HOTEL AND RESTAURANT EMPLOYEES HEALTH AND WELFARE TRUST FUND

Revised Summary Plan Description
And Plan Document

November 2020

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TO: ALL PLAN PARTICIPANTS AND ELIGIBLE DEPENDENTS

The Board of Trustees of the Hotel and Restaurant Employees Health & Welfare Trust Fund takes pleasure in making this Summary Plan Description and Plan Document available to Participants and eligible Dependents.

This booklet outlines the benefits to which you and your dependents, if eligible, may be entitled on account of your employer's contributions to the Fund. ***Please note:*** the amount of work (i.e., hours, shifts, days of work) required to earn a contribution varies among contributing employers and in some cases, between employees of the same employer. Therefore, you should become familiar with the collective bargaining agreement ("CBA") between your employer and UNITE HERE, Local 2850 ("the Union") regarding contribution requirements, rates, and any special eligibility rules that may apply to some employees.

Be sure to read this booklet carefully. It describes the Fund and its operation, general eligibility requirements, claim filing and appeal procedures, and other important information. The benefits provided by this Welfare Fund include medical, dental, vision, prescription drug, durable medical equipment, death, accidental death or dismemberment and chiropractic and acupuncture benefits. Specific benefits which are available may vary by employer (and their respective CBA). The Fund Administration Office may mail you updated materials in order to inform you and your eligible Dependents of any changes in benefits.

Those persons needing assistance in understanding this booklet or anyone who has difficulty understanding it because it is written in English, should contact the Fund Administration Office or your Union for assistance.

此小冊子包括英文摘要根據酒店和餐館員工健康與福利信託基金你擁有的計劃權利。如你對此小冊任何部份理解困難，請聯絡基金管理人Northwest Administrators, Inc.，他們的辦事處位於1182 Market Street, Suite 320, San Francisco, CA 94102。辦事處辦公間是星期一至五上午8:30至下午5:00。你亦可以致電管理人辦事處要求幫助，電話(844) 492-9159。

Este libro contiene un resumen en inglés de sus derechos bajo el Hotel and Restaurant Employees Health and Welfare Trust Fund (el Fondo Fiduciario de Salud y Bienestar de los Empleados de Hotel y Restaurante). Si tiene cualquier dificultad para entender cualquier parte de este libro, comuníquese con Northwest Administrators, Inc., el Administrador del Fondo, en su oficina ubicada en el 1182 Market Street, Suite 320, San Francisco, CA 94102. Las horas de oficina son de 8:30 a.m. a 5:00 p.m. de lunes a viernes. También puede llamar a la oficina del Administrador del Fondo al (844) 492-9159 para pedir ayuda.

BOARD OF TRUSTEES

I. IMPORTANT NOTICES THAT AFFECT YOUR BENEFITS

PLAN MODIFICATION OR TERMINATION

The benefits provided by this Plan, while intended to remain in effect indefinitely, can be guaranteed only so long as the parties to collective bargaining agreements continue to require contributions into the Trust sufficient to underwrite the cost of the benefits. The Trustees of the Fund reserve the full, absolute and discretionary right to amend, modify, suspend, withdraw, discontinue, or terminate the Fund in whole or in part at any time for any or all of the Participants. Therefore, benefits for any persons covered by the Plan are not lifetime guaranteed or vested.

PLAN INTERPRETATION

The Board of Trustees determines policies and benefits in keeping with the assets and income of the Welfare Fund. Benefits are subject to all of the terms and conditions of the Welfare Fund and provider agreements as well as to any rules and regulations the Trustees may adopt from time to time. Unless delegated to one of the providers or insurers providing benefits under the Plan to Participants, only the Board of Trustees and the Fund Administrator are authorized to interpret the terms of the Plan or to determine eligibility for benefits under the Plan. The Trustees shall have the exclusive right, in their sole and absolute discretion, to take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan, to resolve and/or clarify any ambiguities, inconsistencies and/or omissions arising under the Plan or other Plan documents, to process and approve or deny benefit claims and rule on any benefit exclusions, and to make any factual determinations and decide all matters arising in connection with the operation or administration of the Plan. All determinations made by the Trustees with respect to any matter arising under the Plan shall be final and binding on all parties, subject to the appeal and review procedures described in this booklet.

Nothing in this booklet is meant to extend or change in any way the provisions of the Plan or the insurance policies or service agreements negotiated between the Board of Trustees and the insurers providing the benefits established under the Plan. The Board of Trustees of the Fund reserves the right to amend, modify or discontinue all or part of the Plan or specific benefits whenever, in its judgment, conditions are warranted. The Plan of benefits for medical benefits, dental benefits and vision benefits are insured by a contract of insurance or provided by a service agreement, and for these reasons, the Board of Trustees of the Fund are relieved of any liability to provide payment over and beyond those contained in such policies or agreements.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or her newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that the provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans that provide coverage for mastectomies (as yours does) are also required to provide coverage for reconstructive surgery and prostheses following mastectomies. Specifically, the law mandates that a participant or eligible beneficiary who is receiving benefits for a covered mastectomy and who elects breast reconstruction in connection with a mastectomy, will also receive coverage for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Effective April 14, 2003, the Health Insurance Portability and Accountability Act ("HIPAA") requires that group health plans ensure the privacy of health information that identifies you and provide you with a notice of privacy practices with respect to your protected health information maintained by the plan. If you have not received a copy of the Fund's Notice of Privacy Practices, please contact the Fund Administrator.

The law permits us to use and disclose your protected health information without your permission for claims adjudication or payment, the provision of health care services, eligibility determinations, recovery of overpayments, oversight or law enforcement activities required or allowed by law, and under certain other circumstances. In all other cases, the Plan must have your written authorization to use or disclose your health information. You may withdraw this permission at any time, in writing.

You may exercise certain rights with respect to your protected health information, including but not limited to the right in most cases to inspect and copy your health information, to request the amendment of your health information, to request that the Plan communicate with you in a confidential manner, to request restrictions on the use and disclosure of your health information, and to receive a list of disclosures of your health information. The Plan's Notice of Privacy

Practices contains more information about the scope and exercise of these important rights. If you believe that your rights under HIPAA have been violated by the Plan, you may file a written complaint with the Fund Administrator or with the Secretary of the U.S. Department of Health and Human Services.

Protected Health Information is individually identifiable health information (including demographic and genetic information such as family medical history and information about an individual's receipt of genetic services or genetic tests collected from an individual), that is created or received by a health care provider, health plan, Employer or health care clearinghouse; relates to the past, present or future payment for the provisions of health care to an individual, and identifies the individual or could reasonably be used to identify the individual.

The Plan's use and disclosure of health information is protected by HIPAA. Protected health information (PHI) that is transmitted electronically is "Electronic PHI". The Plan is a "Hybrid Entity" under HIPAA because it provides health benefits and non-health benefits. The privacy and security rules apply only to health benefits. The Plan will use PHI and Electronic PHI only to the extent, and in accordance with, the uses and disclosures related to health care treatment, payment for health care and health care operations. The Plan will also use and disclose PHI and Electronic PHI as required by law and as permitted by authorization. "Payment" involves Plan activities to obtain premiums or determine or fulfill coverage or benefit responsibilities including, but not limited to, eligibility determinations, enrollment, coordination of benefits, claims adjudication, subrogation, employee contributions, risk adjusting, billing, collection (including reports to consumer reporting agencies related to collection), claims management and related data processing, obtaining payment under a reinsurance contract, reviews of medical necessity, care or charges, and utilization review. "Health care operations" include, but are not limited to, quality assessment, population-based activities to improve health or reduce health care costs, protocol development, case management, care coordination, disease management, communication regarding treatment alternatives, rating providers, rating Plan performance, accreditation, certification, licensing, credentialing activities, underwriting, premium rating, creation, renewal or replacement of insurance including reinsurance, stop-loss and excess loss insurance, medical reviews, obtaining legal or auditing services, fraud and abuse detection, business planning, development and management, compliance with HIPAA administrative simplification, customer service, internal grievance resolution and compliance with ERISA (including preparation of required documents, such as Forms 5500 and Summary Annual Reports).

