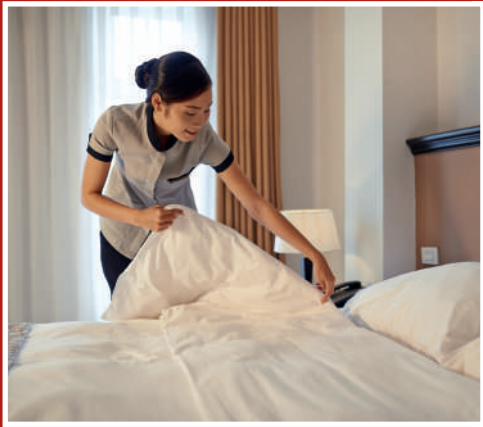
SUMMARY PLAN DESCRIPTION



UNITE HERE Local 25 and Hotel Association of Washington, D.C.

HEALTH AND WELFARE FUND

November 2018

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Dear Participant,

This is the Summary Plan Description of the benefits, rules and regulations ("Plan") provided under the UNITE HERE Local 25 and Hotel Association of Washington, DC Health and Welfare Fund ("Fund") as of September 1, 2018.

The Fund was established as a result of collective bargaining between UNITE HERE Local 25 ("Union") and various Employers that participate in the Fund through the Hotel Association of Washington, DC ("Participating Employers"). The Union and the Participating Employers, through the Hotel Association of Washington, DC, appoint an equal number of Trustees who administer the Fund without compensation from the Fund. The Trustees' authority is established under the Agreement and Declaration of Trust which also establishes the Fund. This authority includes the right to make rules and regulations concerning eligibility for coverage and the level of benefits provided. The Trustees may amend the Plan at any time. If any significant changes are made to the Plan, you will be notified of them within a reasonable time after the change is made.

This booklet is a written description of the benefits which are available to you and your dependents, and of the rules and regulations whereby you receive those benefits. It is designed to be understood by Participants. However, if there is a conflict between this booklet and the separate program documents, such as the insurance companies' Certificates of Coverage, the separate program documents will control. Copies of the Plan documents are available from the Administrative Manager, referred to in this booklet as "the Fund Office." Please read this booklet and keep it in a safe place for future reference. If you have any questions concerning your benefits or the rules and regulations, please call or write to the Fund Office.

Este libro contiene un resumen en ingles de sus derechos y beneficios en este Plan bajo el UNITE HERE Local 25 and Hotel

Association of Washington, DC Health and Welfare Fund. Si tiene dificultad en entender cualquier parte de este libro, puede escribir a Associated Administrators, LLC, el Administrador del Fund, a 911 Ridgebrook Road, Sparks, MD 21152. Tambien puede llamar a la oficina del Administrator en al (301) 459-3020, (800) 638-2972 para ayude entre las horas del las 8:30 de la mañana hasta las 4:30 de la tarde, lunes a viernes.

Sincerely,

Board of Trustees

NOTICE – No Fund Liability

Use of the services of any hospital, clinic, doctor or other provider rendering health care, whether designated by the Trustees (or their delegees) or otherwise, is the voluntary act of Participants and their dependents. Some benefits may only be obtained from service providers which are designated by the Plan. This is not meant to be a recommendation or instruction to use any service provider. You should select a provider or course of treatment which is based on all appropriate factors, only one of which is coverage under the Plan. Service providers are independent contractors, not employees of the Plan. The Fund makes no representation regarding the quality of service of or treatment by any provider. The Fund, the Trustees and their delegees are not responsible for any acts of commission or omission of any service provider in connection with coverage under the Plan. The providers are solely responsible for the services and treatments which they render.

FACTS ABOUT THE FUND

Name of Fund:
UNITE HERE Local 25 and Hotel Association of Washington, DC Health and Welfare Fund

Plan Sponsor
Board of Trustees, UNITE HERE Local 25 and Hotel Association of Washington, DC Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

Plan Administrator
Board of Trustees, UNITE HERE Local 25 and Hotel Association of Washington, DC Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

The Board of Trustees consists of members appointed by UNITE HERE Local 25 and by the Participating Employers. The names and addresses of the current Trustees are shown on page 7.

Employer Identification Number: 36-2941623

Plan Number: 501

Type of Plan: This Plan is a welfare plan maintained to provide dental, optical, hospital and medical benefits.

Type of Administration:
The Board of Trustees has contracted with Associated Administrators, LLC (referred to in this booklet as "the Fund Office"), for administrative management services. Its address is:

Associated Administrators, LLC
911 Ridgebrook Road
Sparks, MD 21152-9451
Telephone: (301) 459-3020, (800) 638-2972

Agent for Service of Legal Process
Associated Administrators, LLC or any Trustee at this address: UNITE HERE Local 25 and Hotel Association of Washington, DC Health and Welfare Fund, 911 Ridgebrook Road, Sparks, MD 21152-9451.

Contributions to the Fund:
The Fund is financed by contributions paid by employers that are parties to collective bargaining agreements with the Union that require the payment of such contributions, and by contributions required to be made by participants as described in this booklet ("Participating Employers"). Upon written request to the Fund Office, you may receive information as to whether a particular employer participates in the Plan and, if so, the employer's address. Copies of the collective bargaining agreements are available for examination at the Fund Office by Participants and their beneficiaries, or copies will be made available upon a Participant's written request made to the Fund Office.

Fund Medium:
All assets are held in a trust by the Board of Trustees. Premiums are paid out of trust assets to the entities that provide services to Fund participants. A current Summary Annual Report gives details of the funding of Fund benefits and is available from the Fund Office upon request.

Plan Year:
The Plan's fiscal year is the 12-month period beginning January 1 and ending December 31.

BOARD OF TRUSTEES

UNION TRUSTEES

John Boardman (Chairman)
UNITE HERE Local 25
901 K Street, NW, Suite 200
Washington, DC 20001

Linda Martin
UNITE HERE Local 25
901 K Street, NW, Suite 200
Washington, DC 20001

Stephanie Steer
UNITE HERE Local 25
901 K Street, NW, Suite 200
Washington, DC 20001

EMPLOYER TRUSTEES

Solomon Keene, President
Hotel Association
of Washington, DC
1201 New York Avenue, NW
Suite 601
Washington, DC 20005-3917

Charles Hill
Embassy Suites-Washington
Convention Center
900 10th Street NW
Washington, DC 20001

William Walsh
Marriott Wardman Park Hotel
2660 Woodley Road, NW
Washington, DC 20008

ELIGIBILITY AND COVERAGE RULES FOR DENTAL AND/OR OPTICAL BENEFITS

You are eligible to become covered by the Fund if you are employed by a Participating Employer and covered by a Collective Bargaining Agreement between that Employer and the Union in a job classification which requires your Employer to pay contributions to this Fund on your behalf. This type of employment is referred to as "Covered Employment."

Date of Coverage

You will become covered under the Fund eligible for the **Dental and/or Optical** benefits described in this booklet, on the first day of the month following three consecutive months for which contributions of **60 or more hours** per month ("Qualifying Contributions") have been made to the Fund on your behalf. The collective bargaining agreement between your Employer and Union specifies when your Employer is obligated to begin paying contributions to this Fund on your behalf.

If Qualifying Contributions are Paid for each of the months of:	You become eligible on:
January-February-March	April 1
February-March-April	May 1
March-April-May	June 1
April-May-June	July 1
May-June-July	August 1
June-July-August	September 1
July-August-September	October 1
August-September-October	November 1
September-October-November	December 1
October-November-December	January 1
November-December-January	February 1
December-January-February	March 1

Loss of Coverage

You will cease to be eligible for benefits upon the earlier of:

1. the date you terminate Covered Employment for any reason including quitting, death, or transfer to employment that is not Covered Employment, ***other than*** lay-off or an approved leave of absence, or
2. the last day of the third consecutive month in which Qualifying Contributions are not made on your behalf for any reason. If your coverage terminates, you and/or your dependents may be entitled to continue coverage under the Plan—at your own expense—under the COBRA rules described on page 27.

