiratory therapy.
  - Social services.
  - Nutritional services.
  - Laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms.

- Medical supplies.
- Drugs and medications prescribed by a physician which are considered approved under the *US Pharmacopoeia* and/or *National Formulary* (not covered when the drug or medication is of an experimental nature).
- Medical care provided by the hospice physician.
- Five (5) visits for bereavement counseling for the covered person's family, either before or after the covered person's death.
- Durable medical equipment (rental only).
- Transportation between home and hospital or hospice organization when medically necessary.

## Skilled Nursing Facility Benefits

Benefits are provided for approved care in a Skilled Nursing Facility as a substitute for all or part of a hospital stay. Skilled nursing care includes:

- Medical care.
- Nursing care.
- Rehabilitation services given to injured, disabled or sick persons in a skilled nursing facility.

Benefits are subject to the following requirements:

- The admission to a Skilled Nursing Facility must follow a hospitalization and be for treatment of the same condition.
- The services at the Skilled Nursing Facility must be provided by skilled personnel to ensure the patient's safety and to achieve the best possible medical result.
- The Medical Management Program must approve all admissions in advance.

**Skilled Nursing Facility care must be approved in advance by calling the Medical Management Program at 1-800-841-2530.**

Members may receive Skilled Nursing Facility care under the direct supervision of any of the following:

- Doctor.
- Registered professional nurse.
- Physical therapist.
- Other health care professional.

**YOUR DOCTOR MUST PROVIDE THE FOLLOWING INFORMATION SO WE CAN DETERMINE IF SKILLED NURSING BENEFITS ARE NECESSARY:**

- ◆ A written treatment plan
- ◆ The projected length of stay
- ◆ An explanation of the services the patient needs to receive

*Treatment will continue based upon medical necessity.*

# Prescription Drug Benefits

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## *How to fill prescriptions, and costs.*

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Most prescription drugs are available through the Plan, which uses a formulary developed in conjunction with Health Center physicians. All prescriptions are filled generically when a generic form of the drug is available.

**A formulary is an official guideline or list of drugs covered under the Plan.**

A formulary is a list of prescription drugs that Health Center physicians are authorized to prescribe and Health Center pharmacists are authorized to fill. Wherever possible, the formulary includes the generic equivalents of brand name drugs. The formulary changes frequently, based on the number of new drugs coming on the market and the needs of Health Center members. If the formulary contains a generic drug which proves ineffective in treating your medical condition, your Health Center physician is authorized to prescribe its name brand version. The Plan Administrator and Plan fiduciaries are responsible for maintaining and updating the formulary. You may obtain a copy of the current formulary upon written request to the Fund's Chief Medical Office at the Fund Office.

**You must have your prescriptions filled by a pharmacy department located at the Harlem, Midtown Manhattan, Brooklyn or Queens Health Centers. Prescriptions written by a licensed physician or other licensed provider may be filled at the Health Centers, provided they comply with applicable New York State law and are written for a drug listed on the formulary.**

## **Benefits Provided**

Under the Prescription Drug Program, generic prescription drugs on the formulary are provided at \$5 per prescription. In cases where a brand name drug found on the formulary is the only choice available, the cost is \$15 per prescription. If the drug prescribed does not appear on the formulary listing, the Fund may make the prescription available at the actual cost to the member, with no mark-up in price. Under the terms of the program, a 30-day maximum supply of medication will be given with each prescription.

## Vision Benefits

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### *Eye care for you and your family.*

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Information concerning eligibility, location and services may be obtained through the Health Centers or the Fund Office. Vision services can be obtained at any participating General Vision Services (GVS) store. There is no coverage for vision services received from non-GVS providers.

### **Benefits Provided**

You and each of your covered dependents are entitled to the following vision benefits once a year at no cost:

- Comprehensive eye examination, including glaucoma testing.
- Selection of various frames in any style, color or size, up to the retail value announced from time to time by the Fund Office.
- All first-quality lenses (any prescription) in plastic or glass, including single vision lenses, bi-focals (kryptok, flat top 28), conventional tri-focals, lenticular lenses, oversize lenses and safety lenses.
- All tints through sunglass shades seventy percent-eighty percent (70%-80%).
- Standard hard or soft daily and extended wear spherical contact lenses in place of eyeglasses, if preferred.

You may purchase services or supplies that are not covered under the Plan by paying an out-of-pocket charge. Plan participants are entitled to a discount of 30% or more on all charges.

### **Direct Pay Plan**

A Direct Pay plan is available to retirees' spouses and dependents, and to employees and their spouses, dependents and domestic partners who are not yet eligible to participate in the vision benefit program because the employee has not completed nine (9) months of full-time covered employment.

In addition, the Direct Pay plan is available to active employees and their eligible family members who have exhausted their vision benefits for the current year.

**To find out more about the Direct Pay plan, call or visit your nearest GVS location.**

# Dental Benefits

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## *Location of providers and what's covered.*

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Full dental coverage is offered for all services shown in the schedule below. Orthodontic work is not covered, nor is general anesthesia used during oral surgery. Services are provided through the Health Centers and dental offices located in Westchester County and Long Island. A listing of these “out of area” dental offices is available at the Fund Office and/or Health Centers. Advance appointments are required for all dental care. To make an appointment, call your Health Center during office hours Monday through Friday. Hours vary according to each office, so call to verify them. If an appointment needs to be canceled, notify the office at least twenty-four (24) hours in advance.

