NEW YORK HOTEL TRADES COUNCIL & HOTEL ASSOCIATION OF NYC, INC.

HEALTH BENEFITS FUND

SUMMARY PLAN DESCRIPTION

January 2014

THE NEW YORK HOTEL TRADES COUNCIL
HEALTH BENEFITS FUND
THE HOTEL ASSOCIATION OF NEW YORK CITY, INC.

305 West 44th Street, New York, NY 10036
(212) 586-6400 • www.hotelfunds.org

To All Participants – A Message from the Board of Trustees

We are pleased to present you with this 2014 Summary Plan Description ("SPD") for the New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund ("Fund" or "Plan"). This SPD is effective as of January 1, 2014 and describes the comprehensive benefits currently available to you and your family members who qualify for coverage under the Plan. The SPD also provides information about how you qualify for benefits, covered services, how to file a claim and your rights under the Plan. Please review this information carefully, and keep your SPD available for future reference.

The Fund will notify you in writing via a Summary of Material Modifications ("SMM") whenever the benefits outlined in this SPD materially changes in the future. Whenever you receive an SMM, please keep such document(s) with your copy of this SPD so that you will always have current information about the benefits available under the Plan. At any time you may also view the Plan's current SPD and all modifying SMM(s) at www.hotelfunds.org.

This SPD constitutes the Fund's plan document and supersedes all prior SPDs, plan rules and other notices. This SPD applies to services rendered on or after the effective date of its issuance, January 1, 2014. For services rendered prior to that date, please refer to the Fund's prior Summary Plan Description, notices and documents for the applicable period. They can be found at www.hotelfunds.org, or you may call the Fund Office at (212) 586-6400 to request copies.

Additional information about the Plan is available in the other official Plan documents, including the Agreement and Declaration of Trust of the Fund, which legally govern the operation of the Plan. All official plan documents are available for your inspection at the Fund Office during normal business hours.

The Board of Trustees strives to provide a health plan that offers quality, comprehensive health coverage to participants enrolled in the Plan and their family members. Your active partnership with the Health Center and the Fund Office will help us to provide you with meaningful benefits and quality service. By understanding how the Plan works and by making sure you satisfy any requirements contained in this SPD, you can maximize your benefits under the Plan. The benefits described in this SPD are paid for entirely by contributions made to the Fund by contributing employers. As a result, you are not required to contribute to the cost of this Plan.

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

Every effort has been made to ensure that this SPD is easy to understand. If you have specific questions about your health benefits, contact the Fund Office at (212) 586-6400.

Sincerely,

The Board of Trustees of the New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund

History of the Fund

The Fund was originally established as a result of an Industry-Wide Collective Bargaining Agreement between the New York Hotel and Motel Trades Council, AFL-CIO ("Union") and the Hotel Association of New York City, Inc. ("Association"). However, before the Fund could begin operations and provide comprehensive medical benefits, a special New York State law was required to create the New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Center, Inc. ("Health Center"). That law was enacted through the joint efforts of the Union and the Association. Those efforts resulted in the necessary legislation being introduced and passed in the New York State Assembly and Senate, then being signed into law by Governor Thomas Dewey in 1949.

Since then, the Fund's health benefits program, which is self-insured and, for the most part, self-administered, has since served as a model for many benefit programs. Even today, more than 50 years after the Health Center was established and the Fund was set up to collect employer contributions to finance the Health Center's operations; other organizations are adopting the concept of "in-house" delivery and administration of comprehensive health care benefits. For example, as of January 1, 1999, the New York Hotel Trades Council and Hotel Association of New York City, Inc. Union Family Medical Fund, Insurance Fund and Dental Fund were combined to form a single fund, renamed the "Health Benefits Fund." Fund revenues were in thousands of dollars per year in 1949, as compared to more than $385,000,000 as of the beginning of the 2014 plan year. Since its inception, the Fund has paid out substantially more than billions of dollars in benefits to participants and their family members.

Notificación de asistencia con traducciones al español

Este documento es un resumen del plan, el cual contiene un resumen en inglés de sus derechos y beneficios según el plan de salud de *New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund* ("Fund"). Si tiene dificultades para entender cualquier parte de este documento, comuníquese con un representante de Fund al (212) 586-6400, de 7:30 a.m. a 7:00 p.m. Hora estándar del Este, o visite una de las oficinas de Fund:

New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund
305 West 44th St., Third Floor
New York, NY 10036

Keep the Fund Informed About Life Changes.

Make sure your Plan benefits change with you. It's important that you update the Fund Office and the Health Center about changes in your life and business affairs — to keep your benefits current and to ensure that you and your dependents receive all the benefits to which you are entitled.

Generally speaking, you have 30 days to notify the Fund Office when a life event that affects your coverage occurs, but be sure to check the specific provisions in this SPD that apply to your situation. You need to understand the time frame within which you must provide notification to Fund Office, and what documentation may be required. To learn what you must do to update and protect your benefits when your life changes, please refer the various life events referenced throughout this SPD.

In addition, you should make sure that the Fund Office always has your current mailing address. This is critically important, as the Fund Office frequently sends you important information about your benefits under the Plan. Also, remember that Fund Office is a separate legal entity from the Union. This means that even if you've already notified the Union of an update of any information or situation (like a change of address), you must also notify the Fund Office. Notifications, along with any required documentation, of any life events which may affect your coverage must be sent directly to the Fund Office.

Use the Fund's Current Forms

The most current versions of all required forms mentioned in this SPD are available at www.hotelfunds.org ("Forms") or may be requested by calling the Fund Office at (212) 586-6400. Always check with the Fund Office to confirm that you are using the most up-to-date versions of required forms.

Questions? Call the Fund Office

If you have questions about your qualification for coverage, your health plan benefits or any other topic listed in this SPD, call the Fund Office at (212) 586-6400 between 7:30 a.m. and 7:00 p.m. Eastern Time Monday-Friday, and a counselor will assist you.

GRANDFATHERED HEALTH PLAN UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (THE AFFORDABLE CARE ACT or PPACA)

The Board of Trustees believes that the New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund ("Plan") 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 or policy] 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 and extension of coverage to dependents until age 26.

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 212-586-6400.

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

As noted above, this SPD contains highlights of the health benefits provided by the Plan. If there is any difference between the language contained in this SPD and the official plan documents that make up the Plan, those official plan documents will always govern.

The Board of Trustees intends to continue the benefit programs described in this guide indefinitely. Nevertheless, it reserves the right, subject to the terms of a collective bargaining agreement, to terminate or amend any or all of the Fund's benefit programs, including benefits for retirees, in whole or in part at any time in the future. . If the Plan is amended or terminated, the ability of any person to participate and receive benefits from the Plan may be modified or terminated. The Trustees have sole and exclusive authority to interpret the Plan and to make final determinations regarding its provisions. The Trustees' decisions are final and binding. For these reasons, no benefits under the Plan are guaranteed.

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

Note: If you live outside Brooklyn, Queens, Manhattan or the Bronx, you are also eligible for medical benefits coverage under the UnitedHealthcare Out-of-Area Coverage. Those medical benefits are described in a separate summary, which will be provided to you automatically when you become eligible. If you need another copy or have questions about this provision, contact the Fund Office.