Reinstatement of Coverage

If your coverage terminates for any reason other than a layoff or approved leave of absence and you return to Covered Employment, your coverage will be reinstated on the first day of the month following three consecutive months in which your Employer has made contributions to the Fund on your behalf. Please refer to the section entitled "Date of Coverage" for further information.

If your coverage terminates because of a layoff or approved leave of absence, it will be reinstated on the day you return to Covered Employment.

Dependent Eligibility for Dental and/or Optical Benefits

The following individuals are also covered under the Plan as your dependents:

1. Your spouse.

2. Children:
   a. Your unmarried children up to 19 years of age who live with you and who are primarily dependent on you for financial support.

b. Your unmarried child may be continued after the child's attainment of age 19 if the child is a full-time student in an accredited school or university upon the child's attainment of age 19. A student certification form must be completed and filed with the Fund Office before the child attains age 19 in order for coverage to be continued. Such continued eligibility will terminate on the earlier of the child's loss of status as a full-time student in an accredited school or university, or the last day of the calendar year during which the child attains age 23. Student coverage is continuation coverage only and applies only to children who were covered as dependent children prior to their attainment of age 19. A student dependent child cannot become eligible for coverage under the Plan if the child becomes a full-time student in an accredited school or university after attaining age 19.

c. In all cases, a dependent includes an unmarried child over the relevant age limit who is incapable of self-support because of a physical or mental disability that began before the child's attainment of the limiting age (age 19, or for a full-time student, age 23), and who is completely dependent on the Participant financially. The Fund may require that a disability certificate, which documents the child's continuing disability, be completed annually and filed with the Fund Office.

d. The term "children" includes foster children, legally adopted children and stepchildren.

3. If you have acquired a new dependent due to marriage, birth, adoption or placement for adoption ("Family Change"), you may enroll your dependent by submitting a new enrollment to the Fund Office. If you submit your form

within 30 days from the date of the Family Change, the new dependent child will be covered retroactively to the date of the Family Change. Otherwise, the new dependent will be covered beginning on the first day of the month after you submit a new enrollment form. The Fund may require you to submit evidence to prove the dependent's status.

Dependents described above will become covered on the same day on which you become covered. You must notify the Fund Office of any new dependent(s). If you acquire a new dependent, by marriage, birth of a child, placement of a child for adoption or adoption, you can add the new dependent at any time for dental and optical coverage by contacting the Fund Office. If you submit your form within 30 days from the date of the Family Change, the new dependent child will be covered retroactively to the date of the Family Change. Otherwise, the new dependent will be covered beginning on the first day of the month after you submit a new enrollment form. A special rule applies for joining new dependents to A List health plan coverage. See page 15. The Fund may require you to submit evidence to prove the dependent's status.

Termination of Dependent Eligibility for Dental and/or Optical Benefits

Eligibility and coverage of a dependent will terminate on the earliest of the following dates:

1. The date on which your coverage terminates or you die.
2. The date on which the dependent becomes covered under the Fund as an employee of a participating employer.
3. Spouse: the date on which a spouse becomes divorced or legally separated from you.
4. Dependent children:
   a. at the end of the calendar year in which the child attains age 19 (or age 23 under the student coverage rules described above), or
   b. the last day of the calendar month during which the child meets the requirements for dependent status described above (other than the attainment of age),

for example, because the child begins regular full-time employment, or ceases to be dependent on you or becomes married.

Termination of Coverage for False Representations or Fraud

If any individual makes a false representation to, or commits any fraud under or with respect to, the Plan, the Board of Trustees has the right to permanently terminate coverage for the individual and his or her dependents, to the extent permitted by law. This may include, but is not limited to, submitting falsified claims or obtaining coverage for an individual who is ineligible (for example, adding a spouse before the date of marriage or failing to notify the Plan of a divorce from a covered spouse). To the extent permitted by law, the Board of Trustees may also seek reimbursement from the individual for all claims or expenses paid by the Plan as a result of the false representation or fraud, and may pursue legal action against the individual.

Domestic Partners

No domestic partners will be covered other than domestic partners who were covered on November 1, 2018, who will continue to be covered under the terms and conditions of the Plan then in effect.

Certificate of Prior Coverage

If you or your covered dependent(s) lose eligibility (including COBRA continuation coverage) for any reason, you will receive what is called a "Certificate of Prior Coverage" from the Fund Office. The certificate verifies that you had group health coverage for a certain period of time (whatever that amount of time was for you).

If you need a Certificate of Prior Coverage, write to the Fund Office at:

Fund Office
911 Ridgebrook Road
Sparks, MD 21152-9451
Attn: Certificate of Prior Coverage

ELIGIBILITY AND COVERAGE RULES FOR HEALTH COVERAGE FOR A LIST EMPLOYEES

A List Medical Coverage — General

Eligible A List employees may elect to receive hospital and medical coverage from the Fund ("A List Medical Coverage"). The Fund provides coverage through Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Detailed information about the benefits is included in the enrollment packet that all A List employees will receive before they become eligible for A List Coverage. If you have questions about the benefits or do not receive an enrollment package after you have been an A List employee for five (5) or more consecutive months, please contact the Fund Office.

PLEASE NOTE: If you do not know whether you will be designated as an A List employee for any month, contact your Employer or the Union far enough in advance of that month so that if you are eligible you can submit your co-payment (and enrollment form, if applicable) by the first of the month.

Initial A List Eligibility and Coverage

You will become eligible for A List Medical Coverage on the first day of the month following six (6) consecutive months for which your Employer designates you as an A List employee ("First Eligibility Month").

In order to receive A List Medical Coverage, you must enroll by submitting a completed eligibility form with the Fund Office. You will begin to receive A List Medical Coverage on the first day of your First Eligibility Month if the Fund Office receives, before the first day of that month, (i) a completed enrollment form, and (ii) your monthly co-payment for your First Eligibility Month. The monthly co-payment amount is listed in your enrollment packet. You will continue to receive A List Medical Coverage for every consecutive month following your First Eligibility Month in which you are designated as an A List employee by your Employer, as long as the

Fund Office receives the required co-payment for that month before the first day of that month.

Changes to A List Medical Coverage

An open enrollment period is held during the month of October of each year. During open enrollment, you can change your type of coverage (for example, from family to single), you can enroll in A List Coverage if you failed to enroll when you first became eligible, or you can terminate your coverage entirely. Contact the Fund Office if you have any questions.

Dependent Eligibility for A List Medical Coverage

You may elect to cover your dependents under A List Medical Coverage. The following individuals are also covered under the Plan as your dependents:

1. Your spouse.

2. Children:
   a. Your children under age 26.

   b. In all cases, a dependent includes an unmarried child over the relevant age limit who is incapable of self-support because of a physical or mental disability which began before the child's attainment of the limiting age (age 26), and who is completely dependent on the Participant financially. The Fund may require that documentation of incapacity and dependency be provided periodically.

   c. The term "children" includes foster children, legally adopted children and stepchildren.

If you enroll your dependents when you first become eligible, they will become covered on the same day on which you become covered. You must notify the Fund Office of any new dependent(s).

An additional premium applies if you elect to cover dependents under A List Medical Coverage.

1. Adding a New Dependent. As discussed below, if you acquire a new dependent due to marriage, birth, adoption or placement for adoption ("Family Change"), you may enroll your dependent by submitting an enrollment form no later than 31 days after the date of the Family Change.

2. Losing a Dependent. If you lose a dependent – for example, because of divorce, death or a child reaching age 26, you can elect to change your A List Medical Coverage from family to individual-only, or dropping your coverage entirely. An election to change coverage due to losing a dependent must be received by the Fund Office within 31 days of the event. Otherwise, you will have to wait to the next open enrollment period to make a change.

Late Enrollment in A List Medical Coverage

If you did not enroll in A List Coverage beginning with your First Eligibility Month, you may enroll in A List Coverage on the earliest applicable date set forth below, ***provided you are an eligible A List employee at the time*:**

1. Loss of Other Coverage. If you were covered under another health plan and lost coverage because you lost eligibility under the other plan, because employer contributions to the other plan terminated, or because you had COBRA coverage and the maximum coverage period has ended, you may elect to receive A List Coverage by submitting an enrollment form to the Fund Office no later than 31 days after you lose the other coverage (or become aware that you have lost such other coverage). You will begin coverage as of the first day of the month following the receipt of your enrollment form so long as you make the applicable co-payment by the first day of coverage.