## Dental Office Locations

The following are the locations of the Fund Offices providing dental services:

<b>Service Areas:</b>	<b>Address:</b>	<b>Telephone number:</b>
Manhattan or the Bronx	Harlem Health Center 133 Morningside Avenue New York, NY 10027	212-923-2525
Brooklyn	Brooklyn Health Center 68-80 Schermerhorn Street Brooklyn, NY 11202	718-858-5830
Queens	Queens Health Center 37-11 Queens Boulevard Long Island City, NY 11101	718-361-5100
All boroughs	14 Penn Plaza – 4 <sup>th</sup> Floor New York, NY 10121	212-563-0095

## Benefits Provided

The following is an outline of dental services provided:

### Diagnostic

- Panoramic, full mouth and bite wing x-rays
- Oral exam & treatment plan
- Study models
- Biopsy
- Vitality test
- Special consultation

### Operative Dentistry

- Amalgam fillings
- Inlays and onlays
- Fillings: composite and sedative
- Composite bonding

### Endodontics

- Pulpotomy
- Pulp capping

- Root canal therapy
- Apicoectomy
- Retrograde fillings

#### **Periodontics**

- Tooth planning
- Gingival curettage
- Occlusal adjustment
- Osseous surgery
- Soft tissue graft
- Prophylaxis

#### **Fixed Prosthetics**

- Crowns: acrylic jacket, porcelain jacket, cast metal and acrylic veneer
- Porcelain bonded to metal crown
- Pontics
- Cast metal post

#### **Removable Prosthetics**

- Full upper and lower dentures
- Partial dentures: cast or acrylic
- Denture relines, repair and adjustment
- Tissue conditioning

#### **Oral Surgery**

- Extractions: simple and surgical
- Frenectomy
- Tori removal
- Cyst removal
- Simple fractures
- Alveoplasty
- Tumor removal
- Incision and drainage of infections

#### **Miscellaneous Services**

- Space maintainers
- Topical fluoride treatment
- Emergency treatments
- Mouth guards

#### **Excluded Services**

- Orthodontia
- General anesthesia used during oral surgery
- Dental implants and implant restoration, unless approved by the dental director in cases of medical necessity
- Any treatment for and relating to Temporo-Mandibular Joint (TMJ) Dysfunction
- Hospital confinements, for dentistry and dental surgery not covered under the Plan
- Services or supplies which are cosmetic, experimental, or not medically necessary

# Members' Health Assistance Program (MHAP)

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***When you need substance abuse treatment or mental health care, this program is available.***

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The Members' Health Assistance Program (MHAP) offers confidential consultative and crisis intervention assistance to all employees and their eligible family members who may be affected by emotional problems (including marital/family problems and stress-related issues), or alcohol or drug related problems. You and your eligible family members are urged to use this program.

## MHAP Office Location

Confidential services are available at:  
709 Eighth Avenue, 3<sup>rd</sup> Floor  
New York, NY 10036  
212-765-1010 or 1-888-615-6427

## Benefits Provided

### ***In-patient Substance Abuse Treatment***

If it is medically necessary for you to be hospitalized for the diagnosis and treatment of alcoholism or substance abuse, you must contact MHAP first. The MHAP Office will arrange for your care. The following benefits are provided:

- Seven (7) days of active treatment per calendar year for detoxification.
- Thirty (30) days of in-patient rehabilitation services per calendar year with a maximum of two (2) admissions per lifetime.

<p><b>Prior approval for substance abuse treatment is required by MHAP.</b></p>
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### ***Out-patient Substance Abuse Treatment***

MHAP has established its own out-patient program for eligible individuals who are registered with a Health Center. There is no limit on the number of visits. If you live outside the Health Center service area and are therefore covered by the Empire PPO, you are covered for sixty (60) out-patient visits per calendar year for diagnosis and treatment of alcoholism/substance abuse. Family counseling can be provided with a maximum of twenty (20) visits for out-of-area members. Payment for out-of-area visits is limited to fifty dollars (\$50) per visit.

### ***Out-patient Counseling Benefits***

MHAP has established its own out-patient counseling program for eligible individuals who are registered with a Health Center. There is no limit on the number of visits. If you live outside the Health Center service area and are therefore covered by the Empire PPO, you are covered for out-patient counseling services providing evaluation/assessment, short-term crisis counseling, and referral to appropriate resources for mental health services with a provider of their choice. However, benefits are limited to one hundred twenty-five dollars (\$125) for an initial assessment and twelve (12) additional visits at fifty dollars (\$50) per session. Members will be responsible for any difference between the covered dollar amount and the fee charged.

# Benefit Limitations and Exclusions

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## *Services Not Covered.*

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Benefits are not provided by the Fund for the following:

- Medically unnecessary or inappropriate services.
  - Services usually given without charge, or services provided by an immediate family member.
  - Confinement in a non-participating hospital within the operating area of Empire BlueChoice, except for emergency care for illness or injury.
  - Hospital confinements for dentistry and dental surgery.
  - Confinement for custodial or convalescent care, or for rest cures, or for long-term care in a hospital.
  - Hospital admissions for cosmetic surgery and physical therapy.
  - All procedures relating to transsexual surgery or reversals, or associated hormone therapies.
  - Durable medical equipment not authorized by Health Center personnel.
  - Hospital confinements or any period of hospital confinement primarily for diagnostic studies.
  - Workers' Compensation cases.
  - Hospitalization furnished under federal, state, or other laws (except Medicaid).
  - Military service-related care in a veterans' facility or a hospital operated by the United States government.
  - Ambulance, air ambulances or ambulette service (except as authorized by Health Center personnel).
  - Expenses associated with private duty or special nurses, or other private attendants.
  - Services in the home, except for those services expressly stated as covered.
  - In-patient admissions for mental health care or electroshock therapy. Drug and alcohol detoxification and rehabilitation are excluded, except as authorized by the Members' Health Assistance Program.
  - Any injury, loss, or partial loss for which mandatory automobile no-fault benefits are recovered or recoverable.
  - Referrals by physicians or other practitioners to facilities in which they or an immediate family member have a financial interest or relationship.
  - Any injury or illness received as a result of war, declared or undeclared, or any act of war.
  - Technology (including treatments, procedures, drugs, biologicals or medical devices), and any hospitalization related to the same, that, in the Plan's sole discretion, are not medically necessary because they are: experimental, investigational, obsolete, or ineffective. "Experimental" or "investigational" means that the technology is:  
Not of proven benefit for either the particular diagnosis or treatment of the covered person's condition.
- or
- Not generally recognized by the medical community (as reflected in the published peer-reviewed medical literature) as effective or appropriate for the particular diagnosis or treatment of the covered person's particular condition.
  - Any services, treatment or supplies which are not identified in this booklet as covered.

# Life Insurance Benefits

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## *Important information for your family.*

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Life insurance coverage is fully insured by ULLICO.

### **Benefits Provided**

A life insurance benefit in the amount of ten thousand dollars (\$10,000) will be paid to your beneficiary in the event of your death from **any cause** at any time, provided you are eligible for coverage at the time of your death. Your beneficiary may be any person or persons you name at the time of enrollment. You may change your beneficiary at any time by writing, calling or visiting the Fund Office to request the appropriate forms. The last written beneficiary designation which has been properly completed and signed by you and actually received by the Fund Office will determine who is eligible to receive a life insurance benefit after your death.

### **Converting Your Life Insurance**

If you stop working for an employer contributing to the Fund, you may change your group life insurance provided by the Fund to an individual life insurance policy, without having a medical examination, during the 31-day period after life insurance benefits under the Fund terminate. Life insurance benefits will be paid in the event your death occurs during the thirty-one (31) days after coverage terminates. You may select any type of individual policy then customarily being issued by ULLICO, except term insurance or a policy containing disability benefits. You are responsible for paying the premiums for this conversion. The individual policy premium will be the same payment as it ordinarily would be if you applied for an individual policy at that time.

**You don't need a medical examination to convert your life insurance within 31 days of losing group coverage.**

If you're disabled, to assure continuous protection, you may change your group life insurance coverage provided by the Fund to an individual life insurance policy issued by ULLICO, during the thirty-one (31) days following the end of the twenty-six (26) week disability period.

If you immediately convert to an individual policy and later on apply and are approved for continued no-cost coverage because of a disability, the individual policy will be voided and any premium payments made will be returned to you.

### **Waiver of Premium**

If you become Totally Disabled while insured by ULLICO and prior to reaching age sixty (60), your life insurance will be continued without payment of premium while your Total Disability continues. The initial continuation of your insurance under this provision will be for twelve (12) months from the date the disability begins. "Totally Disabled" and "Total Disability" mean your complete inability, due to injury or illness, to engage in any business, occupation or employment, even on a part-time basis, for which you are qualified or become qualified by reason of education, training or experience, for pay, profit or compensation.

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\*If you have converted your life insurance protection to an individual policy and again become eligible for insurance under this Fund while the converted policy is in force, you should notify the Fund Office.

No coverage under this Waiver of Premium provision will be provided until the following requirements have been satisfied:

1. You must remain totally disabled for at least nine (9) consecutive months.
2. You must submit satisfactory written proof of Total Disability to ULLICO within twelve (12) months from the date the disability begins.

If acceptable written proof is not received within this twelve (12) month period, any life insurance continued under this Waiver of Premium provision will terminate at the end of the twelve (12) month period.

The amount of life insurance that will be continued under the Waiver of Premium provision will be the amount of insurance in force for you on the date disability begins, subject to any reduction or termination in the amount of insurance due to reaching specific age(s) or retirement.

# Accidental Death and Dismemberment (AD&D) Benefits

## *Benefits for you or a beneficiary in case of an accident.*

Accidental Death and Dismemberment (AD&D) coverage is fully insured by ULLICO.

### Benefits Provided

An AD&D benefit will be paid for any of the following losses occurring on or after July 1, 1998 through accidental means, **on or off the job**. The loss must occur within ninety (90) days after the accident and while you are eligible. Payment will be made in addition to any other benefits you may receive.

**AD&D benefits will be paid whether your accident occurs on or off the job.**

<b>Loss:</b>	<b>Benefit Paid:</b>
Loss of Life	Ten thousand dollars (\$10,000) (Paid to the beneficiary)
Loss of: <ul style="list-style-type: none"> <li>• Both hands.</li> <li>• Both feet.</li> <li>• Sight of both eyes.</li> <li>• One hand and one foot.</li> <li>• One hand and sight of one eye.</li> <li>• One foot and sight of one eye.</li> </ul>	Ten thousand dollars (\$10,000) (Paid to the employee)
Loss of: <ul style="list-style-type: none"> <li>• One hand.</li> <li>• One foot.</li> <li>• Sight of one eye.</li> </ul>	Five thousand dollars (\$5,000) (Paid to the employee)

Payment for all losses by any one (1) accident may not be more than ten thousand dollars (\$10,000), but the benefits paid on account of one (1) loss will not prevent further payment for losses resulting from subsequent accidents.

These benefits will not be paid for death or any other loss caused by war, suicide or attempted suicide, commission or attempted commission of a crime, bodily or mental infirmity or disease, an infection other than a pyogenic infection of an accidental cut or wound, or travel in any moving aircraft aboard which the member is giving or receiving flight training.