The Plan will disclose PHI to the Board of Trustees only pursuant to an authorization or for Plan administration after receipt of a certification from the Board of Trustees that this document contains these provisions. Any Trustee that does not comply with these provisions will receive appropriate sanctions. With respect to PHI and Electronic PHI, the Board of Trustees agrees to:

- not use or disclose genetic information for underwriting purposes;
- not use or further disclose the information other than as permitted or required by the Plan document or law;
- ensure that any agents, including the Fund Administration Office, to whom the Board of Trustees provides PHI and Electronic PHI agree to these restrictions and conditions;
- not use or disclose the information for employment-related actions or decisions unless the use or disclosure is pursuant to an authorization;
- not use or disclose the information in connection with any other benefit or employee benefit plan unless the use or disclosure is pursuant to an authorization;
- report to the Plan any use or disclosure of the information that the Board of Trustees is aware of and that is inconsistent with the allowable uses and disclosures;
- make PHI and Electronic PHI available to the individual, for amendment, or for an accounting of non-routine disclosures in accordance with the requirements of HIPAA;
- incorporate amendments to PHI and Electronic PHI in accordance with HIPAA;
- make internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI received from the Plan available to the Secretary of Health and Human Services for the purpose of determining the Plan's compliance with HIPAA;
- ensure that the adequate separation between the Plan and the Board (i.e., the firewall), required by 45 CFR §504(f)(2)(iii) is established; and
- if feasible, return or destroy all PHI and Electronic PHI received from the Plan (or copies) when the information is no longer needed; if not feasible, limit further use or disclosure to the purposes that make the return or destruction infeasible.

The Board of Trustees further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) on behalf of the Plan, it will:

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that the firewall required by 45 CFR §504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- appropriately address any security incident of which it becomes aware.

CERTIFICATE OF CREDITABLE COVERAGE

If you or your Dependents lose coverage under the Plan for any reason, you or your Dependents may request (up to 24 months following such loss) and will be furnished with a Certificate of Group Health Coverage indicating the length of time you and your eligible Dependents were covered under the Plan. Please address all requests to the Fund Administration Office.

EMPLOYEE CO-PAYMENTS FOR BENEFITS

Because of sharply rising medical costs, employee co-payments for benefits have become increasingly common in this and many other labor-management trust funds and plans. The rules of this Plan regarding employee responsibility for the co-payment for benefits are described in this Plan description. Because a loss of eligibility for benefits may result if employees' co-payments are not received by the Fund in a timely fashion where they are required, **IT IS ESSENTIAL THAT YOU FAMILIARIZE YOURSELF WITH THE RULES AND PROCEDURES FOR MAKING MONTHLY EMPLOYEE CO-PAYMENTS DESCRIBED ON PAGES 13-14 IN THIS BOOKLET.**

OBLIGATIONS OF PARTICIPANTS

It is extremely important that you keep the Fund Administrator informed of any change in address or desired change in beneficiary. This is your obligation. Failure to fulfill the obligation could delay your eligibility for benefits. **The importance of a current, correct address on file in the Fund Administration Office cannot be overstated.** It is the **ONLY WAY** the Trustees can keep in touch with you regarding Plan changes and other developments affecting your interests under the Plan.

TWELVE (12) MONTH OPEN ENROLLMENT – DENTAL PLANS

After your initial plan selection, you will be given the opportunity to change dental plans (e.g., from one dental plan to another dental plan), but only if no change has been made during the most recent 12-month period. Your selection and enrollment in a medical plan is separate from your selection and enrollment in a dental plan. You may also choose not to make any change at all. If you would like written material pertaining to the choice of dental plans mailed to you at your home address, please contact the Fund Administration Office.

SPECIAL ENROLLMENT

If Plan benefits are available without cost to you, you will ordinarily want to enroll in the Plan, along with your spouse, Domestic Partner, and other Dependents. Potentially, however, you might want to decline enrollment for an otherwise eligible family member (e.g., to avoid taxable

income for covering a person who does not meet the definition of dependent under the United States Internal Revenue Code). If you decline enrollment for any eligible individual who has other health insurance coverage, you may later enroll that individual in the Plan if you request enrollment within 31 days after that other coverage ends.

Effective for January 2017 work hours, February 2017 Employer contributions and March 2017 coverage, if you or your dependents were covered under a Medicaid plan under Title XIX of the Social Security Act or under a State Children's Health Insurance Program (CHIP) and you (or your dependent's) Medicaid or CHIP coverage is terminated as a result of loss of eligibility for such coverage or you (or your dependent) becomes eligible for premium assistance with respect to coverage under the Welfare Plan under a Medicaid Plan or CHIP, you may be able to enroll yourself and your dependents provided that you request enrollment with 60 days after the occurrence of such events.

REQUEST FOR ASSISTANCE

If you have any questions about this Plan, the Trustees prefer that you direct your questions to them in writing at the address indicated below. However, if you have difficulty writing to the Trustees for any reason, you may contact the Fund Administration Office for assistance by visiting or calling:

Hotel and Restaurant Employees Health and Welfare Trust Fund
c/o Northwest Administrators, Inc.
1182 Market Street, Suite 320
San Francisco, CA 94102
Phone: (844) 492-9159

II. BACKGROUND AND OVERVIEW OF THE PLAN OF BENEFITS

The Fund was established on July 24, 1963 for the purpose of providing health and welfare benefits to eligible participants covered by collective bargaining agreements between certain culinary unions and signatory employers. The Fund is a collectively bargained, jointly trusteed labor management trust fund financed by employer and in some cases employee contributions pursuant to various collective bargaining agreements between UNITE HERE, Local 2850 and employers within their territorial jurisdiction.

Medical and prescription drug benefits are provided by Kaiser Foundation Health Plan ("Kaiser"). Chiropractic and acupuncture benefits are also provided (to the extent provided for by applicable collective bargaining agreements) by Kaiser. Dental benefits are provided by Delta Dental Plan of California or Delta Care USA. Vision care benefits are provided by Vision Service Plan. Durable Medical Equipment, Death, Accidental Death and Dismemberment benefits are self-insured by the Fund.

The specific benefits offered by each of these plans are fully described in the booklets or brochures sent to you by those insurance providers. Collectively, these booklets and this Summary Plan Description contain a summary of the Plan Benefits. Keep these documents for future reference. **The rules, conditions, descriptions of benefits, exclusions from coverage and limitations on benefits set forth in these brochures or booklets govern unless they are inconsistent with anything said in this Summary Plan Description and Plan Document, in which case this document controls.**

III. ELIGIBILITY RULES

A. INITIAL EMPLOYEE ELIGIBILITY FOR BENEFITS

Eligibility and your participation in the Plan will not start until contributions are required to be made to the Plan on your behalf.

Most employees covered by contracts with UNITE HERE, Local 2850 are eligible for coverage the first day of the month commencing after a full contribution is received on their behalf. At such time such employee shall become a Participant in the Plan. Contributions due in one month are based upon work in the immediately preceding month. Thus, for example, if you work sufficient hours (after your waiting period) in January, a contribution will be made on your behalf in February, which (in addition to any employee contributions, if any, that may be due) will provide you with coverage in March. Thus, eligibility is determined on a "skip-month" basis.

If the collective bargaining agreement so provides, employees of a newly organized employer, or employees of a previously organized employer who have not recently been covered by the Fund, shall be eligible for benefits during the first month in which contributions are paid to the Plan. For example, if an employer commences contributions for employees in January based on hours worked in December, or if employees were eligible under the employer's plan (if there was an employer plan) in the month of December, the employees shall be immediately eligible for benefits in January. In this example, January contributions will then provide eligibility for both January and February, February contributions (based on hours worked in January) will provide March eligibility, and continuing as usual under the "skip-month" rule.