CONTENTS

Overview of the Plan

Lists of benefits provided by the Fund and important phone numbers

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

- Medical benefits through two programs:
  - Health Center Program -- required for members who live "in-area" (Brooklyn, Queens, Manhattan or the Bronx)
  - UnitedHealthcare Out-of-Area Coverage -- available only to members who live "out-of-area", or outside of Brooklyn, Queens, Manhattan or the Bronx
- Hospitalization benefits
- Prescription Drug Program benefits
- Vision benefits
- Dental benefits
- Members' Health Assistance Program benefits
- Life Insurance benefits (employees only)
- Accidental Death & Dismemberment (AD&D) benefits (employees only)
- Accident and Sickness Weekly (Short-Term Disability) benefits (employees only)

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

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

About This Guide

This guide has been prepared to explain your benefits so read through it now to become familiar with these benefits. If you live outside Brooklyn, Queens, Manhattan or the Bronx, you are also eligible for medical benefits coverage under the UnitedHealthcare - Out-of-Area Coverage. Those medical benefits are described in a separate document.

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

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

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

After that, there's information on filing claims, the review and appeal process, and your rights under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

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

Health Benefit Highlights

Benefit	Coverage Summary
Hospital (In-Patient) Participating **Hospital (In-Patient) Non-Participating**	100% for covered services. First one hundred twenty (120) days (semi-private room) covered in full. Next one hundred eighty (180) days covered at 50% of semi-private room rates. 100% for covered services. First one hundred twenty (120) days covered at thirty dollars ($30) a day for room + eighty percent (80%) allowed charges. Next one hundred eighty (180) days covered at $15 a day for room + 40% allowed charges.
Emergency Room: • **Accidental Injury** • **Sudden and Serious Illnesses**	• You must go within seventy-two (72) hours of injury to be covered. • You must go within twelve (12) hours of onset of illness to be covered • The reimbursement level for emergency room services are covered.
Hospital (Out-patient Department) Ambulatory Surgery	100% for covered services.
Home Health Care	**With prior hospital stay:** Plan pays for up to a maximum of two hundred (200) visits per calendar year. **With no prior hospital stay*:*** $50 deductible, then Plan pays 75% of allowed charges up to maximum of forty (40) visits per calendar year.
Hospice Care	Up to 365 days in-patient care, when certified life expectancy is (six) 6 months or less.
Skilled Nursing Facility	Provided as substitute for all or part of a hospital stay.
Office Fee	$0 at Health Centers.
Funds' Health Center	100%. Providers in Manhattan, Brooklyn, Queens.
Providers	**In area:** Health Center providers only. **Out-of-area:** Health Centers or UnitedHealthcare - Out-of-Area Coverage providers only. There is no coverage when a non-Health Center or non-UnitedHealthcare - Out-of-Area Coverage provider is used.
Maternity Care	Covered in full.
Preventive Care	Covered in full.
Mental Health • **In-patient** • **Out-patient**	 • Not covered. • Covered through Members' Health Assistance Program only.
Alcohol & Substance Abuse	Covered through Members' Health Assistance Program.
Prescription Drug	Formulary: $5 for generic, $15 for brand name, where generic is not available. Benefits available from pharmacy department at Health Centers* only. **90-day supplies available – go to www.hotelfunds.org and download the Drug Formulary.**
Vision Services	Coverage is provided through General Vision Services.
Dental	Covered in full at the Health Centers, 14 Penn Plaza Dental Office, or approved facilities on Long Island or in Westchester.
Life Insurance	Employees only. Life insurance of up to $10,000 provided through The Standard.
Accidental Death & Dismemberment (AD&D)	Employees only. Up to $10,000 provided through The Standard.
Accident & Sickness Weekly (Short-Term Disability)	Employees only. 50% of salary ($300 maximum) per week for a maximum of twenty-six (26) weeks.
Durable Medical Equipment (DME)	Covered through Health Centers.
Hearing Aids	Covered for one (1) per lifetime through Health Centers.

*Waiting periods may apply to some benefits.

Important Phone Numbers

If you need the following:	Call:	Phone number:
• Information on your eligibility for benefits • Information on how the Plan works • To change your beneficiary	Fund Office	212-586-6400
Medical care • In area: Health Centers • Out-of-area: UnitedHealthcare - Out-of-Area Coverage	Health Centers Read the UnitedHealthcare Out-of-Area Plan Overview, or go to www.myuhc.com	52nd St., Manhattan: 212-586-1550 Harlem: 212-923-2525 Brooklyn: 718-858-7200 Queens: 718-361-5100 1-866-660-7179
UnitedHealthcare NurseLine	UnitedHealthcare	1-800-846-4678
Hospital care and hospital pre-admission authorization	UnitedHealthcare	1-866-660-7179
Home care authorization	UnitedHealthcare	1-866-660-7179
Hospice care authorization	UnitedHealthcare	1-866-660-7179
Skilled nursing facility care authorization	UnitedHealthcare	1-866-660-7179
Mental Health Services *(MHAP)*	Members' Health Assistance Program	212-765-1010 or 1-888-615-6427
Substance abuse treatment	Members' Health Assistance Program	212-765-1010 or 1-888-615-6427
Prescription medication	Health Centers	52nd St., Manhattan: 212-765-4267 Harlem: 212-923-2525 Brooklyn: 718-222-1018 Queens: 718-361-5170
Vision care	General Vision Services	1-800-VISION-1
Dental care	Dental Centers	14 Penn Plaza: 212-563-0095 Brooklyn: 718-858-5830 Queens: 718-361-5155 Harlem: 212-923-2525
To file a life insurance claim	Fund Office	212-586-6400
To file an AD&D claim	Fund Office	212-586-6400
To file for accident & sickness weekly (short-term disability) benefits	Fund Office	212-586-6400
Appeals for hospitalization	UnitedHealthcare	1-866-660-7179
All other appeals	Fund Office (call or write)	212-586-6400 305 West 44th Street, 3rd Floor New York, NY 10036

Participating in the Plan

What you and your family need to know about eligibility for benefits, choosing a beneficiary and who can participate[+]

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

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

*Any full time or part-time employee who works at least 14 hours per week is eligible for benefits coverage by the Fund. **The term "retiree" does not include persons who left covered employment with a vested right to receive a pension benefit at a future time, when they will reach early retirement or normal retirement age. ***Domestic Partners are not eligible for COBRA. + Casual Employees are not eligible for benefits.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Plan Administrator information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in Domestic Partnership status, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage.

Notify the Plan preferably within 31 days, but no later than 60 days, after any of the above noted events.

Failure to give this Plan a timely notice (as noted above) may cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage, or may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or may result in a participant's liability to repay the Plan if any benefits are paid to an ineligible person.