# Accident and Sickness Weekly Benefits

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## *Information on your weekly benefits when you're disabled by an illness or injury outside of work.*

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Accident and Sickness Weekly (Short-Term Disability) benefits are provided under an insurance contract with ULLICO.

### Benefits Provided

If you are unable to work because of an **off-the-job** accident or sickness, you must contact the Fund office. You will be given a form which you and your physician must complete. Return the form to the Fund office, for verification of your employment and salary. If you are eligible you will receive the following benefit:

- Fifty percent (50%) of salary, up to three hundred dollars (\$300) per week.
- Benefits are payable for a maximum of 26 weeks in a rolling 52-week period.

Benefits are payable from the first (1<sup>st</sup>) day of disability due to an accident, or from the eighth (8<sup>th</sup>) consecutive day if disability is due to sickness. However, if disability due to sickness continues until the eighth (8<sup>th</sup>) day, benefits are retroactive to the first (1<sup>st</sup>) day.

Periods of disability caused by the same or related injury or sickness are considered the same period of disability if they are separated by less than two (2) weeks of continuous active covered employment.

A weekly benefit is payable for disability due to pregnancy and is payable as for any other sickness.

### New York State Disability Benefits Law

In the case of full-time employees working for contributing employers who are subject to the New York State Disability Benefits Law, the Accident and Sickness Weekly Benefit provided by the Health Benefits Fund qualifies as a plan under the New York State Disability Benefits Law.

**This benefit applies to non-work-related injury or illness. Workers' Compensation covers work-related situations.**

## Filing Claims

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### *When you need to file a claim or appeal a denial, and coordination of benefits.*

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The Fund pays only those Health Benefits established by the Union and the Hotel Association through collective bargaining. An equal number of Fund Trustees appointed by the Union and by the Hotel Association are responsible for administering the Fund to provide those Health Benefits to eligible employees and their eligible family members. The Trustees, through the Fund Executives, have hired physicians, dentists, pharmacists, nurses, aides, technicians and administrative personnel to staff the Health Center operations and have contracted with Empire BlueChoice to pay and provide hospital benefits. Any dispute as to eligibility, type or amount of benefits will be resolved by the Appeals Committee of the Fund's Board of Trustees.

### **FOR HOSPITAL APPEALS**

(Administered by Empire BlueChoice)

#### **Medical Management Level 1 Appeals and Timeframes**

An appeal is a request to review and change an adverse determination made by Empire that was based on **medical necessity**. You have one hundred eighty (180) calendar days from the date on the adverse determination notice to appeal.

Level 1 Appeals must be received within one hundred eighty (180) calendar days of the date on the notice of the adverse determination. An appeal submitted beyond the one hundred eighty (180) calendar day limit will **not** be accepted for review.

There are two basic types of appeals:

- **Prospective:** An appeal to overturn an adverse determination that was made *prior to* or *during* a patient's medical service.
- **Retrospective:** An appeal to overturn a claim-related adverse determination that was made *after* the service was provided. Retrospective appeals will not be expedited.

The Medical Management Program will notify you in writing whenever your benefits will be reduced. You may appeal this decision by telephone or in writing within one hundred eighty (180) calendar days of a benefit reduction or denial of a claim if:

- You believe extenuating circumstances prevented you from complying with Medical Management requirements.
- You followed the treating doctor's recommendation even though it was contrary to the Medical Management's opinion as to the appropriate setting or type of care.
- You believe that benefits were otherwise reduced incorrectly by the Medical Management Program.

Empire will acknowledge your appeal in writing within fifteen (15) calendar days from the initial receipt date of the appeal. Empire will render one of the following decisions within thirty (30) calendar days from the initial receipt date:

- **Request additional information necessary to make an Appeal decision:** A detailed explanation of the required information will be requested by Empire in writing within fifteen (15) calendar days from your provider. You will receive a copy of this request. If only some of the information requested is received, Empire will notify you within five (5) business days.

If additional information is requested, the final decision (either upheld or overturned) will be made within forty-five (45) business days from the initial date, regardless of whether the requested information is received. This will be communicated to you in writing within five (5) business days of that decision.

- **Deny the Appeal:** A letter will be sent to you with a detailed explanation (clinical rationale) of why Empire is denying, in whole or in part, the appeal.
- **Approve the Appeal:** A letter will be sent that notifies you Empire is approving the appeal.

Empire's decision will be communicated to you in writing within five (5) business days of making that decision.

## Medical Management Level 2 Appeals and Timeframes

You have one hundred eighty (180) calendar days from the date of the final adverse determination to request a Level 2 Appeal. A Level 2 Appeal provides you or a designated representative with an opportunity to present your case before Empire's Appeals Committee. Whether you appear or not, the Appeals Committee will review the appeal and render a decision. The Appeals Committee will render its decision within thirty (30) business days from the initial receipt date of the Level 2 Appeal. The decision will be communicated to you in writing within five (5) business days of the decision.

Level 2 Appeals must be received within one hundred eighty (180) calendar days of the date on the notice of the final adverse determination. An appeal submitted beyond the one hundred eighty (180) calendar day limit will **not** be accepted for review.

**Expedited Appeals:** Empire will speed up the appeal process (an "expedited appeal") and deliver a rapid decision when the situation involves:

- Continuations or extensions of health care services, procedures or treatments already begun.
- A prospective appeal decision that, if delayed, would pose a serious or imminent threat to your health.
- Additional care during an on-going course of treatment.
- A case in which the provider believes an appeal is justified.