2. Adding a New Dependent. If you acquire a new dependent due to marriage, birth, adoption or placement for adoption ("Family Change"), you may enroll yourself and your dependent, or enroll your dependent if you are already enrolled, by submitting an enrollment form no later than 31 days after the date of the Family Change. An enrollment of a new dependent child will be effective on the date of the Family Change (i.e., date of birth or date of adoption or placement for adoption). In the case of marriage, enrollment will be effective on the first day of the month following the Fund Office's receipt of your enrollment form, or the date of marriage, if later. You must make the applicable co-payment by the date of your election (if coverage begins on the date of the Family Change) or the first day of the month in which coverage is being provided (if coverage begins on the first day of the month following the Fund Office's receipt of your enrollment form). Remember that the enrollment must be received within 31 days of the Family Change.

3. CHIPRA Special Enrollment. If you and/or your dependent's Medicaid or State Children's Health Insurance Program ("CHIP") coverage is terminated due to a loss of eligibility, or if you and/or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, then you may have the right to enroll for A List Coverage within 60 days of the event.

Open Enrollment. In all other circumstances, you may enroll during any open enrollment period (normally held in October) that begins at least 12 months after your First Eligibility Month. Coverage will begin on the following November 1, provided you remit your enrollment form and co-payment to the Fund Office before then.

Termination of A List Medical Coverage

Your coverage will terminate on the earliest of:

1. The last day of the month preceding the first month for which you do not make a co-payment by the due date. In this case, you may become covered in a later month as explained below.
2. The last day of the month preceding the first month for which no Employer designates you as an A List employee.

Eligibility and coverage of a dependent will terminate on the earliest of the following dates:

1. The date on which your coverage terminates or you die.
2. The date on which the dependent becomes covered under the Fund as an employee of a participating employer.
3. Spouse: the date on which a spouse becomes divorced or legally separated from you.
4. Dependent children: the last day of the calendar month during which the child meets the requirements for dependent status described above, for example because the child attains age 26.

If your and/or your dependent's coverage terminates, you and/or your dependents may be entitled to continue coverage under the Plan – at your own expense – under the COBRA rules described on page 27.

Termination of Coverage for False Representations or Fraud

If any individual makes a false representation to, or commits any fraud under or with respect to, the Plan, the Plan Board of Trustees has the right to permanently terminate coverage for the individual and his or her dependents, to the extent permitted by law. This

may include, but is not limited to, submitting falsified claims or obtaining coverage for an individual who is ineligible (for example, adding a spouse before the date of marriage or failing to notify the Plan of a divorce from a covered spouse). To the extent permitted by law, the Plan Administrator may also seek reimbursement from the individual for all claims or expenses paid by the Board of Trustees as a result of the false representation or fraud, and may pursue legal action against the individual.

Reinstatement of A List Medical Coverage

1. Failure to Make Premium Payments. If your coverage terminates because you failed to remit a premium payment by its due date, you must wait at least twelve months before your coverage may be reinstated. Your coverage may be reinstated in accordance with the rules governing late enrollment, as described above, provided you have continued as an A List employee since your First Eligibility Month and have made any required payments.

2. Removal from A List. If your coverage terminates because no Employer designated you as an A List employee for a month, your coverage may be reinstated in accordance with the rules set forth in the section entitled "Initial A List Eligibility and Coverage." Please refer to that section for further information.

Domestic Partners

No domestic partners will be covered other than domestic partners who were covered on November 1, 2018, who will continue to be covered under the terms and conditions of the Plan then in effect.

Transfers between A List Employment and Regular Employment

Regular employees are not eligible for A List Coverage from the Fund. Instead, regular employees may be eligible for coverage under their Employer's hospital and medical plan after six (6) consecutive months of being classified as a regular employee.

If you transfer your employment status from regular employee to A List employee, your service as a regular employee will be counted towards the eligibility waiting period of six (6) consecutive months described above in the A List section entitled "Initial A List Eligibility and Coverage". Your A List Medical Coverage will be available beginning on the first day of the month after you become an A List employee or meet the initial eligibility requirements, as described above.

If you transfer your employment status from A List employee to regular employee, your coverage will end on the last day of the month you leave the A List. Your service as an A List employee will be counted towards the eligibility waiting period of six (6) consecutive months described in detail in your Employer's hospital and medical plan.

Certificate of Prior Coverage

If you or your covered dependent(s) lose eligibility (including COBRA continuation coverage) for any reason, you will receive what is called a "Certificate of Prior Coverage" from the Fund Office. The certificate verifies that you had group health coverage for a certain period of time (whatever that amount of time was for you).

Qualified Medical Child Support Orders

Federal law requires group health plans to honor qualified medical child support orders (QMCSOs). In general, QMCSOs are state court or administrative agency orders requiring a parent to provide medical financial support to a child, for example, in case of separation or divorce. Upon receipt of a QMCSO, a plan is required to pay benefits directly to the child, the child's custodial parent or legal guardian, according to the order. You and the affected child will be notified if an order is qualified. You may obtain a copy of the Fund's procedures governing the determination of whether an order is a QMCSO by contacting the Fund Office at the address above. There is no charge for this document.

Grandfathered Health Plan

The Board of Trustees believes the A List Medical Coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

Board of Trustees
UNITE HERE Local 25 and Hotel Association of Washington, DC Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PRIVACY

The Health Insurance Portability and Accountability Act of 1996, as amended, ("HIPAA") provides for protection of personal health information and stipulates who may have access to the information. Protected health information ("PHI") includes identifiable information about you and your covered dependents, your patient records and "genetic information" within the meaning of the Public Health Service Act.

PHI. The Plan, any employees of an employer performing health benefit functions, and any third party administrators performing services for the health benefit programs, may not use your PHI for purposes other than for treatment, payment or health care operation, or as required or permitted under applicable law, without your written authorization. Such authorization shall specify who will have access to the PHI, when the access expires, and your right to revoke the authorization. The Plan Administrator may grant access to PHI only as necessary to fulfill its obligations to the Plan. PHI will not be disclosed for employment purposes, and genetic information that is PHI will not be used for underwriting purposes.

In addition, you have the right to request a copy of your health information and to make changes to correct errors. You may also request an accounting of all disclosures of your PHI.

Disclosure of Summary Health Information. The Plan, health insurance issuer or health maintenance organization ("HMO") may, however, disclose summary health information to obtain premium bids from insurance companies, to modify, amend or terminate the Plan, or for other uses and disclosures permitted by HIPAA.

Disclosure of PHI. The Plan may disclose to the Trustees information regarding whether or not an individual has enrolled in the Plan. The Plan may disclose PHI to the Trustees for the purpose of payment or health care operations, as defined under the HIPAA

regulations. The Plan may not disclose PHI for purposes of employment-related actions or decisions.

The Trustees will:

- not use or further disclose PHI other than as permitted or required by the Plan's document or as required by law;

- ensure any agents, including subcontractors, who receive PHI, agree to the same restrictions and conditions;

- not use or disclose the information for employment-related actions or decisions;

- make available PHI in accordance with Department of Health and Human Services Regulation ("HHS Reg.") Section 164.524;

- make available PHI for amendment and incorporate nay amendments to PHI in accordance with HHS Reg. Section 164.526;

- make available PHI required to provide an accounting of disclosures in accordance with HHS Reg. Section 164.528;

- make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of HHS for purposes of determining the Plan's compliance with HIPAA;

- if feasible, return or destroy all PHI received from the Plan that the Trustees maintain and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

Adequate Separations. Prior to releasing PHI to the Trustees, the Plan will ensure that the Trustees have established the following adequate separations:

- specific personnel shall be designated to use and disclose PHI on behalf of the Plan to perform payment or health care operations;

- access and use by such personnel will be limited to the minimum necessary PHI required to perform payment or health care operations;

- any issues of non-compliance shall result in disciplinary measures.