INITIAL ELIGIBILITY AND ENROLLMENT

The Enrollment Process: Members & Dependents

All participants must appear personally at the Fund Office and complete all forms necessary to enroll themselves and their dependents for benefit coverage. To enroll dependents for coverage, you present:

- An original marriage certificate for spouses
- Original birth certificate or original adoption papers for children
- Proof of address for yourself
- Original social security card for all being enrolled

Eligible dependents of employees and retirees include:

- Your spouse (same-sex or opposite-sex) to whom you are legally married in accordance with applicable federal and state law.
- Your child(ren), regardless of their marital status, place of residence, student status, access to other health insurance coverage, or financial dependency, who are under the age of 26 including:
  -Biological children,
  -Stepchildren, and
  -Legally adopted child or child placed for adoption (proof of adoption or placement for adoption and age will be required). Note – "Placed for adoption" means the assumption and retention of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates upon the termination of such legal obligation.
  - Unmarried dependent child(ren) (as defined above) who are age 26 or older and who is(are) permanently and totally disabled with a disability that existed prior to the attainment of the Plan's age limit and who is eligible for tax-free health coverage as a "qualifying child" under the applicable requirements of Internal Revenue Code Section 152(c). The Plan will require initial and periodic proof of disability. You will have 31 days from the date of the request to provide this proof before the child is determined to be ineligible.
  -Children born to unmarried eligible dependents of a covered employee, eligible spouse, retiree, or domestic partner receive coverage for thirty (30) days from birth. These children will not be covered past the first 30-days after their birth.
  -Verbal notification is not sufficient. When you enroll a dependent, in addition to completing an enrollment form, you should be prepared to provide proof of dependent status for example: a marriage certificate, birth certificate, proof of partnership status.

Important Notes - If an enrolled child no longer qualifies for dependent coverage and you do not notify the Fund Office, you will be required to reimburse the Fund for any benefits paid incorrectly by the Plan for a child who no longer qualifies for dependent coverage and your coverage — for you and any/all dependents — may be terminated. In addition, if your adult child no longer qualifies for coverage under the Plan due to age, this loss of coverage is a qualifying event that allows him or her to continue coverage under the terms of COBRA (see pages 25-31). If an enrolled child is married, coverage, however, will not be extended to the child's spouse or children.

Domestic Partners

Domestic partners are also covered by the Plan. To enroll your domestic partner for coverage, you both must be at least eighteen (18) years old, and not be related by blood in a manner that would legally prohibit your marriage. A person may not be considered a domestic partner if he or she is married or has had another domestic partner within the last six (6) months. See the Life Events section for further eligibility and coverage requirements for Domestic Partners.

You will be responsible for the fair market value of the coverage provided to domestic partners and children of domestic partners. This is known as "imputed income." This will likely increase both the employee's taxable income and tax liability.

➲ **Coverage will not take effect for your dependents or domestic partner until they are properly enrolled. Once enrolled, dependents cannot be disenrolled (or removed from the coverage plan), unless they reach the maximum age of coverage for a child (26 years of age), obtain a legal divorce or become deceased.**

When Coverage Begins

You become eligible for certain benefits, provided you are working on a full-time basis (i.e., over fourteen (14) hours per week), on the day your employer is obligated to make contributions for you. Other benefits become available after a waiting period. Coverage for your eligible dependents becomes available when your coverage does, as long as you have enrolled them for coverage under the Plan.

Please note that qualification requirements and restrictions for coverage of domestic partners differ from those for other dependents. For example, coverage for an eligible domestic partner becomes available after a 90-day waiting period following enrollment.

You may decline coverage for one or more dependents prior to the start of your coverage period, or prior to the start of any subsequent coverage period. If you decline coverage for your spouse or other dependent as described, they will not receive coverage until you they are properly enrolled. In this circumstance, dependent coverage will be effective as of the first day of the month following receipt of the completed enrollment form and proof of dependent status.

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

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

Designating Your Beneficiary

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

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

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

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

When you experience a life event such as the birth or adoption of a child or a marriage or divorce, please consider whether you want to make any changes to your beneficiary designation. To change your beneficiary or beneficiaries, complete that section on a new Beneficiary Designation form, which is available at www.hotelfunds.org and submit it to the Fund Office. If you name your spouse as your designated beneficiary and then divorce or become legally separated, the divorce or legal separation does not automatically revoke your prior designation, so keep your beneficiary information up-to-date.

Life Events

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

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

If You Get Married or Have a Domestic Partner

Spouses (Same-Sex or Opposite-Sex)

When you marry in accordance with applicable federal and state law, your spouse (same-sex or opposite-sex) is eligible for certain benefits as shown in the chart on page 10.

To enroll your spouse for coverage, you must provide your original marriage certificate and your spouse's original social security card to the Fund Office. If you present these documents within 30-days of your date of marriage, your spouse's coverage will go into effect the date you were married. If you come in to enroll your spouse, more than 30-days after your date of marriage, spousal coverage will begin the date you visit the Fund Office and complete the enrollment forms.

To Do: Enrolling a Spouse

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

A Word About Same-Sex Marriages in light of the U.S. Supreme Court's decision on the constitutionality of the federal Defense of Marriage Act ("DOMA").

Generally speaking, on June 26, 2013 the U.S. Supreme Court held that a portion of DOMA is unconstitutional. The part of DOMA that was found to be unconstitutional limited "marriage", for all federal law purposes, to a legal union between one man and one woman and limited "spouse" to a person of the opposite sex who is a husband or wife. The Supreme Court generally concluded that states have the right to determine issues relating to family matters, including the definition of marriage, and that the federal law should look to those state determinations. Since the Supreme Court's decision, federal regulators have ruled that all same-sex couples legally married in jurisdictions that recognize same-sex marriages will be treated as married for federal tax purposes, regardless of whether the couple lives in a state or other jurisdiction that recognizes same-sex marriage.

This means that if you are legally married in a state or other jurisdiction that permits same-sex marriage, your same-sex spouse will be considered your spouse for all purposes under the Fund regardless of the marriage laws of the state or other jurisdiction in which you currently live. For example, in that case:

- Your spouse will be considered a spouse for purposes of dependent eligibility, COBRA eligibility and HIPAA special enrollment rights.

- Your spouse's children will be recognized by the Fund as Step-Children and they are eligible to be added to the plan as your covered dependents.

In addition, in that case, the value of your same-sex spouse's coverage under the Fund would no longer be taxable income to you for federal tax purposes. Thus, the Fund no longer needs to collect the taxes when you pay your dependent premiums.

You should note that similar rights are not available to same-sex domestic partners who are not "spouses" under state law. So, for instance, couples in domestic partnerships, civil unions or other relationships that are not "marriages" under state law are not considered to be married for federal tax purposes. Domestic partners are eligible for these benefits once you and your partner have lived together continuously for 6 months.

Some participants did not add their same-sex spouses as a dependent on the Fund's coverage because of the federal tax impact of doing so. If, as a result of the new tax treatment of these benefits, you can add your same-sex spouse to the Fund at anytime. To do so, simply complete the steps outlined below:

1) complete a Dependent Enrollment form; and
2) attach a copy of your "certified" marriage certificate.

And your spouse will be added effective as of the day that you file the applicable enrollment forms and relevant documentation with the Fund Office.