When requested under these circumstances the following timeframes will apply:

- Empire will provide you or your provider with reasonable access to our clinical reviewer within one business day of receiving a request for an expedited appeal.
- Empire will finalize and communicate a decision on an expedited appeal to you within two (2) business days following receipt of all necessary information about the case. When additional information is required by Empire, this timeframe can be extended by no more than seventy-two (72) hours. A decision will be made by the 72<sup>nd</sup> hour based on the information at the time.

To make an appeal, write to the following address:

**Medical Management Department  
Empire BlueChoice  
Attn: Appeals Unit  
P. O. Box 1407  
Church Street Station  
New York, NY 10008-1407.**

Call 1-800-841-2530 if you have any questions on how to initiate an appeal.

Qualified professionals consisting of clinicians and physicians who were not involved in your original adverse benefit determination will review your appeal. They will advise you, the attending doctor, and the hospital of the decision within thirty (30) calendar days but no later than forty-five (45) business days from when the additional information is requested.

## **For Medical (Non-Hospital) and Dental Appeals**

Any person who is notified that a claim to receive medical or dental benefits has been denied, who would like the decision denying his or her claim to be reviewed, may submit a written request to the Fund's Appeals Committee. In connection with his or her request for review, the Claimant appealing the denial shall be entitled to review relevant Fund documents and submit issues and comments in writing to the Fund's Chief Operating Officer to be considered by the Appeals Committee.

The written request for review must state in clear and concise terms the reason(s) for the Claimant's disagreement with the decision and *must be filed with the Chief Operating Officer within one hundred eighty (180) days from the date shown on the notice of denial of the claim.*

**IMPORTANT: If a Claimant fails to request review of the denial of his or her claim within this 180-day period, he or she will lose the right to obtain a review of the original decision denying his or her claim and that decision will be final and binding upon the Claimant whose claim for benefits was denied. This failure will not, however, prevent the Claimant from establishing benefit entitlement at a later date based on additional information and evidence which was not available at the time of the decision denying the claim.**

When the Fund receives the Claimant's written request for review, including appropriate material, the Appeals Committee will proceed to review the case, including the Claimant's request and its contents. A decision by the Committee will be made promptly and not later than thirty (30) days after the receipt of the request for review by the Fund's Chief Operating Officer unless special circumstances require an extension of time for processing, in which case a decision shall be made as soon as possible, but not later than forty-five (45) business days after receipt of the Claimant's request for review. The Claimant will be advised of the Appeals Committee's decision in writing. The written notification will include specific reasons for the decision and references to pertinent Plan provisions upon which the decision is based.

## **Expedited Appeals**

The Fund will speed up the appeal process (an "expedited appeal") and deliver a rapid decision when the situation involves:

- Continuations or extensions of health services, procedures or treatments already begun.
- A prospective appeal decision that, if delayed, would pose a serious or imminent threat to your health.
- Additional care during an ongoing course of treatment.
- A case in which the provider believes an appeal is justified.

When requested under these circumstances the following timeframes will apply:

- The Fund will provide you or your provider with reasonable access to our clinical reviewer within one business day of receiving a request for an expedited appeal.
- The Fund will finalize and communicate a decision on an expedited appeal to you within two (2) business days following receipt of all necessary information about the case. When additional information is required by the Fund, this timeframe can be extended by no more

than seventy-two (72) hours. A decision will be made by the 72<sup>nd</sup> hour based on the information at the time.

To make an appeal, write to the following address:

**The New York Hotel Trades Council and  
Hotel Association of NYC, Inc. Employee Benefit Funds  
305 West 44<sup>th</sup> Street, 3<sup>rd</sup> Floor  
New York, NY 10036  
Attn: Appeals Committee**

Call 1-212-586-6400 if you have any questions on how to initiate an appeal. Qualified professionals consisting of clinicians and physicians who were not involved in your original adverse benefit determination will review your appeal.

The decision of the Appeals Committee shall be final and binding upon all parties, including the Claimant and any person claiming benefits under the Claimant. The provisions of this section will apply to and include any and every claim to Medical or Dental Benefits under the Fund and any claim or right asserted against the Fund, regardless of the reason for the claim and regardless of when the act or failure to act upon which the claim is based occurred. (See also "Your Rights Under ERISA")

*Please note: The Appeals Committee does not have the authority to change or add to the types of health benefits provided by the Fund.*

### Appeals Decision Timeframe

	Hospital Appeals	Medical (non-hospital) and Dental Appeals
<b>Level 1 Appeal</b>		
Number of days to appeal adverse determination	180 days from adverse determination	180 days from adverse determination
Timeframe in which you will receive a decision	Within 30 days of receipt of appeal	Within 30 days of receipt of appeal
<b>Level 2 Appeal</b>		
Number of days to appeal adverse determination	180 days from adverse determination	
Timeframe in which you will receive a decision	Within 30 days of receipt of appeal	
<b>Expedited Appeals</b>		
Timeframe in which you will receive a decision	Within 2 business days of receipt of appeal	Within 2 business days of receipt of appeal

### Subrogation and Third-Party Liability

If you or your dependent's injury or illness was in any way caused by a third party who may be legally liable or responsible for the injury or illness, no benefits will be paid under the Fund unless you agree in writing to do *all* of the following:

- Provide the Fund with a written notice of any claim made against the third party for damages as a result of the injury or illness.

- Agree to reimburse the Fund for benefits paid by the Fund when a recovery is received from or on behalf of the third party or the insurer of the third party, in an amount up to, but not exceeding the recovery.
- Execute a lien in favor of the Fund for the amount to which the Fund is entitled.