Some, but not all, collective bargaining agreements permit employees to waive coverage and do not require the employer to make contributions to the Fund if the employee electing to waive coverage has alternative coverage available through another source. Such waiver of coverage is entirely voluntary, and must be made within 30 days of the beginning of employment or the availability of alternate coverage, whichever occurs first. Waivers of coverage will be honored providing these and other conditions established by the Trustees are satisfied. Such waivers are available only if they are provided for in the collective bargaining agreement and only if a ***written*** waiver form is obtained from the employee ***and*** is submitted to the Fund Administration Office. Retroactive waivers will ***not*** be honored. Employees may revoke a waiver of coverage only once and only upon a showing that alternate coverage has lapsed. Any written revocation of the waiver of coverage must be submitted to the Fund Administration Office within 30 days after your alternate coverage ends.

IT IS VERY IMPORTANT THAT YOU CHECK YOUR COLLECTIVE BARGAINING AGREEMENT FOR RULES REGARDING ELIGIBILITY, AS YOUR ELIGIBILITY MAY BE LOST IF YOU DO NOT TAKE ACTION TO ENROLL FOR BENEFITS WITHIN THE TIME PERIOD PROVIDED FOR UNDER THE COLLECTIVE BARGAINING AGREEMENT.

In the event that a Participant elects to discontinue coverage under this Plan for the Participant or his/her Dependents, they may not again enroll in the Plan until such Participant reestablishes initial eligibility under the Plan. Some collective bargaining agreements require that once any initial probationary period has been completed, your Employer will make a monthly contribution to the Fund on behalf of all employees who have worked the required number of hours, shifts, events, etc. established in your collective bargaining agreement.

IMPORTANT: Your eligibility for benefits *may* be affected or lost if your Employer or you are delinquent in making any required contributions to the Fund. See subsections C-D below on pages 13-14.

B. DEPENDENT BENEFITS

Most collective bargaining agreements between the Union and employers provide for coverage for dependents. Your covered Dependents are:

a) your lawful spouse;
b) your Domestic Partner, as defined below; and
c) your child or children to their 26th birthday.

A marriage certificate is required upon initial enrollment of your Dependent spouse.

"Child" or "Children" includes your biological child, stepchild, legally adopted child, foster child, your Domestic Partner's child, or other child, provided such child is living with you (the Employee), in a parent-child relationship and is your dependent within the meaning of the Internal Revenue Code §152; or a child for whom you have been appointed by a court to be legal guardian or are required to provide dependent coverage as an "alternate recipient" pursuant to a Qualified Medical Child Support Order (QMCSO) pursuant to 29 U.S.C. Section 1169. A birth certificate must be provided upon initial enrollment of your Dependent child.

"Domestic Partner" is defined as a person with whom you are in a spousal-equivalent relationship sanctioned by the laws of a state, county, city or other municipality. A Domestic Partnership means an intimate, committed relationship of mutual caring between two persons who live together and intend to do so indefinitely, who agree to be responsible for each other's basic living expenses, who are both 18 years of age or older, neither of whom is married and

neither of whom is a close relative of the other. In order for persons to qualify as Dependents under the Plan as Domestic Partners, or as the Dependent children of Domestic Partners, you must have filed a Declaration of Domestic Partnership for Enrollment in Plan with the Fund Administration Office.

The Plan also provides coverage for a Participant's Dependent Child under the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is a judgment, decree or order (including a community property law), or a National Medical Support Notice (as defined by section 609(a)(5)(C) of ERISA). The QMCSO may not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan. In order for a Medical Child Support Order to be qualified, the children for whom it requires coverage must satisfy the requirements for Dependent Child coverage, as defined above.

When you receive any documentation regarding a QMCSO, please provide such documentation to the Fund Administration Office immediately upon issuance. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. The Fund Administration Office will determine whether or not an order mandating coverage for a Dependent Child is "qualified" as a QMCSO. The Fund Administration Office follows certain procedures to make this determination, and will notify you if it determines that an order is qualified. You may receive a copy of these procedures at no charge from the Fund Administration Office.

You are required to notify the Plan immediately if any individual ceases to be your dependent. The Fund will seek reimbursement for improper benefits and services provided to individuals who are not eligible for coverage under the Plan. Proof of the continued existence of dependent status must be furnished to the Fund Administration Office from time to time at the Fund's request.

Tax codes generally require that you pay taxes on the benefits for some ("non-exempt") Dependents, such as Domestic Partners.

If you choose to continue coverage for children to age 26 who are not dependent upon you for financial support and maintenance and/or are not claimed by you on your federal income tax return, it could affect your tax obligations. Important Tax Notice: You should consult your accountant, tax adviser, or attorney regarding any such tax obligations about tax obligations related to coverage for both Dependent children and Domestic Partners.

NOTE: It is your responsibility to notify the Plan of any change in your Dependent's eligibility for coverage.

Any person who newly attains eligibility to become a family dependent, such as a new spouse or

newborn or newly adopted child or new foster child, may be enrolled by the Participant's submission of a change of enrollment form ***to the Fund Administration Office*** within 30 days of the date of birth, date of marriage or date of adoption or placement. If you fail to notify the Fund, as described above, you will not be able to add your new Dependent until you are next eligible to change plans (i.e. at open enrollment) or at a time when your coverage changes pursuant to a change in collective bargaining agreement).

"Alternate recipient" means your child when he or she is recognized under a QMCSO as having a right to enrollment under this Plan as your dependent. For purposes of the benefits provided under this Plan, an alternate recipient shall be treated as a Dependent, but for purposes of reporting and disclosure requirements under ERISA, an alternate recipient shall have the same status as a Participant.

C. EMPLOYER CONTRIBUTIONS

Some of the Union's collective bargaining agreements with an Employer will state the amount your Employer is required to pay or contribute to the Plan each month on behalf of eligible employees to provide the benefits of the Plan. However, some of the collective bargaining agreements provide that the amount of such contribution shall be established by the Plan's Board of Trustees.

If your Employer is delinquent in making contributions to the Fund on your behalf, this will affect your eligibility for benefits. Accordingly, if you have any reason to believe the Employer is not making monthly contributions to the Fund on your behalf when you are eligible for such contributions, contact your Union representative.

Contributions are required to be made to the Fund Administration Office no later than the 15th day of the month, based on hours worked during the preceding month. (Your Employer will be liable for interest and liquidated damages in the amount of 10% of total contributions if payment is not received by the 20th day of the month.) A copy of the Employer Remittance Reports filed by each contributing Employer is maintained at the Fund Administration Office.

D. EMPLOYEE CONTRIBUTIONS AND CO-PAYMENTS

Your Employer may not be required by the collective bargaining agreement to pay the full amount of monthly contributions needed to pay for the benefits and expenses of the Plan as determined by the Trustees. If so, your Employer's collective bargaining agreement with the Union should provide for employee co-payments; but even if it does not, you will have to make up or pay the difference between the amount your employer is required to pay to the Plan and the actual cost of providing the benefits and administering the Plan, as determined by the Trustees.

If you do not make timely monthly employee co-payments, if required, the Plan will

discontinue some or all of your eligibility for benefits regardless of whether your employer makes a contribution on your behalf, and you will have to reestablish eligibility for the discontinued portion of your benefits until you are next eligible to change plans. Therefore, it is essential that you continue to make monthly co-payments, if they are required, to continue your eligibility for full benefits.

Some collective bargaining agreements which provide for Dependent benefits also require Employee co-payments for such coverage. ***Note:*** **The same basic rules which apply to the payment of co-payments for employees apply with respect to co-payments for Dependent benefits, where required. It is your responsibility to ensure that arrangements are made for the payment of these co-payments to the Plan or your eligible Dependents will lose coverage for which they otherwise might be eligible.**

Note: *When possible*, the Plan will discontinue Dependent benefits before discontinuing your individual benefits so long as the amount of the Employer's contribution covers the cost of providing employee only benefits. However, if employer contributions are insufficient to cover even the cost of employee only benefits, or if a composite rate structure is offered by a provider and your Employer's contributions are less than the composite rate, you will lose all of your coverage and benefits if you do not make the full employee co-payment each month. In the event full monthly co-payments are not received in a timely fashion, the Trustees reserve the discretion to discontinue your eligibility for benefits and to determine which benefits shall be discontinued.

E. FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act of 1993 (FMLA) provides that in certain situations you are entitled to take up to 12 weeks of unpaid leave during any 12-month period, and that in such situations the Contributing Employer is required to continue coverage for you. Determination as to whether a leave of absence is an FMLA leave shall be made by the Contributing Employer. If you believe you have been wrongly denied Family Medical Leave Coverage, notify your Union office. Failure to timely appeal the denial may result in a loss of benefits. If continued coverage under the FMLA is requested, you must submit proof acceptable to the Fund Administration Office that the leave is in accordance with FMLA provisions.

To qualify for continuing coverage under FMLA, you must: 1) be employed by a Contributing Employer with 50 or more total employees within 75 miles from your work site; 2) have worked for your Contributing Employer for at least 12 months; 3) have worked at least 1,250 hours during the 12 month period preceding the start of the FMLA leave of absence; and 4) be on an FMLA-qualified leave from employment with the Contributing Employer. The twelve (12) week Family Medical Leave includes leave for the birth of a child or placement of a child for adoption or foster care; leave to care for an immediate family member (spouse, child or parent)

with a serious health condition; leave due to the fact that you are unable to work due to a serious health condition; or leave due to any "qualifying exigency" arising out of the fact that a Participant's spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation. In the event that both you and your spouse are covered Employees, under most circumstances, the FMLA continued coverage may not exceed a combined total of 12 weeks if the FMLA leave is related to the birth or placement of a child or to caring for a parent with a serious health condition. If you are on a FMLA leave on the day coverage is to begin, coverage will nonetheless begin. Twenty-six (26) week leaves during a "single 12-month period" shall be granted to an eligible Participant who is a spouse, son, daughter, parent, or next of kin of a current member of the Armed Forces, including a member of the National Guard or Reserves, with a serious injury or illness that is incurred in the line of duty on active duty.

Your welfare benefits will be continued during a Family Medical Leave, however, you will be required to continue to make any contributions, copayments, etc., you would normally be required to make. Continuation of coverage under FMLA ends on the earliest of: (1) the day you return to work; (2) the day you notify your Employer that you are not returning to work; (3) the day coverage under the Plan would otherwise end (i.e., Plan maximum has been paid); or (4) the day after coverage has been continued under FMLA for the maximum leave period allowed. **NOTE: Only certain Contributing Employers are subject to the requirements of the FMLA. Therefore, any determination of whether you are entitled to Family and Medical Leave is determined by Federal law and not the Board of Trustees for the Welfare Plan.**

F. CONTINUED COVERAGE WHILE IN UNIFORMED SERVICE

If you are an active employee and you perform service in the Uniformed Services of the United States, Federal law provides certain rights to continued coverage under this Plan. An eligible employee may choose to continue coverage for up to a maximum of 24 months from the date that service commences.

The terms "Uniformed Services of the United States" and/or "Uniformed Services" means the Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If you (and your eligible Dependents) are eligible for benefits as of the date of entry into the Uniformed Services, and your absence is due to a Uniformed Services leave of 31 days or less, coverage will be continued at no cost to you. If you (and your eligible Dependents) are eligible for benefits as of the date of entry into the Uniformed Services of the United States, and your absence is due to a Uniformed Services leave of 31 days or more, you (or your eligible

Dependents) may elect to continue coverage by:

(1) using available coverage earned through Covered Employment; or
(2) self-payment under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). A premium for continuation coverage under USERRA will be in an amount established by the Fund. Such premium shall be payable in monthly installments.

The maximum length of USERRA Continuation Coverage is the lesser of:

(1) 24 months beginning on the day that the Uniformed Services leave commences; or
(2) a period ending on the day after you fail to return to employment within the time allowed by USERRA.

If you were eligible for benefits on the date of entry into the Uniformed Services and upon completion of service you notify the employer of your intent to return to employment as specified in USERRA, your eligibility will pick up as it was the day before you entered into Uniformed Services. If you remain in or re-enter the Uniformed Services or training without being required to do so, you shall not be entitled to reinstatement.

G. FEDERAL COBRA CONTINUATION COVERAGE

1. General Rules of Coverage

Under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), you or your eligible Dependents ("Qualified Beneficiaries") may continue health care coverage past the date coverage would normally end under certain circumstances ("Qualifying Events") for a period of time defined by federal law. A Qualified Beneficiary as defined under COBRA means any individual who on the day before a Qualifying Event was covered under this Plan by virtue of being, on that day, either the employee, the spouse of an employee or retiree, or a dependent child of an employee or retiree. Dependent children include a child born to or placed for adoption with the covered employee during the employee's period of COBRA coverage. New dependents acquired while you are covered under COBRA can be added by notifying the Fund within 60 days of acquiring the new dependent. The Plan will treat Domestic Partners, as defined on pages 11-12 above, as spouses for all COBRA purposes under the Plan.

A Qualifying Event includes: termination of employment (except for gross misconduct), reduction of hours resulting in a loss of eligibility, divorce, legal separation, death of the employee, the employee becoming eligible for Medicare, or a child losing dependent status under the Plan.

If you or your eligible Dependents choose COBRA Continuation Coverage, the Plan will provide coverage which is identical to the medical, dental, and vision care and chiropractic and acupuncture[1] benefits provided under the Plan to similarly situated employees and/or family members. This means that you can continue to receive the same benefits you have been receiving **except for death and accidental death and dismemberment benefits**. However, you can choose medical benefits only, in which case the cost to you will be less. In addition, Qualified Beneficiaries are allowed to make the same choices for dental benefits given to non-COBRA beneficiaries under the Plan, such as during periods of rolling enrollment by the plan.

The cost of COBRA Continuation Coverage shall be determined by the Board of Trustees, but in most cases shall not be greater than 102% of the cost of providing the same level of benefits to active employees. Please contact the Fund Administration Office for the exact amount of the cost of COBRA Continuation Coverage at the time you become eligible for such benefits. The costs are revised annually as the cost of benefits under the Plans change.

If you are a covered employee, you and/or your Dependent(s) have a right to choose COBRA Continuation Coverage for up to 18 months if you lose coverage under the Plan because of a reduction in your hours of employment resulting in a loss of eligibility, the termination of your employment (except for gross misconduct), or if your Employer has filed for a Chapter 11 reorganization. A person with COBRA Continuation Coverage based on one of these Qualifying Events may elect up to an additional 11 months of COBRA Continuation Coverage, for a total of 29 months, if they submit to the Fund, prior to the end of the original 18 month continuation period, a written determination by the Social Security Administration that they were disabled during the first 60 days of COBRA coverage. (Such disabled Participants must notify the Plan if they no longer are disabled within 30 days of such determination, and may be required to pay up to 150% of the cost of active employee coverage plus 2% for administration in order to continue the additional 11 months of coverage.) **Proof of disability must be provided to the Fund Administration Office within 60 days of the date the Social Security Administration makes the determination.** This extended period of Continuation Coverage applies to the person who has been determined to be disabled by the Social Security Administration (and/or any other family members if family coverage is elected).

Note that you, your Qualified Beneficiaries and/or your Employer have the responsibility to inform the Fund Administration Office of a Qualifying Event. It is preferable that you notify the Fund Administration Office that you have been terminated or had your hours

[1] Chiropractic and acupuncture benefits are only provided though COBRA coverage to the extent provided for by the collective bargaining agreement for the Employer for which the Participant was working for (and based upon which the Participant was receiving such benefits) immediately prior to a Qualifying Event.

reduced and apply for COBRA Continuation Coverage in case your Employer has not provided such notice. The Qualifying Event Notice should include a description of the Qualifying Event and the date it occurred.

You or your Qualified Beneficiaries shall have 60 days from the later of 1) the date of the Qualifying Event; 2) the date coverage would be lost on account of the Qualifying Event; or 3) the date of the Notice of Right to Continuation of Health Coverage to inform the Fund Administration Office in writing that you want COBRA Continuation Coverage, and you must pay the required premium within 45 days after coverage is elected. If the Fund Administration Office is not notified within the 60 day time limit, you and/or your Dependent(s) will lose the right to elect COBRA Continuation Coverage and will not thereafter be eligible to enroll in COBRA Continuation Coverage. When the Fund Administration Office is notified that a Qualifying Event (listed above) has happened, it will forward a copy of a "Notice of Right to Continuation of Health Coverage" for your completion and return. If you reject COBRA Continuation Coverage, your spouse/Domestic Partner and/or Dependent children may elect coverage within the 60 day period.