What if I have been paying same-sex/domestic partner (SSDP) taxes but am now legally married?

If you have been paying the SSDP tax but have been legally married, please submit a copy of your certified marriage certificate and your currently quarterly tax payment will be refunded to you and you will no longer be charged the SSDP tax. You should contact your tax advisor regarding whether you are entitled to a refund from the government for past overpaid income tax.

Domestic Partners

To enroll your domestic partner for coverage, you and your partner must visit the Fund Office and provide identification and proof that you are living together and have shared financial responsibilities, which include: a valid driver's license, photo ID of both applicants, joint tenants on a lease or document of ownership of residence, joint bank account, joint credit or charge card or any other available document with both names indicating responsibility for maintaining a household together and original social security cards. In addition, those who live in states or municipalities offering a domestic partner registry will be required to show proof that they have registered as domestic partners. A sample affidavit and declaration is available on the Fund's website for this purpose.

There is a 90-day eligibility waiting period for domestic partnership coverage once all your application paperwork is completed and filed. Domestic partners are required to be re-certified for Fund coverage once every twelve (12) months.

If you are considered the Step-Parent of your registered Domestic Partner's children under state law and you provide documentation of such, then you are also considered the Step-Parent for federal income tax purposes. Therefore, these children will be considered your eligible dependents under the Fund. The Fund, however, does not cover children who are under a participant's (or their spouse's or domestic partner's) guardianship.

You will also need to decide whether to name your spouse or domestic partner as your beneficiary for life and AD&D insurance.

To Do: Enrolling a Domestic Partner

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

If You Have a Baby or Adopt a Child

When you have or adopt a child or a child is "Placed for Adoption" with you, your child is eligible for certain benefits as shown in the chart on page 10. (A child "Placed for Adoption" is defined as a child with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.)

You're required to furnish proof to the Fund Office of your child's birth, adoption, placement for adoption or dependency status within thirty (30) days after the birth, in order for your child to be eligible for benefits. If the recorded birth certificate is not available within 30 days after the birth, the Fund Office will accept a copy of an official birth record (such as a hospital release form that lists the mother's and child's names) to add a newborn to coverage. However, a copy of the recorded birth certificate must be received by the Fund Office within 30 days.

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

To Do: Enrolling a New Born Baby or Adopted Child

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

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

If You Take a Family or Medical Leave of Absence

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

To Do: Taking a Leave of Absence

- Immediately notify your employer.
- Immediately notify the Fund Office.

As required by this federal law, your coverage and any family medical coverage provided by the Fund will continue for the entire period of the leave. Your employer is required to continue contributions on your behalf to the Fund to continue coverage for the entire period of unpaid leave. If you do not return to work after your FMLA leave ends, you may be required to repay the amount your employer paid before or during your leave which applies to your coverage during your leave. However, if you do not return to work due to your or a family member's serious health condition or other circumstances beyond your control, this repayment rule will not apply. If you do not return to work after your FMLA leave ends, you may qualify for COBRA continuation coverage, as described on pages 25-31.

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

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

Expanded FMLA Rules for Military Personnel

The 2010 National Defense Authorization Act ("NDAA") amends the Family and Medical Leave Act of 1993 by expanding its leave provisions relating to "qualifying exigency leave" and "military caregiver leave." FMLA leave is available to covered employees whose spouse, child or parent is in the U.S. Armed Forces, including the National Guard or Reserves, who is ordered to active duty and who is deployed overseas. "Qualifying exigencies" include time preparing for short notice deployment, arranging for child care, updating financial or legal arrangements, attending counseling, time for rest and recuperation and post-deployment activities. You may be entitled to up to 12 weeks of leave within a 12-month period for a "qualified exigency."

The 2010 NDAA also amends the FMLA to create leave protections for family members of injured veterans who provide "military caregiver leave." They may be entitled to a total of 26 weeks of unpaid leave during a 12-month period to care for the service member. This form of leave applies only if the service member in need of care is undergoing medical treatment, recuperation or therapy (including outpatient care) for a serious illness or injury that was incurred in the line of active duty and that may render the service member medically unfit to perform the duties of his or her office, grade, rank or rating. Note: If you take this type of leave along with a FMLA leave for any other purpose (for example, the birth of a child), the combined total leave may not exceed 26 weeks in the 12-month period.

If you believe that you qualify for FMLA leave, please contact your employer and advise the Fund Office.

If You Become Divorced

Your Spouse

If you divorce, your spouse and their children (your stepchildren) loses coverage under the Fund as of the date of the court-entered judgment of divorce. However, they can continue coverage through COBRA for up to thirty-six (36) months. See the section on ***Continuing Coverage (COBRA)*** on page 25 for further information. You must immediately file a written notice of the judgment of divorce with the Fund Office.

To Do: Getting Divorced

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

Your Children

Your divorce settlement may name who will provide health care benefits for your children. Alternatively, you may be required to provide coverage for your children under federal law. A Qualified Medical Child Support Order ("QMCSO") may require the Fund, under certain circumstances, to provide coverage for your children when you and your spouse divorce. A QMCSO is an order issued by a state court or agency that requires an employee to provide coverage under a group health plan to a child. A QMCSO usually results from a divorce or legal separation. Whenever such an order is received, its qualified status is determined in accordance with QMCSO procedures adopted by the Fund. Participants and beneficiaries can obtain, without charge, a copy of the QMCSO procedures from the plan administrator.

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

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

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

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

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

The Fund will comply with a QMCSO issued by a judge, or a National Medical Support Order (NMSO) issued by a state agency which meets the requirements of a QMCSO. These types of orders require the Fund to provide medical coverage for the child of a member who does not have custody of that child. If a QMCSO or a NMSO is received, the Fund Office or your employer will provide written notification to you and each child of his or her eligibility for

coverage and will permit immediate enrollment. This notice will include any required enrollment material, a description of the procedures to be followed and a form for designating the child's custodial parent or legal guardian as his or her representative for all purposes. Contact the Fund Office for more information.

If Your Domestic Partnership Ends

If your domestic partnership ends, your domestic partner and their children (your stepchildren) loses coverage under the Fund as of the earlier of: (i) the date of the dissolution of the domestic partnership or as of the date, or (ii) the date that the Fund denies your recertification of the domestic partnership. You must immediately file a written notice with the Fund Office if your domestic partnership is dissolved or if you fail to continue to meet any of the applicable domestic partnership requirements under the Fund.

If You Lose Other Coverage

If you do not enroll yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You and your dependents may also enroll in this Plan if you (or your eligible dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage and meet all Plan qualification requirements. However, under these circumstances, you must

- request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends; or

- become eligible for a premium assistance program through Medicaid or CHIP and request enrollment in this Plan within 60 days after you (or your dependents) are determined to be eligible for such premium assistance.

If you notify the Fund Office after the applicable thirty (30)-day or sixty (60)-day enrollment periods, your family coverage begins on the date the Fund receives and accepts from you a completed enrollment form.