If the Plan, any employees performing health benefit functions, or any third party administrators performing services for the health benefit programs creates, receives, maintains or transmits any electronic PHI, the Plan will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI, and will ensure that any agent (including sub contractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information.

A HIPAA Privacy Notice further explaining your rights under HIPAA is available to you upon your request.

CONTINUATION OF COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 ("COBRA")

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("*COBRA*") requires that the Plan offer eligible participants and their eligible dependents the opportunity to pay for a temporary extension of health coverage at group rates in instances where coverage under the Plan would otherwise end, in accordance with the provisions of federal law. These events are called "*qualifying events."*

Participant's Rights

Eligible participants who lose eligibility for either of the following reasons may continue coverage for up to 18 months at his/her own expense:

1. Termination of employment (except for gross misconduct)
2. Reduction in hours of employment

Dependent's Rights

The dependent spouse or dependent child of an eligible participant may continue coverage at his/her own expense if he or she loses coverage under the Plan for any of the following reasons:

1. The death of the participant;
2. Termination of the participant's employment (other than for gross misconduct) or reduction in the participant's hours of employment;
3. Divorce or legal separation from the participant;
4. The participant becomes eligible for Medicare; or
5. The dependent child ceases to satisfy the Fund's eligibility rules.

Electing COBRA Coverage

You or your dependent(s) must elect COBRA coverage under the Plan within 60 days of the later of the following:

1. The date you or your dependent(s) would lose health coverage because of the qualifying event; or

2. The date you or your dependent(s) are advised by the Plan of your rights to COBRA coverage.

Type of Coverage

For regular employees, the participant or eligible dependent can continue coverage for:

1. Dental benefits ONLY,
2. Optical benefits ONLY, or
3. Both Dental and Optical benefits

For A List employees, the participant or eligible dependent can continue coverage for:

1. Medical/Prescription Drug benefits through the HMO ONLY,
2. Dental and Optical benefits ONLY,
3. Dental benefits ONLY,
4. Optical benefits ONLY, or
5. Medical/Prescription Drug, Dental and Optical.

You may only elect to continue benefits which were already in place at the time of the event resulting in the loss of coverage.

Only those services that would have been payable under the Plan will be payable under COBRA. The cost that you must pay to continue benefits is determined annually and will be contained in the notice of right to elect continuation of coverage sent to you by the Fund Office.

Duration of COBRA Coverage

COBRA coverage may continue for the following lengths of time depending on the qualifying event:

1. 18 months, if you terminate employment (for reasons other than your gross misconduct) or are on a leave for which employee coverage does not continue;
2. if you had Medicare coverage before you left or became a part-time or inactive employee, your dependents may

continue coverage for 36 months after your Medicare coverage began, if longer than the above 18-month period;

3. 29 months, if the Social Security Administration (SSA) determines that you or your dependent were disabled on or within the first 60 days following your qualifying event, and you notify the Fund Office within 60 days of the determination and before the end of the 18-month period. In this event, your non-disabled family members who are entitled to COBRA will also receive the 11-month COBRA extension. An increased cost of up to 150% of the cost of Plan coverage may be required for the 11 extra months of COBRA coverage;
4. 36 months if you and your spouse divorce or legally separate or if your child no longer qualifies as a dependent. You, your spouse or dependent must notify the Fund Office within 60 days after the event or you will forfeit this right; or
5. 36 months, if you die or become covered by Medicare.

Notification Requirements

The participating employer must notify the Fund in writing, within 30 days of your death, termination of employment, reduction in working hours or entitlement to Medicare. The participating employer's failure to provide timely notice may subject the participating employer to federal excise taxes.

You or your eligible dependent must inform the Fund Office of a divorce or legal separation, or a dependent child's loss of dependent status under the Fund in writing within 60 days of the event that causes the loss of coverage. If you or your eligible dependent is determined to have been disabled at any time during the first 60 days of continuation coverage, you or your eligible dependent must notify the Fund Office within 60 days of the date that the Social Security Administration determines that you (or your eligible dependent) is disabled and within 30 days of any final determination that you (or your eligible dependent) is no longer disabled. If you or your eligible dependent fails to notify the Fund

Office within 60 days of the date that coverage would otherwise cease, the right to elect COBRA continuation coverage will be forfeited.

Second Qualifying Events

If you become eligible for COBRA Continuation Coverage, the 18-month coverage period may be extended for your spouse or beneficiaries for an additional 18 months if a second qualifying event occurs within the 18-month period of COBRA Continuation Coverage. However, in no event will COBRA Continuation Coverage extend beyond 36 months. Such second qualifying events include the death of the participant, divorce or separation from the participant, the participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Fund. However, these events are second qualifying events only if they would have caused the qualified beneficiary to lose coverage under the Fund if the first qualifying event had not occurred. You must notify the Fund Office in writing and in accordance with the notification procedures described below in order to extend the period of continuing coverage.

All notifications under COBRA must comply with these provisions. Both the participant and the affected dependent are jointly responsible for this notice. Notice should be mailed or hand delivered to the Fund Office, Attention:

COBRA Department, UNITE HERE Local 25 and
Hotel Association of Washington, DC
Health and Welfare Fund
8400 Corporate Drive
Suite 430
Landover, MD 20785

The written notice of a Qualifying Event must include the following information: name and address of affected participant and/or beneficiary, participant's Social Security number, date of

occurrence of the Qualifying Event, and the nature of the Qualifying Event. In addition, you must enclose evidence of the occurrence of the Qualifying Event (for example, a copy of the divorce decree, separation agreement, death certificate, or dependent's birth certificate). Once the Fund receives timely notification that a Qualifying Event has occurred, COBRA coverage will be offered to the participant and dependents, as applicable.

Participants and beneficiaries covered under COBRA Continuation Coverage must provide notice of a second Qualifying Event or Disability to the Fund within 60 days of the date of occurrence of the second Qualifying Event or the date of disability determination, and before the end of the 18-month COBRA Continuation Coverage period. The written notice must conform to the requirements for providing notices described above. The notice must include evidence of the second Qualifying Event or disability (for example a copy of the divorce decree, separation agreement, death certificate, Medicare eligibility or enrollment, dependent's birth certificate, or SSA disability determination).

Failure to provide the Fund notice of a disability or second qualifying event within 60 days will result in the loss of the right to extend coverage.

Financial Responsibility for Failure to Give Notice

If a participant or dependent does not give written notice within 60 days of the date of the Qualifying Event, or a participating employer within 30 days of the Qualifying Event, and as a result, the Plan pays a claim for a person whose coverage terminated due to a Qualifying Event, then that person or the participating employer, as applicable, must reimburse the Fund for any claims that should not have been paid. If the person fails to reimburse the Fund, then all amounts due may be deducted from other benefits payable on behalf of that individual or on behalf of the Participant, if the person was his or her dependent.

Notification Regarding Change of Address
It is crucial that participants and beneficiaries keep the Fund informed of their current addresses. If you or a covered family member experiences a change of address, immediately inform the Fund Office.

Termination of Coverage and COBRA Costs
If your participating employer stops participating in the Plan, your continuation coverage will end on the date your employer establishes a new plan, or joins an existing plan, that makes health coverage available to a class of employees formerly covered under the Plan. The cost that you must pay to continue benefits is 102% of the cost of coverage, as determined annually by the Fund. The cost will be specified in the notice of right to elect continuation of coverage sent to you by the Fund Office. However, the COBRA premium for the 11-month disability extension period (if applicable) is increased to 150% of the cost of coverage. If your former participating employer alters the level of benefits provided through the Fund to similarly situated active employees, your coverage and cost also will change.

The Trustees will determine the premium for the continued coverage. The premium will not necessarily be the same as the amount of the monthly contribution that a participating employer makes on behalf of a covered employee. The premium will be fixed, in advance, for each 12-month policy year period. The COBRA premium will be changed at the same time every year for all COBRA beneficiaries, therefore, the premium may change every year for an individual beneficiary before he or she has received 12 months of COBRA coverage.

Payment of Premiums
COBRA payments must be made monthly to the Plan, by check, payable to the Fund. Premium amounts and benefits for COBRA coverage are subject to change. You will be notified of any cost or benefit changes under the Plan.