Summary of Qualifying Events

Qualifying Event	Qualifying Beneficiary (Who May Receive the Extended Coverage)	Maximum Extension Period
Termination of Participant's Covered Employment (for any reason other than gross misconduct) or reduction in hours or shifts of employment resulting in a loss of eligibility.	Participant, Spouse, and Dependent Children	18 months after date of qualifying event
Death of Participant	Spouse and Dependent Children	36 months after date of qualifying event
Divorce of Participant	Divorced Spouse	36 months after date of qualifying event

Dependent ceases to be eligible under terms of the Plan (i.e., no longer has "Dependent" status)	Affected Dependent	36 months after date of qualifying event
Participant's entitlement to Medicare (under Part A, Part B, or both: (1) prior to an initial qualifying event (2) after an initial qualifying event	Spouse and Dependent Children	(1) Later of 18 months from the qualifying event or 36 months from the date of the Participant's Medicare entitlement (2) 36 months after date of initial qualifying event
Disability determination as to any qualified beneficiary under Title II of Social Security Act	Participant, Spouse, and Dependent Children	29 months after date of qualifying event
Participant's employer has filed Chapter 11 reorganization	Participant, Spouse and Dependent Children	36 months after date of losing coverage For Retirees, until the date of death of the Retiree; for Spouses of Retirees, 36 months after the Retiree's date of death

2. **Second Qualifying Event.** If you are on COBRA coverage because of termination of covered employment or reduction in hours, you can extend coverage if a second qualifying event occurs during the initial 18-month period provided, however, that the total period of continuation coverage does not exceed 36 months from the first qualifying event. For example, in the event you pass away after 6 months of being enrolled in COBRA coverage resulting from termination of employment, your spouse and children will be afforded 30 additional months of COBRA coverage, bringing the total number of months of COBRA coverage to the maximum 36 months.

3. **Effect of Medicare on COBRA.** If you become entitled to Medicare while you are an Active employee and subsequently your coverage under the Plan ends because your

covered employment terminates or there is a reduction in hours or shifts, your Dependents may elect COBRA for the greater of either:

(a) 36 months from the date of entitlement to Medicare; or

(b) 18 months from the date of termination of Covered Employment or reduction in hours.

If you become entitled to Medicare during the 18-month COBRA period following termination of covered employment or reduction in hours, your Dependents are entitled to COBRA coverage for up to 36 months. Regardless of the number of qualifying events or the date of entitlement to Medicare, the maximum period on COBRA is 36 months.

4. Notification Requirement for Disability or Loss of Dependent Status. If COBRA extension coverage is desired by: (1) a divorced spouse; (2) a Dependent who ceases to be a Dependent under the Plan; or (3) a disabled participant, each must notify the Fund Administration Office within 60 days of the date upon which the above qualifying event occurs that he or she desires to extend coverage pursuant to COBRA.

Proof of disability must be provided to the Fund Office within 60 days of the date the Social Security Administration makes the determination. This extended period of COBRA Coverage applies to the person who has been determined to be disabled by the Social Security Administration (and any other family members if family coverage is elected).

5. Notification Requirements for Addition of New Dependent. New Dependents acquired while you are covered under COBRA can be added by notifying the Fund Office within 60 days of acquiring the new Dependent. Dependents will include your newborn and adopted children added after the qualifying event, provided the dependent is enrolled within 60 days after the birth or placement for adoption. A child born or placed for adoption while COBRA coverage is in effect will have all the same COBRA rights as Dependents who were covered by the Plan before the qualifying event that resulted in your loss of coverage.

6. No Coverage During Election Period. A Qualified Beneficiary will not be covered for Plan benefits during the 60-day election period and the 45-day period in which you are allowed to pay for COBRA coverage. However, if a COBRA coverage election is made in accordance with the current COBRA laws and all applicable premiums are paid in a timely manner, then coverage through the Plan for the coverage selected will be retroactive to the original loss of coverage date in accordance with federal law. If a medical, dental, or vision provider calls for verification of eligibility or benefits during the election period and the Fund Office does not have a record of a timely and properly completed election form and payment of

premium, the provider will be told that the Qualified Beneficiary does not have coverage but will be covered as of the COBRA effective date provided that a timely and properly completed election form and premium payment are received. Upon timely receipt of a properly completed election form and payment of all applicable premiums, COBRA continuation coverage shall be in effect.

7. Notification Requirements in the Event of the Death of a Participant or Termination of Employment. In the event of your death, if you were eligible for benefits under the Plan at the date of death, the Fund Office will notify your surviving Dependents of the COBRA coverage extension rights upon being made aware of such qualifying event.

In the event your covered employment is terminated or you worked insufficient hours or shifts to qualify for health and welfare coverage, your employer must notify the Fund Administration Office, which will in turn, notify you and your Dependents of your COBRA coverage extension rights following the last date that you were eligible. However, it is advisable that you (or your Dependent) provide notification as well. If your name is stricken from the employer's monthly remittance and contributions report sent to the Plan, the Fund Administration Office will assume that any of the above circumstances occurred, and will send the required COBRA notice.

The election of COBRA rights must be made in writing within 60 days of the later of: (1) the date the notice is sent to you, or (2) the date your regular Plan coverage terminates. You must pay the required premium within 45 days of the election. If you reject COBRA coverage, your Spouse/Domestic Partner and Dependent children may elect coverage within the 60-day period.

8. Termination of COBRA Coverage. COBRA coverage will terminate earlier than the maximum period set forth above for COBRA if certain events occur. The following circumstances will cause COBRA to end:

(a) Coverage Under Other Plan. After you elect COBRA under the terms of the Plan, your COBRA coverage will end on the date you first become covered by another group health plan.

(b) Medicare Entitlement. Your COBRA coverage will end on the date you become entitled to Medicare.

(c) Failure to Timely Pay Premium. Your COBRA coverage will end on the date coverage expires due to nonpayment or delinquent payment of required COBRA continuation payments. A delinquency occurs if:

(i) initial payment is not made within 45 days after the date the

application for COBRA continuation coverage is received in the Fund Office; or

(ii) a subsequent monthly payment is not received within 30 days of the due date set by the Fund Office.

(d) No Plan Benefits. Your COBRA coverage will end on the date the Plan ceases to provide benefits for all Participants.

(e) Employer No Longer Contributes. Your COBRA coverage will end on the date your employer who contributed on your behalf ceases to be a contributing employer to the Plan.

(f) Exhaustion of COBRA period. Your COBRA coverage will end on the date the applicable period of continuation is exhausted.

(g) Social Security Administration Determination of No Disability. Your COBRA coverage will end on the first day of the month which begins 30 days after you or your Dependents receive a final determination from the Social Security Administration that you or your Dependents are no longer disabled. (Applies in situations where the Qualifying Event was termination of employment or reduction in hours or shifts and where COBRA coverage was being continued for an additional 11 months.)

9. **Available Coverage Options.** If you are eligible for continuation coverage pursuant to COBRA, you may elect either "Core coverage" only, or both Core coverage and "Non-Core coverage." "Core coverage" is medical coverage only. "Non-Core coverage" is dental and vision care coverage where applicable. If Non-Core coverage is elected in addition to Core coverage, all Non-Core coverage will be included. An individual may not elect dental or vision coverage only.

10. **Other Coverage Options.** Coverage options other than COBRA may be available to you. You may, for example, obtain health coverage under an individual policy through the Health Insurance Marketplace, Medicaid, or some other group health plan (such as a spouse's plan) through what is called a "special enrollment period." Any of these options may be less expensive than COBRA and you may be eligible for premium tax credits and cost-sharing reductions that reduce your overall out-of-pocket costs. In general, however, if you elect COBRA, you will not be able to drop COBRA coverage and enroll through the Health Insurance Marketplace unless you are enrolling during the Marketplace's annual open enrollment period or during one of the applicable special enrollment periods. Visit California's Department of

Managed Care website for information regarding additional HMO continuation coverage options. (See: http://www.dmhc.ca.gov/HealthCareinCalifornia.aspx)

H. CALIFORNIA COBRA COVERAGE MAY EXTEND RIGHTS

Under California law, HMOs, such as Kaiser are required to offer to continue benefits for certain individuals beyond the period of federal COBRA in certain situations. You may contact Kaiser for information on this program. Kaiser will provide the appropriate notices and options if this becomes applicable to your situation.