If Your Child Loses Coverage

Your children lose eligibility for benefits on their twenty-sixth (26^{th}) birthday, unless he or she remains eligible to be a dependent upon the participant due to a physical or mental disability.

If your children lose eligibility for benefits under the Plan, they can continue coverage through COBRA for thirty-six (36) months.

To Do: When Your Child Loses Coverage

- Notify the Fund Office when your child gets married
- Notify the Fund Office when your child reaches age 26

If You Become Disabled

If you become disabled by an off-the-job injury or illness and can't work, certain Plan programs are available to assist you. See, in particular, Accident and Sickness Weekly Benefits. Depending on the nature of

your disability, you may also become eligible for Social Security disability benefits. In addition, you may want to apply for a disability pension through the Industry Pension Fund if you're eligible.

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

Disabled Under Age 60

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

To Do: If You're Disabled

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

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

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

Disabled Between Age 60 to 65

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

Disabled When You Reach Age 65

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

If you become entitled to Medicare because of End-Stage Renal Disease, while actively employed

If while actively employed, you (or an eligible dependent) become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

If You're Injured on the Job

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

To Do: If You Get Hurt On Your Job

- Notify your employer immediately

If You Lose Your Eligibility

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

To Do: If You Lose Your Eligibility for Benefits

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

If You Stop Working for a Contributing Employer

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

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

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

If You Enter Military Service

A participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the employee has been called to active duty in the uniformed services. USERRA protects employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy,

Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

If you enter military service, your coverage by the Fund will continue for the first thirty (30) days of your military leave. When your Fund coverage ends, you and your eligible family members may elect USERRA coverage (which, under this Plan, will be administered in the same way as COBRA coverage and run concurrently with COBRA) for up to twenty-four (24) months.

If you are called to active duty, you must notify the Plan Administrator as soon as possible but no later than 60 days after the date on which you will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice. Once the Fund Office receives notice that you have been called to active duty, you will be offered the right to elect USERRA coverage for yourself and any eligible dependents covered under the Plan on the day your leave started. Unlike COBRA coverage, if you do not elect USERRA for your dependents, they cannot elect it separately.

In addition to USERRA or COBRA coverage, an employee's eligible dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This Plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this plan's benefits under USERRA or COBRA is the best choice.

Upon your return to active employment with a Contributing Employer after an honorable discharge from military service and within the time requirements of federal law, your Fund coverage will resume immediately; provided that you return to employment within:

- 90 days from the date of discharge, if the period was more than 180 days, or
- 14 days from the date of discharge, if the period of service was at least 31 days but less than 180 days, or
- On the next regularly scheduled working day following discharge (plus travel time and an additional eight (8) hours) if the period of service was less than 31 days.

Other Losses of Eligibility

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

for a claim-related injury and the treatment is received before the date that you begin work in non-covered employment.

- In addition, a HIPAA Certificate will be provided to you and/or any covered dependent on receipt of a request for such a certificate if that request is received by the Fund Office within two (2) years after the later of the date your coverage by the Fund ended or the date COBRA Continuation Coverage ended.
- A HIPAA Certificate can be requested in writing, addressed to the following:

Plan Administration-HIPAA Certifications
NY Hotel Trades Council & Hotel Association of New York City, Inc.
Health Benefits Fund
305 West 44th Street, 3rd Floor
New York, NY 10036

Important Notice Regarding Termination of Healthcare Coverage for Cause, Including Fraud or Intentional Misrepresentation:

As always, the Fund reserves the right to terminate coverage for you and /or your dependent(s) if you and/or your dependent(s) are otherwise determined to be ineligible for coverage**.** In accordance with the requirements in the Affordable Care Act, the coverage will not be rescinded retroactively (as opposed to prospectively) except:

- in cases when you or your covered dependent commit fraud or intentional misrepresentation (for example, in enrollment materials, a claim or appeal for benefits or in response to a question from the Plan Administrator or its delegates). In such cases of fraud or misrepresentation, your coverage may be retroactively rescinded upon 30-days' notice.

- due to non-payment of premiums (including COBRA premiums).

Failure to provide complete, updated and accurate information to the Fund Office on a timely basis regarding your marital status, employment status of a spouse or child, or the existence of other coverage constitutes intentional misrepresentation of material fact to the Plan.

Reinstatement of Coverage If You Return to Work

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

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

Continuing Coverage

Information on continuing your coverage when your benefits end

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

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

The COBRA continuation periods are as follows:

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

*Please note that under current law, Domestic Partners are not "spouses" under federal law and, thus, are not eligible for COBRA Continuation Coverage under the Plan.

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

How to Elect COBRA Continuation Coverage

When your employment terminates or your hours are reduced so that you are no longer entitled to coverage under the Plan, or when the Fund Office is notified on a timely basis that you died, divorced, or became entitled to Medicare, or that a dependent child loses dependent status, the Fund Office will give you and/or your covered dependents notice of the date on which your coverage ends and the information and forms they need to elect COBRA Continuation Coverage. Under the law, you and/or your covered dependents will then have only 60 (sixty) days from the date you or they receive that notice to apply for COBRA Continuation Coverage. **IF YOU AND/OR ANY OF YOUR COVERED DEPENDENTS DO NOT CHOOSE COBRA CONTINUATION COVERAGE WITHIN SIXTY (60) DAYS AFTER RECEIVING THAT NOTICE,**

YOU AND/OR THEY WILL NOT HAVE ANY GROUP HEALTH COVERAGE FROM THIS PLAN AFTER COVERAGE ENDS.

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

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

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

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

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

Under federal law, you or your covered family member have the responsibility to notify the Fund Office in writing within sixty (60) days of a divorce, legal separation or a child losing dependent status, which may qualify for a COBRA election. That written notice should be sent to the Fund Office. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the qualifying event, the date of the event, and appropriate documentation in support of the qualifying event, such as divorce documents.

Your Employer has the legal obligation to notify the Fund Office of your death, termination of employment, reduction in hours or Medicare entitlement within 30 days of the event. COBRA Continuation Coverage runs from the date of loss of coverage due to the qualifying event, not the qualifying event.

Paying COBRA Premiums

Generally speaking, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The amount that you and other qualified beneficiaries will need to pay will be 102 percent (102%) of the cost to the Plan (including both employer and participant contributions) for coverage of a similarly situated Plan participant or beneficiary who is not receiving continuation coverage (in the case of an extension of continuation coverage due to a disability, the amount is 150 percent (150%) of the cost, provided the disabled individual elects the extension).

The monthly premium rates may be adjusted due to changes in coverage. Even in the absence of any changes in coverage, premiums charged for continuation coverage may change yearly or as otherwise permitted by applicable law. After you or your family members experience a qualifying event, you will receive an election form and notice of the actual premium that will apply.

If you (or another qualified beneficiary) elect COBRA continuation coverage on time (as outlined above on page 25-31), you will receive an invoice for the COBRA premium after the Fund Office receives your completed COBRA Continuation Coverage Election Form. If you (or another qualified beneficiary) do not make your first premium payment within 45 days after your Election Authorization Form is postmarked, regardless of whether you receive an invoice for the COBRA premium, you (or the qualified beneficiary, as applicable) will lose all rights to COBRA continuation coverage under the Plan, and your coverage will terminate (as of the date it would otherwise terminate under the Plan).