The initial payment must be made by you either at the time of the election or within 45 days of the election. The initial payment must cover the entire period from the date of the qualifying event to the date of your payment. There is no grace period for the initial contribution. **Ongoing payments must be made by the last day of the month for which coverage is to be continued**. (For example, if you want coverage for October, payment is due no later than October 31st).

Important: Timely retroactive payments must be made to the date of loss of coverage.

Claims incurred following the date of the event which resulted in the loss of coverage, but before the eligible participant or dependent has elected continuation coverage, will be held until the election has been made and premiums have been paid in full. If the participant or eligible dependent does not make a timely election and pay premiums, no Fund coverage will be provided. Coverage under the Plan will remain in effect only while the monthly premiums are paid fully and on time.

You will not be billed; it is your responsibility to remit payments to the Fund Office. Late payments can result in termination of coverage. You are responsible for the payment of required premiums. The Fund Office will not accept premiums paid on your behalf by a third party, such as a hospital or any employer.

Trade Act Rights

The Trade Act of 2002 provides a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("PBGC") (eligible individuals). Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these tax provisions, you may call Health Coverage Tax Credit Customer

Contact Center toll-free 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/. The federal government offers this program and the Fund Office has no role in its administration.

Other Rights

This notice describes your rights under COBRA. It is not intended to describe all of the rights available under ERISA, HIPAA, the Trade Act of 2002, and other laws.

Contact for Additional Information

If you have questions or wish to request additional information about COBRA coverage or the health plan, please contact the Fund Office as follows:

COBRA Department, UNITE HERE Local 25 and
Hotel Association of Washington, DC
Health and Welfare Fund
8400 Corporate Drive
Suite 430
Landover, MD 20785
Telephone: (800) 638-2972 or (301) 459-3020

CONTINUATION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act of 1993 ("FMLA") requires employers with 50 or more employees to provide eligible employees with up to 12 weeks (or up to 26 weeks for "servicemember family leave" as defined in the FMLA) per year of unpaid leave in the case of the birth, adoption or foster care of an employee's child or for the employee to care for his/her own sickness or to care for his/her own sickness or to care for a seriously ill child, spouse, or parent.

In compliance with the provisions of the FMLA, your participating employer is required to maintain pre-existing coverage under the Plan during your period of leave under the FMLA just as if you were actively employed. Your coverage under the FMLA will cease once the Fund Office is notified or otherwise determines that you have terminated employment, exhausted your 12 week (or 26 weeks for "servicemember family leave" as defined in the FMLA) FMLA leave entitlement, or do not intend to return from leave. Your coverage will also cease if your participating employer fails to maintain coverage on your behalf by making the required contribution to the Fund.

Once the Fund Office is notified or otherwise determines that you are not returning to employment following a period of FMLA leave, you may elect to continue your coverage under the COBRA continuation rules, as described in the previous section. The qualifying event entitling you to COBRA continuation coverage is the last day of your FMLA leave.

If you fail to return to covered employment following your leave, the Fund may recover the value of benefits it paid to maintain your health coverage during the period of FMLA leave, unless your failure to return was based upon the continuation, recurrence, or onset of a serious health condition which affects you or a family member and which would normally qualify you for leave under the

FMLA. If you fail to return from FMLA for impermissible reasons, the Fund may offset payment of outstanding medical claims incurred prior to the period of FMLA leave against the value of benefits paid on your behalf during the period of FMLA leave.

CONTINUATION OF COVERAGE UNDER USERRA

The Uniformed Services Employment and Re-Employment Rights Act of 1994 ("USERRA") requires that the Fund provide you with the right to elect continuous health coverage for you and your eligible dependent for up to 24 months, beginning on the date your absence begins from employment due to military service, including Reserve and National Guard Duty, as described below.

If you are absent from employment by reason of service in the uniformed services, you can elect to continue coverage for yourself and your eligible dependent under the provisions of USERRA. The period of coverage for you and your eligible dependent ends on the earlier of:

1. The end of the 24 month period beginning on the date on which your absence begins; or

2. The day after the date on which you are required but fail to apply for or return to a position of employment for which coverage under the Plan would be extended (for example, for periods of military service over 180 days, you must re-apply for employment within 90 days of discharge).

You may be required to pay a portion of the cost of your benefits. If your military service is considered an approved Leave of Absence, your participating employer must pay the cost of the premium for the first 12 months that you are eligible for coverage. If your military service is not considered an approved Leave of Absence, there is no charge for the cost of the premium for the first 31 days of coverage. Beyond 31 days, you must pay the cost of the coverage. The cost that you must pay to continue benefits will be determined in accordance with the provisions of the USERRA.

You must notify your participating employer or the Fund Office that you will be absent from employment due to military service unless you cannot give notice because of military necessity or unless, under all relevant circumstances, notice is impossible or unreasonable. You also must notify the Fund Office that you wish

to elect continuation coverage for yourself or your eligible dependent under the provisions of USERRA.

If you have satisfied the Plan's eligibility requirements at the time you enter the uniformed services, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan when you return from uniformed service if you qualify for coverage under USERRA.

Military Personnel

Participants who are retired from active military service are entitled to benefits from the Plan for themselves and their eligible dependents even though they may be provided benefits under the CHAMPUS Program. Participants married to active duty military personnel are entitled to benefits from the Plan for themselves and any eligible dependents not in active military service. Notwithstanding the foregoing, benefits will be provided to participants and eligible dependents as required under federal law.

COORDINATION OF BENEFITS

Coordination of Benefits applies when a participant or covered dependent is entitled for benefits under any other kind of group health coverage in addition to the Fund. When duplicate coverage exists, the primary plan normally pays benefits according to its Schedule of Benefits and the secondary plan pays a reduced amount. **The Fund will never pay, either as the primary or the secondary plan, benefits which, when added to the benefits payable by the other plan for the same service, exceed 100% of the usual, customary, and reasonable ("UCR") charge.** This provision applies whether or not a claim is filed under Medicare or another plan. The Fund is authorized to obtain information about benefits and services available from Medicare or other plans in order to implement this rule.

The following rules apply:

If one plan does not have a Coordination of Benefits provision, it is primary. Otherwise, the plan which covers the person as an employee is the primary plan and the plan which covers the person as a dependent is the secondary plan.

Where both parents are covered by different plans and the parents are not separated or divorced, and the claim is for a dependent child, the primary plan is the plan of the parent whose birthday falls earliest in the year.

If two or more plans cover a child whose parents are separated or divorced, benefits will be paid as follows:

1. If a court determines financial responsibility for a child's health care expenses, the plan of the parent having that responsibility pays first.

2. If a court determination has not been made, the plan of the parent with custody pays before the plan of the other parent. If the parent remarries, the payment order will be as follows: The plan of the

step-parent married to the parent with custody pays before the plan of the parent who does not have custody.

If none of the above apply, then the plan in which the patient has been enrolled the longest will be primary.

What Happens When You Become Medicare-Eligible?

If you are still an active employee when you reach age 65, this Plan will generally continue to be your primary coverage, with Medicare as secondary coverage. If you have an enrolled dependent who is eligible for Medicare, this Plan generally is primary unless the dependent waives coverage under this Plan.

Rules governing the coordination of Medicare are complex, and this is only a brief summary. As you or your spouse approach age 65 (or older), or are considering your retirement options, you should make an appointment with your local Social Security office to discuss Medicare coverage options, enrollment procedures and effective dates for you, your spouse and any covered dependents. You also may contact the Fund Office for more information.

Right to Offset

If someone else, including your automobile insurance company, makes payments relating to a sickness or injury for which benefits are paid under the Fund, then the Fund is entitled to recover the amount of those benefits (or, if less, the full amount of the third party payments, reduced for reasonable attorney's fees). You may be required to sign a reimbursement agreement if you seek payment of expenses from the Fund before you have received the full amount you would recover through a judgment, settlement, insurance payment or other source. In addition, you may be required to sign necessary documents (including a subrogation agreement and assignment) and to promptly notify the Plan of the details of relevant legal actions.