The term “recovery” includes any amount received by way of a court judgment, arbitration award, settlement or any other arrangement including amounts received from uninsured motorist coverage.

If you or your dependents receive any money from a third party as a result of an injury or illness, through any means, including a settlement, court judgment or arbitration award, you **must** reimburse the Fund for any benefits that it has paid. In no event will the reimbursement exceed the *lesser* of the amount of benefits actually paid by the Fund or the amount of the recovery. The Fund will not pay any portion of your attorney’s fees incurred in connection with your claim against the third party. If your attorney receives a portion of your recovery, however, the reimbursement will not exceed the amount of recovery as reduced by the amount retained by your attorney as his or her fee.

If you or your dependent do not execute a lien, you will still be personally liable to the Fund for reimbursement from any monies received from a third party of any benefits paid by the Fund. Reimbursement of benefits paid by the Fund for an injury or illness, for which you or your dependent have received any settlement from a third party or received reimbursement from uninsured motorist coverage for an injury or illness caused by a third party, is your personal liability. If reimbursement is requested and not received, the Fund will pursue all available legal and equitable remedies.

This subrogation provision does not apply to any coverage not required by law for which you pay the entire premium.

## **Claims and Appeals Procedures – Life Insurance and AD&D Benefits**

If a claim for life insurance or AD&D benefits insured by ULLICO is denied in whole or in part by ULLICO, you will be notified in writing within ninety (90) days of receipt of your claim. In special circumstances, an additional ninety (90) days may be required for consideration of your claim. If additional time or information is needed, you will be notified in writing of the reasons before the first 90-day period expires. In no case will the extension exceed one hundred eighty (180) days from the date your claim was received by ULLICO.

The notice of decision on your claim will contain specific reasons for the decision and a specific reference to the provisions of the Plan or policy on which the decision is based. The notice will also describe any additional information you must provide to perfect your claim and explain why this information is necessary. You will have forty-five (45) days to submit this additional information to ULLICO.

An employee or dependent whose claim has been denied in whole or in part by ULLICO may appeal the decision to the Appeals Committee of the Board of Trustees of the Fund. An appeal to the Appeals Committee must be in writing, submitted to the Chief Executive Officer of the Fund within sixty (60) days of the initial denial of the claim, accompanied by a statement giving the reasons the denial is believed to be incorrect. You will be given full access by ULLICO to all documents or other information that relates to your claim for this purpose.

A decision by the Appeals Committee shall be made within sixty (60) days after the receipt of the appeal. An additional sixty (60) days may be required under special circumstances. If

additional time or information is needed, you will be notified in writing of the reasons before the first 60-day period expires. In no case will the extension exceed one hundred twenty (120) days from the date your appeal was received. The notice of the decision will contain specific reasons for the decision and a specific reference to the provisions of the Plan or policy on which the decision is based.

The decision of the Appeals Committee on your claim is final. If you disagree with the decision, you have the right to bring a legal action against the Fund and its Trustees in Federal Court. See the “Your Rights Under ERISA” section of this booklet.

## **Claims and Appeals Procedures – Short-Term Disability Benefits**

If a claim for short-term disability benefits provided through ULLICO is denied in whole or in part by ULLICO, you will be notified in writing within forty-five (45) days of receipt of your claim. In special circumstances, an additional period of thirty (30) days may be required for consideration of your claim. If additional time or information is needed, you will be notified in writing of the reasons before the initial 45-day period expires. A second 30-day extension of time to consider your claim may be obtained by ULLICO if you are notified in writing, before the end of the first 30-day extension, that additional time is necessary to make a decision upon your claim. Notice of any extension of time needed by ULLICO to decide your claim will include a description of the rules of the Plan, the unresolved issues which prevent ULLICO from making a decision and the additional information you must submit to ULLICO. You will have forty-five (45) days to submit this additional information to ULLICO. In no case will the extension exceed seventy-five (75) days from the date your claim was received by ULLICO.

The notice of decision on your claim will contain specific reasons for the decision and a specific reference to the provisions of the Plan or policy on which the decision is based. The notice will also describe any additional information you must provide to perfect your claim and explain why this information is necessary. You will have forty-five (45) days to provide any additional information requested by ULLICO.

An employee whose claim for short-term disability benefits has been denied in whole or in part by ULLICO may appeal the decision to the Appeals Committee of the Board of Trustees of the Fund. An appeal to the Appeals Committee must be in writing, submitted to the Chief Executive Office of the Fund within one hundred eighty (180) days of the initial denial of the claim, accompanied by a statement giving the reasons the denial is believed to be incorrect. You will be given full access by ULLICO to all documents or other information that relate to your claim for this purpose, including the identity of any medical or vocational professionals who were consulted by ULLICO.

A decision by the Appeals Committee shall be made with forty-five (45) days after receipt of your appeal. An additional forty-five (45) days may be required under special circumstances. If additional time or information is needed, you will be notified in writing of the reasons and the date by which the Committee expects to reach a final decision before the 45-day period expires. In no case will the extension exceed ninety (90) days from the date your appeal was received. The notice of the decision will contain specific reasons for the decision and a specific reference to the provisions of the Plan or policy on which the decision is based.

The decision of the Appeals Committee on your claim is final. If you disagree with the decision, you have the right to bring a legal action against the Fund and its Trustees in Federal Court. See the “Your Rights Under ERISA” section of this booklet.

## **Coordination of Benefits**

If you or your dependents are also covered under another group health plan, the amount paid by the Fund and the other group health plan as hospital benefits will never be more than 100% of the “allowable expenses.” “Allowable expenses” are any necessary and reasonable expenses for hospital services, treatment or supplies covered by the Fund.