After you make your first payment for continuation coverage, the Fund Office will send you monthly invoices. You are required to pay for continuation coverage for each subsequent month of coverage. Payment is due by the invoice date. If you fail to make timely COBRA premium payments, your COBRA continuation coverage will terminate. As long as you make the required payment on or before its due date, your coverage under the Plan will continue for that coverage period without interruption. Note that the Fund Office must receive your premium on time even if you do not receive the invoice sent to you. If payment is received late but within 30 days after the due date, however, the coverage will be retroactively reinstated.

You may pre-pay premiums for COBRA coverage

You may choose to pre-pay your COBRA premiums for up to 18 months. If you pre-pay and subsequently qualify for active coverage with this Plan at any point during the pre-paid period, the remainder of your pre-paid amount will be refunded to you upon request. If you pre-pay and later decide to terminate your COBRA coverage, the Fund will refund the remainder of the pre-paid amount effective the first of the month following receipt of notice from you requesting termination. For more information on this option, contact the Fund Office at (212) 586-6400.

If you fail to make a monthly payment before the end of the late payment period for that month, your coverage will terminate and you will lose all rights to continuation coverage under the Plan. Once continuation coverage is lost, it cannot be reinstated.

COBRA Coverage in Cases of Social Security Disability

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

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

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

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

Cost of COBRA Coverage in Cases of Social Security Disability

If the 18-month period of COBRA Continuation Coverage is extended because of Social Security disability, the Plan will charge employees and their families 150% of the cost of coverage for the COBRA family unit that includes the disabled person for the 11-month extension period.

Special Second Election Period for TAA Eligible Individuals

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance ("TAA Eligible Individuals"). Under the applicable tax provisions, TAA 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.

TAA Eligible Individuals who did not previously elect continuation coverage during the original 60-day COBRA election period that applied to the TAA-related loss of coverage may elect continuation coverage during a second 60-day election period. This second 60-day election period begins on the first day of the month in which he or she is determined to be a TAA Eligible Individual, provided that such election may not be made later than 6 months after the date of the TAA-related loss of coverage. TAA Eligible Individuals may elect continuation coverage for themselves and their eligible family members. Any continuation coverage elected will begin with the first day of the second 60-day election period, and not on the date the coverage originally was lost. However, the time between the loss of coverage and the start of the second election period will not be counted for purposes of determining whether the individual has a 63-day break in coverage under the Health Insurance Portability and Accountability Act (HIPAA).

If you have questions about these tax provisions or you are not sure whether you are a TAA Eligible Individual, contact the Health Coverage Tax Credit Customer Contact Center toll-free at 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.

Acquiring New Dependents While Covered by COBRA or Other Health Insurance

If you or any of your dependents acquire a new dependent through marriage, birth, adoption, or placement for adoption while enrolled in COBRA Continuation Coverage, you or they may add that dependent to COBRA coverage for the balance of the COBRA coverage period. For example, if you have five (5) months of COBRA left and you get married, you can enroll your new spouse for five (5) months of COBRA coverage. However, your new spouse will not be considered to be a qualified beneficiary. In order for the dependent to be covered, you must notify the Fund Office within thirty (30) days of either the date of your marriage or the child's birth, adoption, or placement for adoption. The dependent will be covered immediately, for the balance of the COBRA continuation period, provided the required COBRA premiums are paid. There may be a change in your COBRA premium amount in order to cover the new dependent.

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

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

Multiple Qualifying Events While Covered by COBRA

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

Termination of Employment/Reduction in Hours Following Medicare Entitlement

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

There will then be a grace period of thirty (30) days to pay any future monthly premiums due. If payment of the required premiums is not received by the Fund by the end of the applicable grace period, COBRA Continuation Coverage will terminate. The Fund Office will notify you of the cost of the coverage at the time you receive your notice of right to elect COBRA Continuation Coverage.

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

If you become covered by another group health plan after your Fund coverage ends, you may continue health benefits coverage by the Fund if the other plan has a pre-existing condition limitation that applies to you. You would be responsible for paying for this coverage.
COBRA Continuation Coverage by the Fund will end before the end of the maximum eighteen (18), twenty-nine (29) or thirty-six (36) month continuation period described above when the earliest of the following occurs:

- You fail to make any required COBRA premium payment before the end of the forty-five (45) day or thirty (30) day grace period, whichever applies.
- You or your dependents become enrolled in Medicare.

- You or your dependents become covered under another group health plan (unless that plan does not provide benefits for a pre-existing condition for which you are being treated).
- Continuation coverage has been extended for up to 29 months due to disability and there has been a final SSA determination that the individual is no longer disabled. In this case, coverage will end as of the month that begins more than 30 days after the date of such final determination; you are required to notify the Fund Office in writing within 30 days of any such final determination.
- This Fund and its plan of health care benefits are terminated for all employees.
- You make a false statement, or furnished fraudulent or incorrect information regarding your coverage.

The Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

In addition, a HIPAA Certificate will be provided to you and/or any covered dependent on receipt of a request for such a certificate if that request is received by the Fund Office within two (2) years after the later of the date your coverage by the Fund ended or the date COBRA Continuation Coverage ended.

You should address all requests for a HIPAA Certificate to:

Plan Administration-HIPAA Certifications
NY Hotel Trades Council & Hotel Association of New York City, Inc.
Health Benefits Fund
305 West 44th Street, 3rd Floor
New York, NY 10036

Please note, however, that this Plan does not contain any preexisting condition exclusions or limitations.

Important: Avoid a Significant Lapse in Coverage

When considering whether or not to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under HIPAA. A lapse in health coverage of 63 or more days may make it difficult for you to obtain group health plan coverage or cause you to be subject to exclusions or coverage limitations for pre-existing conditions when you seek group health coverage in the future. If there will be some delay between the end of your active coverage under this Plan and your enrollment in a new plan, for example, your new employer has a 90 day waiting period to begin participation in a health plan, a break in health coverage can be avoided by maintaining COBRA coverage in the meantime.

HIPAA – Notice of Privacy Practices (NOPP)

HIPAA also gives you certain rights with respect to your health information, and it also imposes certain obligations on the Fund as a group health plan. The following describes how medical information about you may be used and disclosed and how you can get access to this information. This information also applies to your spouse and other qualified dependents. So, please share it with them.

The Fund is committed to maintaining the confidentiality of your private information and has drafted this NOPP in accordance with the HIPAA Privacy Rule, contained in the Code of Federal Regulations at 45 C.F.R. Parts 160 and 164. Terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule, as amended by Health Information Technology For Economic and Clinical Health Act (HITECH).

This NOPP describes our efforts to safeguard your protected health information (PHI) from impermissible use or disclosure. As a group health plan, the Fund is a covered entity under HIPAA and, as a result, is required under such law to provide you with notice of its legal duties and privacy practices with respect to PHI. PHI includes any individually identifiable information that relates to your physical or mental health, the health care that you have received or benefit payments for your health care, including your name, address, date of birth and Social Security number. These rules do not apply to any disability, death or other non-health benefits provided under the Fund.