Full details of this Continuation Coverage will be provided to you or your Dependents when a Qualifying Event occurs.

I. COORDINATION OF BENEFITS

Members of a family are often covered by more than one group health insurance plan. As a result, two or more plans are paying for the same claim. To help control costs, your health plan provides a Coordination of Benefits (COB) provision. This provision affects all of your health coverages. Any Coordination of Benefits matters will be determined by the rules of the HMO or Dental plan you are enrolled in.

IV. BENEFITS AND PROVIDERS

Benefits are determined by the collective bargaining agreement between your employer and the Union. For specific information on the benefits to which you may be entitled, it is important to check with your employer and the Union or the providers listed in part G below on page 28.

A. MEDICAL PLAN AND CHOICE OF DENTAL PLAN

For New Employees

Upon initial eligibility of a newly hired employee for benefits under the Plan, you will be provided with enrollment cards and an application card to make a choice of dental plans. You must complete the enrollment and application cards and mail them to the Fund Administration Office. If you decline enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. Please note that you can only enroll once per year under the Plan's rolling enrollment process.

At the time this Summary Plan Description is being printed, Participants may select and be enrolled in Kaiser for themselves and their eligible Dependents.

See the health plan brochures supplied from Kaiser and/or the Summaries of Benefits and Coverage ("SBCs") for a description of the specific benefits, copayments and other rules and regulations applying under the Kaiser plan. ***The rules and procedures for filing claims, the limitations on coverage, exclusions, benefits maximums, etc., stated forth in these brochures are important and must be followed.***

Emergency Services, Reimbursement for Out-Of-Plan Expenses

Pay special attention to the requirements of Kaiser for obtaining reimbursement for emergency medical services, "out-of-plan" expenses, i.e. for services rendered by a physician or facility not part of Kaiser or its replacement HMOs or providers. Those rules govern whether reimbursement for emergency medical services or out-of-plan services will be made. Typically, Kaiser conditions reimbursement for emergency medical services or out-of-plan expenses to a bona fide medical emergency or showing of medical necessity for out-of-plan services. In the case of emergency medical services, you may be required to transfer to a Kaiser plan facility or physician as soon as medically possible and typically, you must give Kaiser immediate notice of a medical emergency and your treatment at an out-of-plan facility or

provider. Also, prior approval generally is required for non-emergency medical services provided at a facility or provider not part of the plan you select.

You may select one of two (2) dental plans for yourself and your eligible Dependents:

1) **Delta Dental (an indemnity plan); or**
2) **Delta Care USA (a closed panel plan)**

See the dental plan brochures for details of each plan. These dental plans have limitations on emergency services and reimbursement for out-of-plan services.

For Continuing Employees

After your initial selection, you may change dental plans only once each year pursuant to the Plan's rolling enrollment process. If you wish to change dental plans, you must file a new fund enrollment card for the dental plan which will be sent to *you* upon your request at open enrollment.

Any person who newly attains eligibility to become a Dependent, such as a new spouse or newborn or newly adopted child or a new foster child, may be enrolled by the Participant's submission of a change of enrollment form to the Fund Administration Office within 30 days of the date of birth, date of marriage or date of adoption or placement. If you fail to notify the Fund as described above, you will not be able to add your new Dependent for dental coverage until you are next eligible to change plans.

You will need to enroll your dependent with the plan or plans in which you are enrolled, as well as with the Fund Administration Office.

If you have difficulty understanding the enrollment cards and the description of benefits provided by the Trustees or upon qualifying as a newly hired eligible employee, or if you require a translation of the enrollment cards or the description of benefits, contact the Fund Administration Office.

B. MENTAL HEALTH AND CHEMICAL DEPENDENCY

Because the Plan is required to offer mental health and substance abuse benefits and limits that are equivalent to the medical benefits and limits under the Plan, those are benefits available to you under the same coverage option you are enrolled in for medical benefits. Kaiser will also be your provider of chemical dependency services.

C. PRESCRIPTION DRUGS

Prescription drug coverage, and any required co-payments or deductibles, are governed by the rules of the HMO you are enrolled in, Kaiser.

D. VISION CARE

Vision Care benefits for eligible Participants and Dependents include full coverage or partial reimbursements for eye examinations and prescription glasses or contact lenses. There is a single copayment of $5.00 for eye examinations, lenses and frames; there is no copayment for contact lenses. These benefits are provided through Vision Service Plan (VSP): see the VSP brochure for a full description of benefits. Kaiser also provides eye examinations for eligible Participants and Dependents (if eligible) for a $5.00 co-payment.

E. DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment (DME) will be covered for those Participants and Dependents enrolled under the Traditional Kaiser HMO plan. Participants needing Durable Medical Equipment (DME) that has been prescribed by a Kaiser physician will need to purchase the equipment and submit their receipts to the Fund Administration Office for reimbursement. Participants should check with the Fund Administration Office in advance of purchasing the equipment to verify that the equipment is covered Durable Medical Equipment (DME).

The benefit amount allowed for Durable Medical Equipment will be based on Usual and Customary charges (UCR). The benefit is subject to a 20% Participant co-payment (50% Participant co-payment for external dysfunctional devices). DME will only be covered if prescribed by a Kaiser physician.

F. DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (FOR <u>ELIGIBLE</u> <u>PARTICIPANTS</u> <u>ONLY)</u>

(YOU MUST BE ACTIVELY AT WORK ON A FULL TIME BASIS AND BE ELIGIBLE FOR AND RECEIVING BENEFITS FROM THE PLAN AT THE TIME OF YOUR DEATH OR DISMEMBERMENT TO BE ELIGIBLE FOR SUCH BENEFITS)

The Plan provides the following benefits to Eligible Participants (Dependents are not covered):

1) Death benefit of $12,500 paid to your beneficiary in the event of your natural death.

2) Accidental Death or Dismemberment benefits. These benefits are paid for an accidental death or dismemberment resulting from your accidental bodily injury. Accident means a sudden, unforeseen and involuntary event caused by external, violent and visible means.

a) Accidental Death Benefit: $12,500 benefit paid to your beneficiary in the event of your accidental death.

b) Dismemberment benefits are paid to you as follows:

The full $12,500 benefit is paid for the loss of both hands, both feet, sight in both eyes and any loss of two or more of the following: foot, hand, sight in one eye, speech or hearing. A $6,250 benefit will be paid for the loss of one hand, one foot or the sight of one eye.

Loss means [a) severance of hand or foot at or above the wrist or ankle joint; b) the total and irrecoverable loss of sight; c) total and irrecoverable loss of audible speech communication; or d) total deafness in both ears, which cannot be corrected to any functional degree by any aid or device. If more than one loss is suffered in any one accident, payment will be made only for the loss with the largest benefit. Payment will be made only for the loss that results from the accident without regard to any former loss.

"Eligible Participant" means a Participant who is an employee performing work covered by the collective bargaining agreement, provided that:

1. the Employer is obligated to make contributions to the Fund for the purposes of obtaining Fund benefits for the employee;
2. the Participant meets the Fund's criteria for eligibility for Fund benefits;
3. the Employer's regular employment records indicate that the employee worked in Covered Employment for the required period preceding the date of death; and
4. the Employer is withholding income taxes and paying unemployment insurance benefits for the Employee

"Actively at Work" means you are is performing the regular duties of employment on that day either at an Employer's place of business or at some location to which the Employee is required to travel for the Employer's business. Actively at work includes each day of a regular paid vacation and each regular non-work day if the Employee was Actively at Work on the last preceding regular work day but does not include time off as a result of injury or illness.

CLAIMS FOR DEATH, ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS MUST BE FILED WITH THE FUND ADMINISTRATION OFFICE <u>WITHIN ONE (1) YEAR</u> FROM THE DATE OF YOUR DEATH OR DISMEMBERMENT. YOU OR YOUR BENEFICIARIES (IN THE CASE OF YOUR DEATH) SHOULD CONTACT THE FUND ADMINISTRATION OFFICE FOR A BENEFIT APPLICATION.