A group health plan is considered to be any group program providing coverage for hospital benefits whether on an insured or uninsured basis. This includes group blanket or franchise insurance, group Blue Cross or Blue Shield, group practice and any other group pre-payment coverage, labor-management trusteed plans, union welfare plans, employer organization plans, any coverage under governmental programs and any coverage required or provided by law, including any mandatory state no-fault automobile insurance.

This coordination of benefits (COB) provision does not apply to any coverage not required by law for which you pay the entire premium.

## **Coordination of Group Coverage**

If a person is covered by two (2) group health plans and one (1) plan does not have a COB provision, that plan is always primary and pays its benefits in full. The other plan (the secondary plan) will then pay any covered expenses in excess of the primary plan benefits, up to the maximum amount that it would pay if the COB provision did not exist.

Any plan that does not have a COB provision is always the primary plan. Any plan that covers a person as an eligible employee is always primary over the one that covers that person as a dependent. Any plan that covers a person as an employee who is not laid-off, terminated or retired is primary over a plan covering that person as a laid-off, terminated or retired employee. If a dependent child is covered under two plans, the plan that insures the parent whose day of birth (not year) occurs earlier in the calendar year is the primary plan and pays first. If the birthday of both parents occurs on the same day, the plan which has covered the parent for the longer period of time pays first. If the parents are divorced or separated, the plan of the parent with custody pays first. This order of payment can change if a court decree directs one of the parents to be financially responsible for the medical, dental or other health care expenses of the dependent.

If none of the COB rules works to identify which plan is primary, then the plan covering the patient for the longer period of time is primary.

You have an obligation to report to the Fund any changes in marital status or group health plan coverage that may affect the order of payment for your spouse or any dependent covered by the Fund.

## Plan Information

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### ***General resource about how the Plan is administered and funded.***

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The following will help members properly identify the Plan if they have any questions about their benefits:

Official Name of Plan	The New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund
Sponsor Name and Address	Board of Trustees, The New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund, 305 West 44 <sup>th</sup> St, 3 <sup>rd</sup> Floor, New York, NY 10036
Employer Identification Number (EIN) Assigned by the Internal Revenue Service	13-1531223
Plan Number	501
Type of Plan	Welfare Benefit Plan
Plan Administrator	Board of Trustees, The New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund, 305 West 44 <sup>th</sup> St, 3 <sup>rd</sup> Floor, New York, NY 10036
Plan Administration	Jointly trustee administration by Union and Employer representatives  The following benefits are provided through insurance policies:  Life Insurance, AD&D, Accident & Sickness Weekly benefits: ULLICO (Insured and Administered)  Hospital and out-of-area (PPO) benefits: Empire BlueChoice  Vision Benefits: General Vision Services
Agent for service of legal process	Linda McDowell, Chief Executive Officer, The New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund, 305 West 44 <sup>th</sup> St., 3 <sup>rd</sup> Floor, New York, NY 10036
Source of Contributions	Employers in accordance with collective bargaining agreements with the Union, or a participation agreement.

## **Funding Medium and Benefits**

The New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund is operated under rules included in the Industry-Wide Collective Bargaining Agreement between the New York Hotel Trades Council, AFL-CIO and Hotel Association of New York City, Inc. This collective bargaining agreement requires that the employers contribute to the Fund on behalf of each covered employee.

Benefits are provided from the Fund's assets accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement. These are held in a Trust Fund for the purpose of providing benefits to covered participants and paying reasonable administrative expenses. The Fund's assets and reserves are currently invested in cash equivalents, bank registered certificates of deposit, bank commercial paper, corporate bonds, mutual funds and obligations of the government of the United States of America.

A copy of the Industry-Wide Collective Bargaining Agreement and any other agreement requiring employer contributions to the Health Benefits Fund can be obtained upon written request to the Plan Administrator and may be examined at the Fund Office. Participants or beneficiaries can request, in writing, a copy of these agreements.

## **Participating Employers**

The Fund Office will provide, upon written request, the information as to whether a particular employer is contributing to this Fund on behalf of employees working under a collective bargaining agreement.

## **Plan Year**

For the purpose of maintaining the Fund's fiscal records, December 31 is the last date of the fiscal year.

## **Privacy, Confidentiality, Release of Records or Information**

Any information collected by the Plan will be treated as confidential information, and will not be disclosed to anyone without your written consent, except as follows:

- Information will be disclosed to those who require information to administer the Plan or to process claims.
- Information with respect to duplicate coverage will be disclosed to the plan or insurer that provides duplicate coverage.
- Information needed to determine if health care services or supplies are *medically necessary* or if the charges for them are *usual and customary* will be disclosed to the individual or entity consulted to assist the Plan Administrator or its designee to make those determinations.
- Information will be disclosed as required by law, regulation, or in response to a duly issued subpoena.

## **Information You or Your Dependent Must Furnish to the Plan**

In addition to information you must furnish in support of any claim for plan benefits under this Plan, you or your covered dependents must immediately furnish any information you or they may have that may either affect eligibility for coverage under the Plan or the Fund Office's ability to properly administer your benefits. These events include, but are not limited to:

- Change of name.

- Change of address. (Advise the Fund Office promptly so its records will be up-to-date to communicate with you about any matters concerning your coverage.)
- The marriage, divorce, legal separation, or death of you or any covered spouse or dependent child.
- Any information regarding the status of your dependent child, including, but not limited to:
  - Your dependent child's reaching the Plan's limiting age.
  - The school status of a dependent child over age nineteen (19).
  - The existence of any physical or mental handicap.
  - The marriage of your dependent child.
- Medicare enrollment or dis-enrollment.
- Social Security disability benefits award or termination.
- The existence of other medical or dental coverage.