The Fund is legally required to maintain the privacy of your PHI. The primary purpose of this NOPP is to describe the legally permitted uses and disclosures of PHI, even though some may not apply to this Fund in practice. This NOPP also describes your right to access and control your PHI. Although the Fund is required to abide by the terms of this NOPP, it reserves the right to change the terms of this NOPP and to make new provisions regarding your PHI that it maintains, as permitted or required by law. If the Fund makes a material change to this Notice, it will provide you with a copy of the revised Notice of Privacy Practices. Additionally, you may contact the Fund directly at any time to obtain a copy of the most recent NOPP, or visit www.hotelfunds.org to view or download the current NOPP. This NOPP is effective as of September 23, 2013.

Your Protected Health Information

Protected Health Information (PHI) Defined.

The term "Protected Health Information" (PHI) includes all health information, including demographic information, collected from you or created or received by the Fund, a health care provider, a health care clearinghouse, a health plan, or your employer, from which it is possible to individually identify you and that relates to your (i) past, present or future physical or mental health or condition, (ii) the provision of health care to you, or (iii) the past, present, or future payment for the provision of health care to you. Individually identifiable information includes your name, address, date of birth, employee ID number, and Social Security number that is linked to the above-referenced matters concerning your health care, regardless of whether such information is transmitted orally, in writing, electronically or in any other form.

How the Fund May Use and Disclose Your Protected Health Information.

Generally speaking, the Fund has amended its plan documents to protect your PHI as required by federal law. Under the law, however, the Fund may disclose your PHI without your consent in the following cases:

- Upon your request, the Fund is required to give you access to certain PHI in order to inspect and copy it.

- As required by an agency of the government. The Secretary of the United States Department of Health and Human Services (HHS) may require the disclosure of your PHI to investigate or determine the Fund's compliance with privacy regulations.

In addition, under the law, the Fund may also use or disclose your PHI under other certain circumstances without your permission. The following categories (as well as those described in "*Other Permitted Uses and Disclosures of Your PHI for Which Consent, Authorization or Opportunity to Object is Not Required")* describe the different ways that the Fund may use or disclose your PHI without your consent. For each category of uses or disclosures, this Notice will explain the scope of the unauthorized disclosure and provide some examples. Please note that not every use or disclosure in a category will be listed. Nevertheless, all of the ways that the Fund will be permitted to use or disclose PHI will fall into one of these categories.

For Treatment, Payment and Health Care Operations.

Treatment. Although the Fund does not provide treatment, it may use or disclose your PHI to support the provision, coordination or management of your health care treatment. For this compliance purpose, "treatment" also includes, but is not limited to, consultations and referrals between one or more providers. For example, in the process of arranging for durable medical equipment services ordered by your attending physician with a contracted service provider, the Fund may disclose your name, address, telephone number and diagnosis to the service provider's intake coordinator.

Payment. The Fund may use or disclose your PHI with regard to its payment activities. "Payment" includes, but is not limited to, actions to make eligibility determinations, coverage determinations and payment (including resolving payment disputes, responding to payment inquiries, subrogating or obtaining reimbursement, conducting medical necessity and appropriateness of care claim reviews, utilization review and precertification). For example, the Fund may advise a physician's office whether you are eligible for coverage and the benefit

amount payable by the Fund. Also, explanation of benefit statements are mailed to the address the Fund has on record for a participant.

Health Care Operations. The Fund may use or disclose your PHI as part of its general administrative or business functions in order for it to function as a health plan. These functions include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, case management, disease management, activities relating to the creation and renewal of insurance and benefit administration contracts, legal services, auditing services, and general administrative activities, including data and information systems management. For example, the Fund may use information from your claims to refer you to case management, determine benefit costs, or for auditing the accuracy of claims processing functions.

Disclosure To Third Parties. The Fund may contract with individuals and entities known as Business Associates to perform various functions on its behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use and/or disclosure your PHI, but only after they agree in writing with the Fund to implement appropriate safeguards regarding your PHI. For example, the Fund may contract with a service provider to perform the administrative functions necessary to pay your medical claims.

Reminders. The Fund may use your PHI to provide you with reminders. For example, the Fund may use your child's date of birth to remind you that you may purchase COBRA continuation coverage for your child who would otherwise lose coverage under the Fund due to age, or to remind you to make an appointment with your physician.

Treatment Alternatives. The Fund may use your PHI to inform you about treatment alternatives.

Health-Related Benefits and Services. The Fund may use or disclose your PHI to inform you about other health-related benefits and services that may be of interest to you.

Disclosure to the Plan Sponsor. The Fund may disclose your PHI to its Board of Trustees ("Board" or "Trustees"), which serves as the Plan Sponsor for the Fund, (or its designated committee) for purposes related to the Fund's payment and health care operations, including in connection with appeals that you file following a denial of a benefit claim. In addition, the Fund Office may receive your PHI if you request assistance in filing or perfecting your claim for benefits under the Fund. The Trustees may also receive your PHI if necessary for them to fulfill their fiduciary duties with respect to the Fund. When disclosing PHI to the Board, the Fund will make reasonable efforts not to disclose more than the minimum necessary amount of PHI to achieve the particular purpose of the disclosure. Unless authorized by you in writing, your PHI: (1) may not be disclosed by the Fund other than as permitted in this Notice or as required by law, or (2) will not be used with respect to any employment-related actions or decisions, or (3) with respect to any other benefit plan sponsored by or maintained by the Board.

In addition, the Fund may disclose "summary PHI" to the Board for obtaining premium bids or modifying, amending or terminating the Fund. Summary PHI summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor (such as the Board of Trustees) has provided health benefits under a group health plan. Identifying information will be deleted from summary PHI, in accordance with federal privacy rules.

When the Disclosure of Your PHI Requires Your Written Authorization.

The Fund must generally obtain your written authorization before (each of these includes defined exceptions under which the Fund may use or disclose your PHI for these purposes without your authorization):

- Using or disclosing psychotherapy notes about you from your psychotherapist.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Fund is not likely to have access to or maintain these types of notes.

- Using or disclosing your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Fund receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed.

- Receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI.

- Using and disclosing your PHI for any use or disclosure not described within this Notice.

At any time, you may revoke your authorization in writing except where the Fund has taken action in reliance on your authorization.

Other Uses and Disclosures for Which Consent, Authorization or Opportunity to Object are Not Required.

In addition to the above, the following categories describe other possible ways that the Fund may use and disclosure your PHI without your specific consent, authorization or request. For each category of uses or disclosures, this Notice will explain the scope of the unauthorized disclosure and provide some examples. Please note that not every use or disclosure in a category will be listed. Nevertheless, all of the ways that the Fund will be permitted to use or disclose PHI will fall into one of these categories.

(1) When required by law.

(2) When permitted for purposes of public health activities. This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

(3) When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under

law when the parents or other representatives may not be given access to the minor's PHI.