NOT COVERED
No benefits for Accidental Death and Dismemberment benefits will be paid for losses resulting from or caused directly by:

1. War or any act of war, whether declared or undeclared terrorism, insurrection, rebellion, or your voluntary participation in a riot or civil commotion;
2. Sickness, disease or bodily infirmity. (This does not include bacterial infection which results from an accidental cut or wound or accidental ingestion of a poisonous food substance);
3. Intentionally taking a poison or asphyxiation from intentional inhaling of gas, or intentionally taking narcotics, drugs, barbiturates, hallucinogenic drugs, alcohol or any combination of these when not part of a professional medical treatment;
4. Intentionally self-inflicted injury while sane or insane;
5. Suicide or attempted suicide, while sane or insane;
6. Injury sustained while engaged in or taking part in aeronautics and/or aviation of any description or resulting from being in an aircraft except while a fare-paying passenger in any aircraft then licensed to carry passengers; or
7. Commission of or participation in a crime.

Unless one of the above exclusions apply, if you qualify for Death and Accidental Death and Dismemberment benefits at the time of your death, and your death is accidental (as defined above) your beneficiary will be entitled to both a Death and Accidental Death benefit.

Beneficiary Designation for Death and Accidental Death Benefits

Be certain to name the beneficiary to whom you want benefits paid on the Fund enrollment card. Your beneficiary may be any person or persons you name in writing on the enrollment form supplied by the Fund Administration Office. You may request a change of beneficiary at any time by filing a new beneficiary designation form with the Fund Administration Office.

If there is no beneficiary designated by you, or if the designated beneficiary does not survive you, then the benefit will be paid to the surviving person or persons in the order of priority of listing of the following classes:

(i) Spouse or Domestic Partner;
(ii) in equal shares, children, including legally adopted children;
(iii) in equal shares, parents;
(iv) in equal shares, brother(s)/sister(s);
(v) the executor or administrator of the estate

If you name more than one beneficiary, but do not say how much each beneficiary should receive, the total amount will be shared equally by all surviving beneficiaries.

PLEASE NOTE THAT DEATH, ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS ARE NOT AVAILABLE THROUGH COBRA COVERAGE.

G. CHIROPRACTIC AND ACUPUNCTURE (only provided to the extent provided for in the Collective Bargaining Agreement)

Chiropractic and acupuncture coverage, and any required co-payments or deductibles are governed by the rules of the Kaiser plan.

H. TABLE OF BENEFIT PROVIDERS

1) Medical, Hospital, Prescription, Chiropractic and Acupuncture Benefits

Kaiser Foundation Health Plan
1800 Harrison Street, 13th Floor
Oakland, CA 94612
www.kp.org

2) Vision Benefits

Vision Service Plan ("VSP")
3333 Quality Drive
Rancho Cordova, CA 95670
www.vsp.com

3) Dental Benefits

Delta Dental
P.O. Box 7736
San Francisco, CA 94120
www.deltadentalins.com

Delta Care USA
P.O. Box 1810
Alpharetta, GA 30023
www.deltadentalins.com

V. CLAIMS AND APPEALS PROCEDURE

If your claim or appeal concerns a denial of the specific benefits provided by the HMOs or Providers whose individual brochures are provided to you (Kaiser, Delta Dental, Delta Care USA, or VSP), you should carefully consult the specific brochure, pamphlet or other document from the insurance provider for the specific procedures which apply to your claim or appeal. The brochure will explain exactly to whom you should address your claim and what you must provide to the Provider. Study the procedures carefully.

If your claim or appeal concerns the general eligibility rules for the benefit coverage under the Plan (see Eligibility Rules on Pages 10-13 above), open enrollment (Page 7 above) or common features of the Plan, your claim or appeal should be directly addressed to the Trustees, care of the Fund Administrator. And, if you are in doubt about who to address your claim or appeal to, CONTACT THE FUND ADMINISTRATOR. **You must submit your claims to the Fund Administration Office within one (1) Year after you receive any service.** Claims will not be paid if submitted after one (1) Year from the date of service.

If the Fund Administrator determines that the person filing a claim is incompetent and no guardian has been appointed, the Fund Administrator may pay benefits to the claimant's spouse or a blood relative. If you die before all amounts due have been paid, the Fund may pay any remaining benefits to a person or institution designated by the Fund to be entitled to the payments or to your estate, if applicable.

Claim Denial

If your claim is fully denied or denied in part by the Fund Administrator, notice will be given to you in writing and will state: (1) specific reasons for denial of the claim; (2) specific reference to provisions of the Plan, or contract provisions upon which the denial is based; (3) a description, if appropriate, of additional information or material which might enable you to perfect the claim; (4) an explanation of how, where and when you may obtain a review of the denial and your rights under ERISA after administrative remedies have been exhausted; (5) the internal rule, guideline, or protocol, (if any) your denial was based on and your right to request a free copy of the rule, guideline, or protocol; and (6) if the denial is based on a determination that the treatment or services are not considered to be medically necessary or experimental treatment , you have the right to request a free copy of the scientific or clinical judgment on which such determination is based.

Notice of your claim denial shall be given to you in writing within a reasonable period of time, but not later than 30 days after the date the claim is received. This period may be extended an additional 15 days if the Fund Administrator determines that an extension is necessary due to matters beyond its control. You will be notified of the extension before the end of the initial 30-

day period and the date by which the Fund Administrator expects to render a decision on the claim. If an extension is required because you failed to submit sufficient information to enable the Fund Administrator to make a determination of the claim, the notice of the extension will also describe the additional information required. In such a case, you will be given at least 45 days to provide the additional information.

Claim Review by Trustees

Within 180 days after notice that a claim has been denied by the Fund Administration Office, or after the claim is deemed denied as provided above, you or your representative may make a written request for a review of the denial by the Trustees. You or your representative may request copies, free of charge, of all documents, records and other information relevant to the claim. This includes documents relied on in making the benefit determination or submitted or generated in the course of the review.

A request for a review by the Trustees must be submitted to:

Board of Trustees
Hotel and Restaurant Employees Health and Welfare Trust Fund and Plan
P.O. Box 12267
Seattle, WA 98102

The Board of Trustees only has the power to interpret and construe the Plan, determine all questions of eligibility and status under the Plan and determine all questions arising in the administration of the Plan, including the power to determine the rights or eligibility of employees, Participants, their Dependents and beneficiaries. This includes the authority and right to make findings of fact relating to these decisions.

The Trustees, or a committee of the Trustees, will render their decision no later than the date of the Trustee meeting that immediately follows the Plan's receipt of a request for review unless the request is filed within 30 days preceding the date of such meeting. In such a case, a benefit determination may be made by no later than the date of the second Trustee meeting following the Plan's receipt of request for review. If special circumstances exist, the Fund Administrator shall provide you with a written notice of the extension prior to the Trustee meeting in which your request was scheduled to be heard, describing the special circumstances and the date the determination will be made prior to the commencement of the extension. The Trustees will then review the request for review no later than the third Trustee meeting that followed your request for review. The decision of the Trustees will be communicated to you in writing, and will include specific references to this Plan document and Summary Plan Description or contract provisions upon which the decision is based within five (5) days after the benefit determination was made. You will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. The Trustees will review all comments, documents,

records and information submitted by you, whether or not the information was considered in the initial determination. Upon request, you will be provided reasonable access to, and copies of, all documents, records and other information relevant to your claim of benefits.

The decision by the Trustees will not afford deference to the initial adverse benefit determination. If appeal decision is based on whole or in part on medical judgment, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved. The Trustees shall identify any medical and/or vocational expert whose advice was obtained on behalf of the plan in connection with claimant's adverse benefit determination, whether or not that advice was relied upon. If the Trustees consult a medical and/or vocational expert, the Trustees will not consult one that was involved in the initial benefit determination or who is a subordinate of the Trustee.

