UAW HEALTH & WELFARE PLAN
PLAN B – BALLY'S & CAESARS CASINOS

QUICK REFERENCE GUIDE

EFFECTIVE: FEBRUARY 1, 2025

Important Notice: This is an outline of the principal plan provisions of the UAW Health and Welfare Plans and is not intended to completely describe the Plan provisions. In the event of any discrepancy between this outline and the Plans, the Plan Documents shall govern. For further information, please review your Summary Plan Description or contact the office of the Administrator, I. E. Shaffer & Co., at P. O. Box 1028, Trenton, NJ 08628. Telephone 1-800-792-3666.

UAW HEALTH & WELFARE PLAN

Effective February 1, 2025

ELIGIBILITY RULES

As a new employee, you will become eligible for coverage under the Welfare Plan beginning on the 1st day of the month for which a contribution is made on your behalf. Unless you opt-out of coverage (see below), you will automatically be enrolled in the Plan upon becoming enrolled for benefits.

ELIGIBILITY RULES – DEPENDENTS

1. Your spouse. The term spouse shall mean your legally recognized marital partner and except to the extent otherwise provided under the Fund documents. If you are married, the Fund office will require documentation proving a legal marital relationship. A divorce decree terminates the eligibility of a covered spouse (and stepchildren), regardless of any appeals from therefrom. If you fail to timely provide to the Fund Office a copy of your decree (and receive an acknowledgement from the Fund Office of that divorce decree), you will be responsible for all claims incurred relating to your spouse or ex-spouse after the required notification date.

2. The employee's biological child, stepchild, adopted child or child placed with you in anticipation of adoption who is under the age of 26 years of age.

3. You or your spouse's legal ward who: (a) resides with you in a regular parent-child relationship: and (b) is chiefly dependent on you for support and maintenance.

4. Your child who is mentally or physically incapable of earning his or her own living and providing his or her own support who attains the age of 26, provided you submit proof of the child's incapacity no later than January 31st each year and as otherwise required by the trustees and further provided that the child's handicap must have started before he or she reached age 26 and while the child was a covered Dependent under the Plan.

5. As required by the Federal Omnibus Budget Reconciliation Act of 1993, your child or stepchild who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan.

The Fund will require proof of dependent status.

WAIVER

If you are required to make an employee contribution in order to become eligible for coverage, you may opt-out of coverage (and may waive dependent coverage, if permitted by law). If you opt-out of coverage (or waive dependent coverage), you may only opt back in during open enrollment unless you (or your dependent) are eligible for special enrollment rights.

COBRA

If you fail to satisfy the above requirements and lose eligibility, you and your dependents may continue coverage under COBRA for up to 18 months (29 months if you are totally disabled and awarded Social Security Disability). If your dependent loses eligibility due to divorce or legal separation, or your child ceasing to satisfy the definition of an eligible dependent, they may continue coverage under COBRA for up to 36 months. The current monthly self-pay rates for the full plan under COBRA are:

Single	$ 647.27
Husband/Wife	$ 1078.77
Parent/Child(ren)	$ 1006.86
Family	$ 1438.36

This includes medical, prescription and vision coverage.

TERMINATION OF COVERAGE

A Covered Employee's eligibility for benefits will automatically end at the earliest of the following dates:

- The last day of the month for which your Employer is required to make contributions to the Plan on your behalf (unless the applicable collective bargaining agreement or participation agreement provides a later date), or
- The date you cease to qualify for COBRA or Self-Pay, if permitted; or,
- The date the Plan is terminated; or,
- The date specified in a written notice from the Trustees to the Employers and the Union stating that the Benefit Programs for any Employer shall terminate on such date.

TYPES OF BENEFIT PLANS OFFERED BY THE WELFARE FUND

- **MEDICAL – Horizon Blue Cross Blue Shield of NJ**
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for member services

- **PRESCRIPTION – Prime Therapeutics/Horizon Blue Cross Blue Shield of NJ**
  - See following pages for plan information
  - Call Prime Therapeutics at 1-800-370-5088 for more information

- **BEHAVIORAL HEALTH – Horizon Blue Cross Blue Shield of NJ**
  - See following pages for plan information
  - Call I.E. Shaffer & Co. at 1-800-792-3666 for member services

- **VISION – Horizon Vista II (Horizon/Davis Vision View Network)**
  - See following pages for information
  - Call Horizon (Davis) Vision at 1-800-278-7753 for more information