### **Plan Administrator's Authority**

The Board of Trustees, as the Plan Administrator of the Health Benefits Fund's benefit programs, has full discretion and authority to make the final decision regarding all areas of plan interpretation and administration, including eligibility for benefits, the types and level of benefits provided, or interpretation of plan language (including this summary plan description) or administrative procedures. The decision of the Plan Administrator is final and binding on all individuals dealing with or claiming benefits under the Health Benefits Fund, and if challenged in court, the Fund intends for the Plan Administrator's decision to be upheld, unless found by a court of competent jurisdiction to be arbitrary and capricious.

No participating employer, employer organization or labor organization, nor any individual employed thereby, has authority to answer questions on behalf of the Fund and the Plan. Please refer all questions to the Board of Trustees.

### **Plan Termination or Amendment**

The Board of Trustees intends to continue the benefit programs described in this Summary Plan Description indefinitely. Nevertheless, it reserves the right, subject to the provisions of any pertinent collective bargaining agreement, to terminate or amend any or all of the Fund's benefit programs in whole or in part at any time in the future. If any questions concerning eligibility for benefits arise, the Trustees have sole and exclusive authority to resolve the issue. The Trustees' decisions are final and binding. The Plan may be terminated by the Board of Trustees when there is no longer in effect an agreement between an employer and the New York Hotel and Motel Trades Council, AFL-CIO requiring contributions to the Fund. Upon termination of the Fund's benefit programs, the Board of Trustees will apply the monies of the Fund to provide benefits or otherwise to carry out the purposes of the Fund in an equitable manner until all of the remaining assets of the Fund have been disbursed.

### **Rights and Responsibilities**

Services for the Fund's benefit programs are provided in accordance with the provisions of the benefit programs out of a Trust Fund, which is used solely for that purpose. Any questions or problems as to benefits or benefit payments should be directed to the Trustees who administer the Plan or the Fund Office personnel who are authorized to act on behalf of the Trustees.

# **Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)**

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## ***Information about this federal benefits protection law.***

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As a participant in the New York Hotel Trades Council and Hotel Association of New York City, Inc., Health Benefits Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Fund Office and at all other specified locations, such as worksites 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 US Department of Labor.
- Obtain, upon written request to the Administrator, copies of documents governing 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 the copies.
- Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.

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. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to one hundred ten dollars (\$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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. (However, please follow the instructions described earlier in the guide, which provides for a claims review procedure that must be followed before you may file a suit.) In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of 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 US Department of Labor, or you may file suit in a 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 if, for example, it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, US Department of Labor,

listed in the telephone directory or the Division of Technical Assistance and Inquiries. You may write to them at:

Pension and Welfare Benefits Administration  
US Department of Labor  
200 Constitution Avenue, NW  
Washington, DC 20210

**New York Hotel Trades Council  
and  
Hotel Association of New York City, Inc.  
Health Benefits Fund**

**Board of Trustees  
Union Trustees**

Michael Carney  
Business Manager  
Local 94, 94-A, 94-B, IUOE  
331-337 44th Street  
New York, NY 10036

John Hickey  
Vice-President  
Local 758, SEIU  
330 West 42nd Street  
New York, NY 10036

Chris Cusack  
President & Business Manager  
Local 43U, Local 1  
709 Eighth Avenue  
New York, NY 10036-5498

Lynn Hoffard  
Secretary-Treasurer  
Local 6, HERE  
709 Eighth Avenue  
New York, NY 10036

James Donovan  
Executive Vice President  
Local 6, HERE  
709 Eighth Avenue  
New York, NY 10036

Larry McNeil  
Regional Director/President  
Local 56, SEIU  
One Beekman Street, Room 407  
New York, NY 10038

Michael Gadaleta  
Business Representative  
Local 94, IUOE  
331-337 44th Street.  
New York, NY 10036

Peter Ward  
President/Co-Chairman  
NY Hotel & Motel Trades Council, AFL-CIO  
707 Eighth Avenue  
New York, NY 10036

Michael Goodwin  
President  
Local 153, OPEIU  
265 West 14th Street  
New York, NY 10011

**New York Hotel Trades Council  
and  
Hotel Association of New York City, Inc.  
Health Benefits Fund**

**Board of Trustees  
Employer Trustees**

William Alvarado  
General Manager  
New York City Salisbury Hotel  
123 West 57th Street  
New York, NY 10019

Xavier Lividini  
General Manager  
The Mayflower Hotel  
15 Central Park West  
New York, NY 10023-7709

Chester S. Deptula  
General Manager  
The Surrey Hotel  
20 East 76th Street  
New York, NY 10021-2688

Joseph E. Spinnato  
President/Co-Chairman  
NY Hotel Association  
437 Madison Avenue – 36th Floor  
New York, NY 10022-7398

Fred J. England  
Chief Operating Executive  
Roger Smith Hotel Corporation  
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Tony Vasquez  
Dir./Labor Relations  
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New York, NY 10022

George Greene  
Director, Human Resources  
Sheraton New York/Manhattan  
Russell Complex  
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New York, NY 10019-6017

**Chief Executive Officer**  
Dr. Robert H. Greenspan

**Legal Counsel**  
Pryor Cashman Sherman & Flynn, LLP  
Kane Kessler, PC

**Consultant**  
The Segal Company

**Accountant**  
Armao, Costa & Ricciardi, PC