If the appeal of your claim is fully denied or denied in part, notice will be given to you in writing and will state: (1) specific reasons for denial of the claim; (2) specific reference to provisions of the Plan, or contract provisions upon which the denial is based; (3) an explanation of how, where and when you may review or receive copies of all documents related to your claim of benefits; (4) the internal rule, guideline, or protocol (if any) your denial was based on and that you have the right to request a free copy of the rule, guideline, or protocol; (5) if the denial is based on a determination that the treatment or services are not considered to be medically necessary or experimental treatment, you have the right to request a free copy of the scientific or clinical judgment on which such determination is based; and (6) your right to bring action under section 502(a) of ERISA.

Judicial Review

You have the right to file a suit in a court of law if your claim is denied or partly denied by the Trustees. Plan provisions and applicable law require, however, that you first exhaust all of your appeal rights under the Plan. This means that you must obtain determinations by the Trustees before you may file a lawsuit for a benefit under the Plan.

The Trustees of the Welfare Fund have the final authority and discretion to determine the eligibility of all Participants, their Dependents and beneficiaries for all benefits provided by the Fund, and to interpret and apply the provisions of the Plan. The Trustees shall not be responsible for the denial of any benefit offered by the Fund by one of the providers contracting with the Fund where the denial of that benefit is not brought to the Trustees' attention by the Participant or beneficiary in the manner described above.

VI. INFORMATION CONCERNING THE FUND AND YOUR RIGHTS UNDER ERISA

As a participant in the Hotel and Restaurant Employees Health and Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

(a) Examine, without charge, at the Fund Administration Office and at union offices, all Plan documents, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration such as detailed annual reports and plan descriptions.

(b) Obtain, upon written request to the Board of Trustees or the Fund Administration Office, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. A reasonable charge may be made for these copies.

(c) Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report which will be mailed to you.

(d) Receive a written explanation of the reason a benefit is denied in whole or in part, and to have the Plan review and reconsider your claim.

(e) Continue health care coverage for you or your eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage.

(f) Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

(g) Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or Health Insurance Issuer when you lose coverage under the plan and when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it up to 24 months after losing coverage.

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 or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. 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 under ERISA, you may seek assistance from the U.S. 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, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Fund Administrator.
If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The Fund is administered by a Board of Trustees, which includes an equal number of representatives appointed by the Union, UNITE HERE, Local 2850, and Employer representatives. The current Trustees of the Fund are listed below.

Management Trustees

Douglas Cornford, Co-Chairperson
Hotel and Restaurant Employees
Health and Welfare Plan
c/o Northwest Administrators, Inc.
1182 Market Street, Suite 320
San Francisco, CA 94102

Jose Zarate
Hotel and Restaurant Employees
Health and Welfare Plan
c/o Northwest Administrators, Inc.
1182 Market Street, Suite 320
San Francisco, Ca 94102

Kevin Gleason
Hotel and Restaurant Employees
Health and Welfare Plan
c/o Northwest Administrators, Inc.
1182 Market Street, Suite 320
San Francisco, Ca 94102

Union Trustees

Wei-Ling Huber, Co-Chairperson
UNITE HERE Local 2850
1025 3rd Street
Oakland, CA 94607

Lian Alan
UNITE HERE Local 2850
1025 3rd Street
Oakland, CA 94607

Yulisa Elenes
UNITE HERE Local 2850
1025 3rd Street
Oakland, CA 94607

A. NAME AND TYPE OF ADMINISTRATION OF THE PLAN

The name of the Plan is Hotel and Restaurant Employees Health and Welfare Trust. The **Fund Administrator**, who has day-to-day responsibility for the management of the Fund and is the party to whom requests for assistance should be made, is:

Hotel and Restaurant Employees Health and Welfare Trust Fund
c/o Northwest Administrators, Inc.
1182 Market Street, Suite 320
San Francisco, CA 94102

B. INTERNAL REVENUE SERVICE PLAN IDENTIFICATION NUMBER

The Employer Identification Number (EIN) issued to the Board of Trustees is 92-1229312. The Plan Number is 501.

C. TYPE OF PLAN

The Plan is a welfare plan providing for the following health benefits: Medical, Dental, Vision, Prescription Drug, Death and Accidental Death & Dismemberment benefits to Eligible Employees. The Plan also provides Chiropractor and Acupuncture benefits to Eligible Employees of employers whose collective bargaining agreement provides for such coverage. The Plan also provides Medical, Dental, Prescription Drug and Vision benefits for eligible Dependents.

D. COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained pursuant to collective bargaining agreements between UNITE HERE Local 2850 and Employers working within their jurisdiction. A copy of any such agreements may be obtained by Participants, their Dependents and beneficiaries, upon written request, to the Board of Trustees or the Fund Administration Office and are available for examination by Participants, their Dependents and beneficiaries. UNITE HERE Local 2850 and employers within Local 2850's jurisdiction appoint an equal number of trustees to the Board of Trustees of the Hotel and Restaurant Employees Health and Welfare Trust Fund Plan. The Board of Trustees is the Plan Administrator and the named Fiduciary with the authority to control and manage the operations and administration of the Plan.

E. NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS

Board of Trustees
Hotel and Restaurant Employees Health and Welfare Trust Fund
c/o Northwest Administrators, Inc.
1182 Market Street, Suite 320
San Francisco, CA 94102

Service of legal process may be made upon any member of the Board of Trustees. Names and addresses of the current Board members are contained above on page 35.

F. REQUIREMENTS REGARDING ELIGIBILITY FOR PARTICIPATION AND BENEFITS

The Plan's requirements with respect to eligibility for benefits are shown on pages 10-13 above.

G. IDENTITY OF ORGANIZATIONS THROUGH WHICH BENEFITS ARE PROVIDED

The organizations through which benefits are provided are:

1. Delta Care USA
2. Delta Dental
3. Kaiser Foundation Health Plan
4. Vision Service Plan

H. SOURCE AND METHOD OF FUNDING

The programs of the Plan are financed through the Trust Fund, which is funded by contributions of employers and Participants and investment income, if any. Employers contribute to the Welfare Plan at rates determined by applicable collective bargaining agreements between UNITE HERE Local 2850 and Employers working within their jurisdiction as established by the Board of Trustees. A complete list of such Employers may be obtained by Participants or Dependents upon ten (10) days advance written request to the Fund Administration Office. The Trustees may impose a reasonable charge for the costs of providing such list. As described in this booklet, Participants are able to make payments for certain periods of time when they are not covered by employer contributions.

I. CLAIM AND APPEAL PROCEDURES

The procedures for filing claims and appealing claim denials are set forth beginning on pages 29-31 of this Booklet.

J. PLAN YEAR

The fiscal year of the Plan is the twelve-month period ending each December 31st, and the Plan's records are maintained on that basis.

K. PLAN BENEFITS ARE NOT GUARANTEED

The benefits provided by this Plan, while intended to remain in effect indefinitely, can be guaranteed only so long as the parties to collective bargaining agreements continue to require contributions into the Fund sufficient to underwrite the cost of the benefits. **The Trustees reserve the right to amend this Plan document and to modify benefits at any time, or to reduce or eliminate benefits if necessary to maintain the financial soundness of the Plan. The benefits of the Plan are not lifetime guaranteed nor vested benefits.**

L. MERGER WITH OTHER TRUST FUNDS AND PLANS

The Board of Trustees shall have the power and authority to effectuate a merger of the Fund and/or the plan of benefits established by the Trustees, with such other trust fund and/or plan of benefits which provides similar benefits in kind, (but not necessarily in amount), and is tax-qualified under the provisions of IRC 501(c)(9), providing the known or suspected liabilities of such Fund and/or plan are ascertained as far as reasonably possible to do so, and such merger is prudent and beneficial to this Fund and plan.

M. TERMINATION OF THE PLAN

In the event that the collective bargaining agreements between the contributing employers and the Union terminate or are hereafter amended so as to relieve such employers of any obligation to make contributions to this Fund, then the Trustees, after accounting for any and all monies and property remaining in the Fund, and after the payment of or adequate provision for all liabilities relating to or affecting this Fund, shall use the balance of said monies and property remaining on hand in this Fund to continue the Plan until said monies and other property in said Fund are exhausted.