- **OPTIONAL BENEFITS – You may have coverage with your employer, not through UAW for the below benefits:**
  - Life Insurance
  - Accidental Death and Dismemberment
  - Long Term and Short Term Disability
  - Dental

UAW HEALTH & WELFARE FUND
PLAN B – BALLY'S & CAESARS CASINOS
SCHEDULE OF BENEFITS
HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY DIRECT ACCESS NETWORK WITH BLUE CARD
EFFECTIVE DATE: FEBRUARY 1, 2025

MEDICAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE (Calendar Year)		
Individual	$500	Not covered
Family	$1,000	Not covered
ANNUAL OUT-OF-POCKET MAXIMUM (Copays, deductibles, and coinsurance count towards this out-of-pocket limit). The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage. An individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum.		
Individual	$6,000	Not applicable
Family	$12,000	Not applicable
LIFETIME MAXIMUM	Unlimited	Not applicable
DOCTOR'S OFFICE VISITS		
Primary Care Office Visit	100% after $20 co-pay	Not covered
Specialist Office Visit	100% after $30 co-pay	Not covered
Maternity Visits *maternity not covered for dependent children	100% after $30 co-pay (applies to 1st visit only)	Not covered
Urgent Care Center	100% after $20 co-pay	Not covered

	IN-NETWORK	OUT-OF-NETWORK
PREVENTATIVE CARE (as defined by the Patient Protection and Affordable Care Act)	100% coverage	Not covered
DIAGNOSTIC PROCEDURES		
Laboratory (Out-patient)	100% coverage	Not covered
Laboratory (Hospital)	90% after deductible	Not covered
Radiology (Out-patient)	100% coverage	Not covered
Radiology (Hospital)	90% after deductible	Not covered
HOSPITAL CARE		
Inpatient Admission	90% after deductible	Not covered
Inpatient Physician Services	90% after deductible	Not covered
Surgery in Outpatient Facility	90% after deductible	Not covered
Outpatient Hospital Services	90% after deductible	Not covered
*Inpatient hospital care requires prior authorization		
EMERGENCY CARE		
Emergency Room	90% after $200 co-pay	90% after $200 co-pay
*This copay is waived if admitted		
Ambulance	90% after deductible	90% after deductible
*Covers transport if emergent and medically necessary		
Urgent Care Center	100% after $20 co-pay	Not covered
OUTPATIENT SURGERY		
Surgery Outpatient Facility	90% after deductible	Not covered
Surgery in Primary Care Phys Office	100% after $20 co-pay	Not covered
Surgery in Specialist's Office	100% after $30 co-pay	Not covered
BEHAVIORAL HEALTH		
Office Visit	100% after $30 co-pay (in office or outpatient)	Not covered
Inpatient	90% after deductible	Not covered
*Inpatient requires prior authorization and includes intensive outpatient and sub-acute partial hospitalization.		

	IN-NETWORK	OUT-OF-NETWORK
SUBSTANCE USE DISORDER		
Office Visit (in office or outpatient)	100% after $30 co-pay	Not covered
Inpatient	90% after deductible	Not covered
*Inpatient requires prior authorization and includes intensive outpatient and sub-acute partial hospitalization		
THERAPY SERVICES		
Occupational Therapy	100% after $30 co-pay	Not covered
*maximum 30 visits per person per calendar year		
Physical Therapy	100% after $30 co-pay	Not covered
*maximum 30 visits per person per calendar year		
Respiratory Therapy	100% after $30 co-pay	Not covered
* maximum 30 visits per person per calendar year		
Speech Therapy	100% after $30 co-pay	Not covered
*maximum 30 visits per person per calendar year		
OTHER SERVICES		
Chiropractic Care Visit	100% after $20 co-pay	Not covered
*Up to 25 visits per person per calendar year		
Home Health Care Services	90% after deductible	Not covered
*No custodial care. Prior authorization required.		
Hospice Services	90% after deductible	Not covered
* 10-day respite limit Excludes pastoral care and counseling.		
Skilled Nursing Care		
Inpatient	90% after deductible	Not covered
Outpatient	90% after deductible	Not covered
*Maximum 100 days per benefit period. Medical treatment only.		
Orthotics	100% after $30 co-pay	Not covered
Acupuncture	Not Covered	Not covered
Bariatric Surgery	90% after deductible	Not covered
All Other Covered Medical Services	90% after deductible	Not covered

PRIOR AUTHORIZATION REQUIREMENTS:

Benefits may be denied if prior authorization is not obtained for the below services:

For all **in-patient hospital** stays (both medical and behavioral health), providers must receive prior authorization from or Horizon Blue Cross Blue Shield **at least 24 hours prior to admission**. Emergency admissions must be authorized within 72 hours after hospital admission.