The Fund also has the right to **offset against any future benefit payment from the Fund** on an individual's behalf, if he or she fails to notify the Fund Office of the availability of other health coverage or third party payment, or to cooperate with the Fund Office in recovering payments. This right of offset does not keep the Fund from recovering erroneous payments in any other manner.

Read Below – Important!
To ensure that the Fund coordinates and pays your benefits properly, you must keep the Fund informed of any and all coverage for you and your eligible dependent.

If Your Dependent Is Offered Coverage through another Employer
When an eligible dependent under the Plan is offered a program of dental, optical, and/or medical benefits by another employer as a result of his or her employment, and the dependent has the option of selecting the other employer's coverage or receiving cash, the Plan coordinates its benefits as if the other employer coverage were applicable. It does so even when the dependent does not elect coverage under the other employer's plan.

Before the Fund will pay benefits to an employed dependent, he or she must provide the Fund Office with information explaining the other health coverage, if any. Coordination of Benefits saves the Fund money by making sure other plans pay benefits where they are available.

A LIST COVERAGE:
MEDICAL BENEFITS
Provided through Kaiser Permanente HMO

This is a summary only. Refer to your Certificate of Coverage for complete details and Claims Procedures.

Your medical benefits are provided through Kaiser Permanente HMO. Under an HMO, you must use a provider of care that participates with the HMO and coordinate through your designated primary care physician. Under Kaiser Permanente, that generally means going to a Kaiser Center, although participants in the Baltimore area may also use individual physicians who participate in the Affiliated Primary Care Physician Network. Services by a physician who does not participate in Kaiser will not be covered unless you were referred to an out-of-plan specialist by your Kaiser Primary Care Provider.

Co-Payments
You are required to pay a co-payment for some services. For example, currently there is a $15 per visit co-payment for visits to your Primary Care Physician (waived for children under age three), and there is a $100 co-payment for admission to the hospital (per person, per contract year). These co-payment amounts will be listed in the enclosed Kaiser Permanente Certificate of Coverage booklet and are subject to change each year. See your Kaiser booklet for more details.

Obtaining Benefits
There are no claim forms to fill out. Simply present your membership card at the time of service and make the required co-payment to the provider.

Important! Read Below

The first thing you should do when you enroll is to **choose a Primary Kaiser Center and/or Primary Care Physician ("PCP") from the Kaiser directory. All of your care must be coordinated through this physician or center—this is very important.** If you need to go to a specialist, the physician will give you a referral. You MUST contact your physician at the Primary Care Center or your individual PCP before going to a specialist in order for your treatment to be covered. Check your Kaiser Permanente or Certificate of Coverage booklet for details.

Coverage

Below is a Benefit Summary for Kaiser Permanente which shows the covered service and the co-pay per visit (cost to you) required. It is not a complete list -- see your Kaiser Permanente Certificate of Coverage booklet for detailed descriptions of covered services. Exclusions and limitations will also be described in the Kaiser Certificate of Coverage booklet.

Benefit Description	Co-Pay Per Visit
Office Visit (other than routine physical exams and preventative tests for adults, and well child care visits).	$15
In-Patient Hospital	$100
Prescription Drug Benefits	$10/$20 at KP Pharmacy; $20/$40 Any Other Pharmacy; $8/$18 for Mail Order
Emergency Room	$50
Durable Medical Equipment	20% Co-Pay (for 3 months immediately following hospitalization)
Infertility	50% Co-Pay

Allergy Injections	$15
Ambulance	No Co-Pay
Contacts	15% Discount
Glasses	25% Discount
Out-Patient Surgery	$15
Prenatal Office Visit	No Co-Pay
Skilled Nursing Facility	100 days, $100 Co-Pay
Speech/Occupational/ Physical Therapy (out-patient)	$15 Co-Pay, 90 Days
Office Visit/Child Under 3 Years	No Co-Pay

Limitations and Exclusions
Certain services are specifically excluded. Such limitations and exclusions are listed in your Kaiser Certificate of Coverage booklet.

Maternity Benefit Notice
Group health plans and health insurance issuers 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, vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's physician, after consulting with the mother, from discharging the mother or newborn earlier than 48 (or 96, as applicable) hours. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Important Notice Regarding Mastectomy Benefits
Under federal law related to mastectomy benefits, the Plan is required to provide coverage for (1) reconstruction of the breast on which a mastectomy was performed; (2) surgery on the other breast to produce a symmetrical appearance, and (3) prostheses and physical complications of all stages of mastectomy, including

lymphedemas. Such benefits are subject to the Plan's annual deductibles and coinsurance provisions.

Mental Health Parity Act

The Mental Health Parity and Addiction Equity Act requires that group health plans and group health insurers provide coverage for mental health and substance abuse disorders on terms that are similar to the terms of coverage provided for other medical illnesses. For example, group health plans can no longer place annual or lifetime dollar limits on mental health and substance abuse benefits that are lower than the dollar limits placed on medical and surgical benefits.

Claims and Appeals Procedures

Claims and appeals for medical benefits (discussed in this section) and prescription drug benefits (discussed in the section below) will be processed in accordance with procedures set forth in your certificate of coverage with Kaiser. If you do not have a Certificate of Coverage, contact Kaiser or the Fund Office:

Kaiser Permanente
2101 East Jefferson Street
Rockville, MD 20849
(301) 468-6000
(800) 777-7902 (outside of the Washington DC Metropolitan area)

A LIST COVERAGE
PRESCRIPTION DRUG COVERAGE
(as Part of Your HMO Benefit through Kaiser Permanente)

This is a summary only. Refer to your Certificate of Coverage, provided directly by Kaiser Permanente, for complete details and Claims Procedures.

Coverage

Kaiser Permanente covers drugs, supplies and supplements when prescribed in accord with its drug formulary guidelines. Currently, you pay $8.00 per covered prescription if you use Kaiser's mail order program, $10 per covered prescription or refill if you use a Kaiser Permanente Medical Center's pharmacy, and you pay $20 per covered prescription or refill at any other participating Kaiser pharmacy. Weight management drugs, drugs used to treat infertility, and smoking cessation drugs (when prescribed by a Plan physician as part of a smoking cessation program) are covered at 50% of the member standard value. Growth hormones are provided at 20% of the member standard value. The co-payments are subject to change.

Limitations and Exclusions

When available, generic drugs will be dispensed unless a brand name drug is medically necessary as stated by your doctor. If you request a brand name drug when a generic is available (and the brand name is not medically necessary as noted by your doctor), you pay the appropriate co-payment for the prescription plus an additional $15 per prescription.

Each prescription refill is subject to the same conditions as the original prescription.

Certain drugs are **not** covered under the Plan. These excluded drugs are listed in your Kaiser Certificate of Coverage booklet.

DENTAL BENEFITS

Benefits are provided through a fully insured dental program provided by Dentegra Insurance Company (Dental Plan).

This is a summary only. Refer to the benefits summary provided to you, or the Evidence of Coverage booklet, which may be provided upon request, for complete details and Claims Procedures.

To Receive Dental Care

The Dental Plan provides benefits for the services listed in the Evidence of Coverage booklet for all eligible Participants and eligible dependents only when performed by a UNITE HERE Local 25 EPO Network Provider ("Network Provider"). You may obtain a list of Network Providers by contacting the Dental Plan's Administrative Office at (855) 245-8310. No benefits are payable under this Contract for services performed by a Non-Network Provider except as provided under the Out-of-Network Benefits section in this Evidence of Coverage booklet. If you seek treatment from a Dentist who is not a Network Provider ("Non-Network Provider"), you will not be covered for services received, except in the following circumstances:

1. Your Network Provider refers you to a Non-Participating specialist for covered services, or you have obtained prior approval directly from the Dental Plan to go to a Non-Network Provider;
2. You have an Emergency that occurs further than 50 miles from a Network Provider while temporarily away from home. "Emergency" means an unforeseen situation requiring services necessary to treat a condition or illness that, without immediate dental attention, would result in unalleviated acute dental pain, dental infection, and/or dentally related bleeding. In the case of such an Emergency, you will be reimbursed for dental expenses relating to the Emergency up to the limits of the Plan for covered services;

3. If you do not reside or work within 20 miles of a Network Provider, you may choose to be treated by a Non-Network Provider within your vicinity. In that case, the Dental Plan's reimbursement, upon the Plan's receipt of written proof of the service, will be equal to the amount that the Dental Plan would pay to a Network Provider to provide the same services. You may contact the Dental Plan's Administrative Office at (855) 245-8310 prior to receiving dental services from a Non-Network Provider to determine the amount of the Dental Plan's reimbursement for the services. You will be fully responsible for the Non-Network Provider's charges in excess of Dental Plan's reimbursement under this Article; or
4. If none of the Network Providers can render necessary care and treatment for you due to certain circumstances not reasonably within the control of the Dental Plan.