Radiology:

- Stress Testing: Myocardial Perfusion Imaging (SPECT and PET), Stress Echocardiography
- Echocardiography: transthoracic and transesophageal
- Diagnostic Heart Catherization
- Implantable Device Services: Pacemakers, Implantable cardioverter Defibrillator (ICD)
- Advanced Imaging: Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiograms (MRAs), Positron Emission Tomography (PET) scans, Positron Emission Tomography – computed tomography (PET-CT), Computed Tomography Angiography (CTA) scans, Nuclear Medicine and Nuclear Cardiac Imaging
- Primary Imaging: OB Ultrasound and Non-OB Ultrasound

Pain Management:

- Epidural Injections
- Facet Joint Injections
- Medial Branch Blocks
- Interventional Pain Procedure Imaging
- Monitored Anesthesia for Interventional Pain Procedures

Spine Surgery:

- Decompressions and Fusions
- Vertebroplasty/Kyphoplasty
- Discectomy
- Disc Arthroplasty

Radiation Therapy:

- External Beam Radiation Therapy
- Brachytherapy
- Intensity Modulated Radiation Therapy
- Image Guided Radiation Therapy

- Stereotactic Radiosurgery
- Proton Therapy
- Tomotherapy
- Radiopharmaceuticals

Specialty Pharmaceuticals

In addition to the prior authorization requirements above, the following will require providers to obtain an authorization by **Horizon**:

- Air Ambulance (retroactive review)

PROVIDER PHONE RESOURCES: HORIZON MEDICAL/BEHAVIORAL HEALTH

- Behavioral Health Services: 1-800-626-2212
- Utilization Management: 1-800-664-2583
- Provider Services: 1-888-456-7910
- Advanced Radiology Prior Auth: 1-866-496-6200
- Spine/Pain Management Services: 1-855-339-2010

In-Network Only

The medical coverage provided under the Plan is **in-network only**. The Plan does not provide out-of-network coverage for providers who do not participate in the HORIZON DIRECT ACCESS NETWORK. The only exception is "***emergency***" treatment rendered by an out-of-network provider with "***emergency***" defined as the sudden onset of an illness or injury where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

- Placing the covered person's life in jeopardy, or
- Causing other serious medical consequences, or
- Causing serious impairment to bodily functions, or
- Causing serious dysfunction of any bodily organ or part.

How to Find a Horizon Blue Cross Blue Shield of New Jersey Healthcare Provider

- Visit www.HorizonBlue.com and click on "Find a Doctor" at the top of the page. Then look for "Not a member" at the bottom of the next page. Select "Find Care in NJ" if within NJ. Enter "Direct Access" as your Plan and enter your location or browse by category. If outside NJ, click on "Find Care Outside NJ" and select "BCBS PPO" as your plan and enter location or browse by category.
- Call I.E. Shaffer & Co. at 1-800-792-3666
- Confirm with your treating physician, hospital, lab or other provider prior to services.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider you did not elect at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit. This Plan does NOT provide elective out-of-network benefits, meaning if you elect to have care with an out-of-network provider, the Plan may not pay for such services.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition **unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.**

Federal Law

The Consolidated Appropriations Act, 2021 (CAA) was signed into law on December 27, 2020. The CAA includes a provision known as the No Surprises Act. No Surprises Act opens a dialog window, which establishes protections from surprise billing, effective January 1, 2022. The No Surprises Act offers protections that are similar to the New Jersey OON Mandate and applies to those surprise bills not subject to the New Jersey OON Mandate, including bills for care provided outside of New Jersey and air ambulance services, if air ambulance is a covered benefit under a health plan's contract.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network to avoid balance billing.

<u>When balance billing isn't allowed, you also have these protections:</u>

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed or have questions, please contact I.E. Shaffer & Co. and ask to speak with the Manager of the Claims Department at (609)-718-6147.

You may visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

UAW HEALTH & WELFARE FUND – PLAN B
PRESCRIPTION DRUG BENEFIT
HORIZON/PRIME THERAPEUTICS

Retail Prescriptions*

(Mandatory generic substitution) –up to 30 day supply

- **Generic Drugs** – $5 co-payment
- **Preferred Brand Name Drugs** – 20% co-payment, $20 minimum co-pay, $50 maximum co-pay
- **Non-Preferred Brand Name Drugs** – If no generic available: 30% co-pay, $35 minimum co-pay, $75 maximum co-pay. If generic available: $5 co-pay plus cost differential between brand name and generic
- **Specialty Drugs** – 20% co-pay, $35 minimum co-pay, $250 maximum co-pay, up to $2,500 individual maximum out-of-pocket maximum

Mail Order and/or 90 Day Supply Retail Prescriptions*

(Mandatory generic substitution) –up to 90 day supply

- **Generic Drugs** – $10 co-pay
- **Preferred Brand Name Drugs** – 20% co-pay, $40 minimum co-pay, $100 maximum co-pay
- **Non-Preferred Brand Name Drugs** – If no generic available: 30% co-payment, $70 minimum co-pay, $150 maximum co-pay. If generic available: $10 co-pay plus cost differential between brand name and generic

*After $2,500 per person or $5,000 per family of out of pocket prescription expenses during a calendar year, there will be no co-payments required for the remainder of the year. If a name brand drug with a FDA approved generic is requested, the total co-pay will be the generic co-pay plus the difference in cost between the brand and generic medications. This penalty is not subject to the maximum co-pay limitations. The annual out-of-pocket maximum for self-only coverage applies to all individuals, including those enrolled in family coverage (an individual's out-of-pocket maximum is embedded in the family's out-of-pocket maximum).

Understanding the Prescription Drug Formulary

The drug formulary utilized by the Welfare Fund is a list of medications published by the Welfare Fund's Pharmacy Benefit Managers. Medications on the list fall into one of the four categories:

Generic Drugs – Generic drugs are the un-branded form of a prescription medication. They use the same active ingredients as brand name drugs and work the same way. The FDA puts all generic drugs through a rigorous, multi-step process to ensure that they are the therapeutic equivalent of their brand name counterparts. That means that a generic drug can be substituted for a brand name drug, and it will produce the same clinical effect while meeting the same safety profile as the brand name drug.

Preferred Brand Name - These brand-name drugs have been identified as the most therapeutically safe and effective options for treatment of most medical conditions. These drugs do not have less-costly generic equivalents because they are sold under a trademarked name.

Non-Preferred Brand Drugs - These products often have either a generic equivalent or a preferred-brand drug alternative.

Specialty Drugs – Specialty pharmaceuticals is a class of prescription drugs that are typically produced through biotechnology (sometimes known as biologicals) and require special patient monitoring and handling, in addition also require unique education prior to use.

VISION BENEFIT – DAVIS VISION

Covered once every calendar year

Eye examination -$0 in-network copay
Lenses - $10 in –network copay
Frame - $0 copay

- Covered in full frames: any fashion or designer level frame from Davis Vision's collection (retail value up to $160), or
- Frame allowance: $130 toward any frame from provider plus 20% off any balance, or
- Visionworks frame allowance: $180 allowance plus 20% off any balance toward any frame from a Visionworks retail store.

Contact Lens Evaluation, Fitting & Follow-Up Care

- Davis Vision Collection Contacts: Covered in Full
- Non-Collection Standard Contacts: 15% discount
- Non-Collection Specialty Contacts: 15% discount

Contact Lenses (in lieu of glasses)

- Covered in Full Contacts: up to 2 boxes planned replacement or 4 boxes of disposable, or
- Contact Lens Allowance: $130 toward any contacts from provider plus 15% off balance. Or
- Medically Necessary Contacts: covered in full with prior approval

UAW HEALTH & WELFARE FUND – PLAN B
BENEFIT PLAN MAXIMUM

Annual In-Network Medical Maximum Out-of-Pocket Limit-$6,000 person/$12,000 family (Co-pays, deductibles and co-insurance count towards this out-of-pocket limit)

Annual Prescription Maximum Out-of-Pocket Limit - $2,500 person/$5,000 family (Prescription co-pays count towards this limit)

Chiropractic Care Maximum – 25 visits per person per benefit period

Hearing Aids – not covered

Home Health Care Maximum - no visit limit

Hospice Care Maximum – no visit limit, but has a limitation of 10 respite days

Infertility Treatment – 4 egg retrievals maximum

Lifetime maximum for surgical procedures performed to correct myopia (near sightedness) or hyperopia (far sightedness) – no coverage

Occupational Therapy Maximum – 30 visits per person per calendar year

Physical Therapy Maximum – 30 visits per person per calendar year

Respiratory Therapy Maximum – 30 visits per person per calendar year

Skilled Nursing Care Maximum – 100 days per benefit period. Medical treatment only

Speech Therapy Maximum – 30 visits per person per calendar year