Orthodontic benefits will not be provided beyond a period of 24 consecutive months of active treatment; nor beyond a period of 18 consecutive months of retention treatment. If a patient loses coverage under the Dental Plan after his or her teeth have been banded and is later reinstated, the months during which no services are provided under the Dental Plan are not counted toward the 24-month or 18-month. Orthodontic benefits will not be provided beyond a period of 24 consecutive months of active treatment; nor beyond a period of 18 consecutive months of retention treatment. Dental Plan will not be liable for the replacement and/or repair of any appliance that was not initially furnished by Dental Plan. Benefits will be provided to an Enrollee not more than once within a five-year period. Patients must be age 11 or older.

If you seek dental care from a Non-Network Provider for any other reason, you will not be covered for that dental care under the Dental Plan.

If a condition can be treated by more than one procedure, the Dental Plan will only cover the least costly professionally adequate procedure. If you, in consultation with the Network Provider, elect to have a more costly alternative procedure performed, you will be responsible for paying the difference.

Broken Appointment

When an appointment is made with a Network Provider, you are expected to honor it. If you do not cancel the appointment at least 24 hours in advance, you will be charged a fee for each half-hour segment of the missed appointment, for which the Dental Plan shall not be liable. This missed appointment fee is $20 per half-hour appointment scheduled. If a participant arrives more than thirty (30) minutes late for a scheduled appointment, the Network Provider may treat the tardiness as a failure to keep a scheduled appointment and the missed appointment charge will apply.

Services that are more expensive than the form of treatment customarily provided under accepted dental practice standards are called “Optional Services”. Optional Services also include the use of specialized techniques instead of standard procedures.

Examples of Optional Services:

a. a crown where a filling would restore the tooth;
b. an inlay/onlay instead of an amalgam restoration.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means Dentegra will base Benefits on the lower cost of the customary service or standard practice instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

Pre-Treatment Review

A Network Provider may file a Claim Form before treatment, showing the services to be provided to you. We will estimate the amount of Benefits payable under the Plan for the listed services. The Benefits will be processed according to the terms of the Plan when the treatment is actually performed. Pre-Treatment Estimates are valid for 365 days unless other services are received after the date of the Pre-Treatment Estimate, or until an earlier occurrence of any one of the following events:

- the date the Dental Plan terminates;
- the date Benefits under the Dental Plan are amended if the services in the Pre-Treatment Estimate are part of the amendment;
- the date your coverage under the Dental Plan ends; or
- the date the Provider's agreement with the Dental Plan ends.

A Pre-Treatment Estimate does not guarantee payment. It is an estimate of the amount the Dental Plan will pay if you are enrolled and meet all the requirements of the program at the time the treatment you have planned is complete.

Limitations and Exclusions

Certain services are specifically excluded. Such limitations and exclusions are listed in the Evidence of Coverage booklet. Any service that is not specifically listed as a covered dental service in the Evidence of Coverage booklet is excluded. If you do not have an Evidence of Coverage booklet, contact the Fund Office at (301) 459-3020 or Dentegra Insurance Company at (855) 245-8310.

Continuation of Coverage

If your coverage terminates, the Dental Plan will provide an extension of benefits for any treatment in progress at the time of termination, provided the treatment requires two or more visits on separate days to the dentist's office. For all care other than

orthodontics, such continuation of coverage will exist until completion of the procedure or ninety (90) days, whichever is earlier. For orthodontics, coverage will extend at least 60 days if the orthodontist has agreed to or is receiving monthly payments when coverage terminates, or, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis, to the end of the quarter in progress or 60 days, whichever is longer. Thereafter, orthodontic treatment shall be available on a fee-for-service basis at prevailing rates.

Payment of Claims

If, as a result of prior special arrangements made by a Network Provider, an Out-of-Area Emergency or as otherwise provided under the Evidence of Coverage booklet, you use a dentist other than a Network Provider, the Dental Plan shall reimburse you upon receipt of written proof of such claim. Such written proof shall cover the occurrence, character and extent of the event for which a claim is made, and must be furnished to the Dental Plan within 90 days after the commencement of the period for which the Dental Plan is liable.

Claims and Appeals Procedures

Claims and appeals for dental benefits will be processed in accordance with procedures set forth in your Evidence of Coverage booklet from Dentegra Insurance Company. If you do not have an Evidence of Coverage booklet, contact Dentegra Insurance Company or the Fund Office:

Dentegra Insurance Company
P.O. Box 1850
Alpharetta, GA 30023

OPTICAL BENEFITS
Provided through Group Vision Services

This is a summary only. Refer to the benefits summary provided to you, or the Certificate of Coverage, which may be provided upon request, for complete details and Claims Procedures.

How to Use the Program:

Currently for your use there are many providers that participate in the Group Vision Services program, contracted through EyeMed Vision Care, located in the Maryland-Washington, DC-Northern Virginia area. You have a choice of independent optometrists and ophthalmologists, as well as retail locations such as Lens Crafters, Pearle Vision, Sears, Target Optical and JC Penney Optical. When you are ready to use the program and wish to locate a provider near you, simply visit www.gvsmd.com. Schedule an exam with the provider of your choice. For questions regarding your coverage, you may call 1-866-265-4626.

Available Benefits

The Plan will provide the optical benefits listed in the chart below once every 12 months. There will be no charge to you or to your covered dependents when the services are rendered at a network provider. You also may be able to obtain partial reimbursement on certain services you receive from a non-network provider, provided that you submit a claim for reimbursement. Refer to the benefits summary provided to you for more information.

*Benefits from a Network Provider**		Copayment
Vision Examination – includes dilation as indicated	Once Every 12 Months*	$ 0.00
Eyeglass Lenses – single vision, bifocal, or trifocal in standard/basic plastic w/Standard Scratch Resistance, Photochromatic lenses, Tints, Polycarbonate lenses	Once Every 12 Months*	$ 0.00
Frame – covered in full up to a $150.00 retail value. Members receive 20% off balance for selection costing more than the plan allowance.	Once Every 12 Months*	N/A
Contact Lenses - in lieu of spectacle lenses (does not include fitting and follow-up) • **Elective** – Disposable or Conventional, covered in full up to $ 120.00 Allowance. Conventional lenses: members receive 15% discount off balance over plan allowance. • **Medically Necessary** – Covered in full up to **$ 250.00**	Once Every 12 Months*	N/A
* Benefits are available 12 months from last date of service		

Certain other optical benefits are available at a discount, as provided in the chart below:

Additional Savings Program *Pricing available in conjunction with funded benefits*			
Lens Options	**Member Pricing**	**Other Options/Services**	**Member Pricing**
Tint (solid & gradient)	Covered	**Other Lens Add-Ons and Services**	20% off Retail
UV Coating	$15.00	**Additional Complete Pair Purchases *****	40% off Retail
Standard Scratch Resistance*	Covered	**Conventional Contact Lenses**	15% off Retail
Standard Polycarbonate Adult	Covered	**Premium Contact Lens Fitting and Follow-up**	10% discount
Children	Covered		
Standard Anti-Reflective	$45.00	**Standard Contact Lens Fitting and Follow-up**	$40.00
Standard Progressive Lens**	$65.00	**Lenticular Lenses**	20% Discount
Premium Progressive Lens**	20% off Retail	**Photochromatic**	Covered
** Standard/Premium Progressive lenses are not covered benefits – however when upgrading in conjunction with your funded benefit the bifocal lens amount will be applied. Participants are responsible for the lens copayment and any additional charges.			

Exclusions and Limitations
Certain services are specifically excluded. Such limitations and exclusions are listed in the Certificate of Coverage. Any service that is not specifically listed as a covered service in the Certificate of Coverage is excluded. To get a Certificate of Coverage, contact the Fund Office at (301) 459-3020 or GVS at (866) 265-5626.

Phone Number and Website
If you have any questions or need any additional information about this program, you may call Group Vision Services' Customer Service Department at (866) 265-4626 or visit the website at www.gvsmd.com.

Payment Procedures
If a participant uses a Group Vision Services' center or provider, there are no claim forms to complete. At the time of service, you will pay the required co-payment for that procedure. You would also pay for any upgrades you requested that are not covered by the Plan.

If, for some reason, you are required to pay for services at the time of your visit, you may request reimbursement (up to the limits of the Plan) by mailing or faxing your paid, itemized receipts to Group Vision Services. **Be sure to include the participant's name and Social Security Number on the receipt, the patient's name (if different) and your mailing address. This is very important.**

Claims and Appeals Procedures
Claims and appeals for optical benefits will be processed in accordance with procedures set by Group Vision Services. To file a claim for benefits, please contact Group Vision Services in writing at:

First American Administrators, Inc.
Attn: Quality Assurance Department
4000 Luxottica Place
Mason, OH 45040

Telephone inquiries concerning claims should be directed to (877) 226-1115.

CLAIMS FILING AND REVIEW PROCEDURE

Procedures for Benefit Claims and Appeals

Claims for benefits, and appeals from denials of those claims, will be processed in accordance with the procedures established by each provider, as described above.

If you wish to appeal a denial of a claim for eligibility for benefits, you must file an appeal with the Board of Trustees within 180 days of receipt of notification of the denial. Send your appeal to the following address:

Board of Trustees
UNITE HERE Local 25
and Hotel Association of Washington, DC
Health and Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451

In support of the appeal, you may submit written comments, documents, records and other information relating to the claim, and the Board of Trustees will provide you upon request and at no charge with reasonable access to, and copies of, all documents, records or other information relevant (as defined in section 2560.503-1(m)(8) of title 29 of the Code of Federal Regulations) to the claim.

In reviewing the appeal, the Board of Trustees will: (i) take into account all materials and information submitted by you relating to the claim (even if not submitted or considered in connection with the initial claim); (ii) consider the claim *de novo*, without any deference to the initial claim denial; and (iii) ensure that the review is not conducted by the individual who denied the initial claim (or that individual's subordinate).

Your appeal will generally be reviewed within a reasonable period of time appropriate to the medical circumstances and notified of the Board's decision within 60 days after receipt of your appeal. However, in the case of an appeal of an "urgent care claim"

(involving eligibility for care or treatment with respect to which the application of the otherwise applicable time periods could seriously jeopardize your life or health or ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment the eligibility for which has been denied, in the opinion of a physician with knowledge of your medical condition), you may request an expedited review process in which you submit the request for appeal orally or in writing, and all necessary information will be transmitted between you and the Board of Trustees by telephone, fax, or other similarly expeditious method. The Board of Trustees will notify you of its decision on your appeal of an urgent care claim as soon as possible but no later than 72 hours after receipt of the appeal.

The notification described above will be in written or electronic form and will include, in the case of an adverse decision: the specific reason(s) for the adverse decision; reference to the specific provisions of the Plan on which the decision is based; a statement that you are entitled to receive, upon request and at no charge, reasonable access to, and copies of, all documents, records or other information relevant (as defined in section 2560.503-1(m)(8) of title 29 the Code of Federal Regulations) to your claim for benefits; a statement of your right to bring an action under section 502(a) of ERISA; the internal rule, guideline, protocol, or other similar criterion (collectively, "Rule") guideline relied upon in making the decision, if any, or statement that such a Rule was relied on and that a copy of such Rule will be provided free of charge to you on request; if the adverse benefit decision is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the decision (applying the terms of the Plan Rules to your medical circumstances), or a statement that such explanation will be provided free of charge upon request; and the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what

may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

No legal action concerning a denial of benefits under the Plan may be commenced against the Plan, its Board of Trustees, or any representative of the Plan until you have exhausted all of the administrative remedies set forth under the foregoing claims procedures. Further, no such action may be brought more than one year after the Board of Trustees has made its decision on review with regard to the relevant claim.

Where to file claims and get information	
Medical Medical and prescription drug benefits are provided under an insurance contract with this insurance company:	Kaiser Permanente 2101 East Jefferson Street Rockville, MD 20849 (301) 468-6000 (800) 777-7902 (outside of the DC Metropolitan area)
Dental Dental benefits are provided under an insurance contract with this insurance company:	Dentegra Insurance Company. Member Services Department P.O. Box 1850 Alpharetta, GA 30023 (855)245-8310
Optical Optical benefits are provided under an insurance contract with this insurance company:	EyeMed Vision Care Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111
The insurance coverage booklets provided by these insurance companies govern your benefits under the Plan.	
Eligibility and General Information	Board of Trustees Hotel & Restaurant Employees Local 25 and Employers Health and Welfare Fund 911 Ridgebrook Road Sparks, MD 21152-9451

AMENDMENTS TO THE PLAN

The Trustees reserve the right to amend, modify or discontinue all or part of the Fund or the Plan in their sole and absolute discretion whenever, in their judgment, conditions so warrant, consistent with the applicable Collective Bargaining Agreements.

YOUR RIGHTS UNDER ERISA

As a participant of the Hotel & Restaurant Employees Local 25 and Employers Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Board of Trustees complies fully with this law and encourages you to first seek assistance from the Fund Office when you have questions or problems that involve the Plan.

ERISA provides that all participants are entitled to:

- Examine all Plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions. Participants may examine these documents without charge at the Fund Office and at other specified locations, such as union halls and worksites where at least 50 Plan participants are employed.

- Obtain copies of all Plan documents and other Fund information upon written request to the Fund Office. The Fund may make a reasonable charge for the copies.

- Receive a summary of the Fund's annual financial report. The Fund is required by law to furnish each participant with a copy of this summary annual report.

- File suit in a federal court, if any materials requested are not received within thirty (30) days of the Participant's request, unless the materials were not sent because of matters beyond the control of the Administrator. The court may require the Fund administrator to pay up to $110 for each day's delay until the materials are received.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

This Plan is maintained pursuant to Collective Bargaining Agreements. A copy of these documents may be obtained by participants and beneficiaries upon written request to the Fund Office. The documents are also available for examination by participants and dependents.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for the operation of the Plan. The people who operate your Plan, called fiduciaries, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. The Plan does not give you any right to continue in employment. However, no one, including your participating employer, your union, or any other person, may fire you or discriminate against you in any way for the purpose of preventing you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to obtain copies of documents relating to the decision without charge, and to have the Trustees review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these 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 case, the court may require the Fund to provide the materials and pay you a fine until you receive them, unless the materials were not sent because of reasons beyond the control of the Fund Office. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in the appropriate court. 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 Plan fiduciaries ever misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees -- if it finds your claim is frivolous, for example.

If you have any questions about your Plan, you should contact the Fund Office. Should you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

TELEPHONE NUMBERS AND ADDRESSES

FUND OFFICES:

Fund Office
911 Ridgebrook Road
Sparks, MD 21152-9451

Fund Office
8400 Corporate Drive
Suite 430
Landover, MD 20785

Fund Office Telephone.....	(800) 638-2972 or (301) 459-3020
Fund Office Website.....	www.associated-admin.com
Dental Coverage..... Dentegra Insurance Company P.O. Box 1850 Alpharetta, GA 30023	(855) 245-8310
Optical Coverage..... Group Vision Services 111 Rockville Pike, Ste. 735 Rockville, MD 20850	(866) 265-4626
HMO (for Medical and Prescription Drug Benefit Questions) Kaiser Permanente..... 2101 East Jefferson Street Rockville, MD 20852	(800) 377-7902 or (301) 468-6000