(4) The Fund may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations and audits; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud); or for the government to monitor the health care system, government programs and compliance with civil rights laws.

(5) The Fund may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request or other lawful process by someone involved in such legal dispute, provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Fund that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

(6) When required for law enforcement health purposes, including the reporting of certain types of wounds. Also when required for law enforcement emergency purposes if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Fund in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement emergency purposes include identifying or locating a suspect, fugitive, material witness or missing person, and disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.

(7) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(8) The Fund may use or disclose PHI for research, subject to certain conditions and limitations.

(9) When consistent with applicable law and standards of ethical conduct if the Fund, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(10) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

(11) The Fund is permitted to disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has established protocols to ensure the privacy of your PHI, or the research involves a limited data set which includes no unique identifiers (information such as name, address, social security number, etc., that can identify you).

(12) When the appropriate conditions apply, the Fund may use or disclose PHI of individuals who are Armed Forces personnel: (1) for activities deemed necessary by military command authorities; or (2) to a foreign military authority if you are a member of that foreign military service. The Fund may also disclose your PHI to authorized federal officials conducting national security and intelligence activities.

(13) If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Fund may disclose your PHI to the institution or official if the PHI is necessary for the institution to provide you with health care; to protect the health and safety of you or others; or for the security of the correctional institution.

(14) If you are an organ donor, the Fund may release your PHI after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Any other Fund uses and disclosures not described above will be made only if you provide the Fund with written authorization, subject to your right to revoke your authorization. If you provide us with written authorization to use or disclose your PHI for purposes other than those set forth in this Notice, you may revoke that authorization in writing at any time. If you revoke your authorization, the Fund will no longer use or disclose your PHI for the reasons covered by your written authorization. However, the Fund is unable to take back any disclosures that the Fund has already made with your authorization, and the Fund is required to retain records of the care that the Fund provided to you.

Disclosures to Others Involved in Your Health Care.

Disclosure of your PHI to family members, other relatives and your close personal friends without your written consent or authorization is allowed if the information is directly relevant to the family or friend's involvement with your care or payment for that care and you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

If you are not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of your incapacity or emergency circumstance, the Fund may nevertheless make a disclosure of your PHI to family members, other relatives and your close personal friends if the Fund concludes, based on professional judgment and its experience with common practice, that the disclosure is in your best interest.

You can ensure that no disclosures will be made by the Fund under this section to your family members, other relatives and close personal friends by filing a written restriction with the Fund as described below.

YOUR INDIVIDUAL PRIVACY RIGHTS

Breach Notification.

If a breach of your unsecured PHI occurs, the Fund will notify you.

Uses and Disclosures Requiring Your Written Authorization.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization, subject to your right to revoke such authorization. Your authorization must be in writing and contain certain elements to be considered a valid authorization. You may call or write the Fund Office to request an authorization form be sent to you.

Personal Representatives.

You may exercise your rights through a personal representative. An individual purporting to act as your personal representative will be required to produce evidence of authority to act on your behalf before being provided access to your PHI or being allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a Notary public;
- A court order of appointment of the person as conservator or guardian;
- An Appointment of Personal Representative form that is completed and signed by you; or
- An individual who is the parent of a minor child.

Notwithstanding the foregoing, the Fund retains the right to deny access to your PHI to a personal representative in certain abuse, neglect or endangerment situations where the Fund concludes it is in your best interest to deny access. This also applies to personal representatives of minors.

Rights of Individuals.

Right to Request Restrictions on PHI Uses and Disclosures.

You may request, in writing, that the Fund restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Fund is not required to agree to a requested restriction. If the Fund does agree to the request, the Fund will not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment or the Fund terminates the restriction with or without your agreement. Your request must include the PHI you wish to limit, whether you want to limit the Fund's use, disclosure, or both, and (if applicable), to whom you want the limitations to apply (for example, disclosures to your spouse). You have the right to request that the Fund not disclose PHI to a health plan for "payment or health care operations," as defined by HIPAA, if the provider has already been paid in full by the individual for the health care services.

The Fund will accommodate reasonable written requests for communications of PHI by alternative means or at alternative locations (e.g., send your Explanation of Benefits to your

office, instead of at home). You or your personal representative will be required to complete the Fund's model form to request restrictions on uses and disclosures of your PHI.

Make such requests to the Fund's Privacy Officer who may be contacted at (212) 586-6400.

Right to Inspect and Copy PHI.

You have the right to inspect and obtain a copy of your PHI (in hardcopy or electronic form) that is contained in a "designated record set" – medical records and other records maintained and used in making enrollment, payment, claims adjudication, case management and other decisions about you – for as long as the Fund maintains the PHI. You may request your hardcopy or electronic information in a format that is convenient for you, and the Fund will honor that request to the extent possible. You also may request a summary of your PHI. Requests for access to your PHI must be made in writing. Requested information will be provided within 30 days of receipt of your request. A single 30-day extension is allowed if the Fund provides you with a written statement of the reasons for the delay and the expected date by which the Fund will provide the information.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set.

You may be charged a reasonable, cost-based fee for copying the PHI, or preparing a summary of you PHI. The Fund will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. Requests for access to PHI should be made to the Fund's Privacy Officer who may be contacted at (212) 586-6400.

If access is denied, you or your personal representative will be provided with a written denial explaining the basis for the denial. Such notice will advise you that you may request in writing to have the denial reviewed by a licensed health care professional designated by the Fund to act as a reviewing official and who did not participate in the original decision to deny. Such denial will also describe how you may complain to the Fund or the Secretary of the Department of Health and Human Services pursuant to the complaint procedures described herein.

Right to Amend PHI.

You have the right to submit a written request to amend your PHI contained in a "designated record set" for as long as the Fund maintains the PHI. The Fund will act on the request within 60 days of receipt. The Fund is allowed a single 30-day extension if the Fund is unable to comply with the 60-day deadline.

The Fund, however, may deny your request for an amendment if it is not in writing or does not include a valid reason to support the request. In addition, the Fund may deny your request if you ask the Fund to amend information that did not originate with the Fund; is not contained in the records maintained by the Fund; is not part of the information that you would legally be permitted to inspect and copy; or is accurate and complete.

If your request is denied in whole or in part, you or your personal representative will be provided with a written denial explaining the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Your request to amend your PHI must be made in writing to the Fund's Privacy Officer who may be contacted at (212) 586-6400.

You or your personal representative will be required to complete the Fund's model form to request amendment of your PHI.

Right to Receive an Accounting of PHI Disclosures.

The Fund will also provide you with an accounting of disclosures by the Fund of your PHI during the six (6) years prior to the date of your written request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; (4) based on your written authorization; (5) to friends or family in your presence or because of an emergency; (6) for national security purposes; and (7) incidental to otherwise permissible disclosures. Any request for an accounting must be submitted in writing. An accounting will be provided within 60 days of receipt of your request. Your first request for an accounting in a 12-month period will be responded to without charge. You may be charged a reasonable, cost-based fee for each additional request for an accounting within such 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Submission of Requests.

The Fund has 60 days to provide the accounting. The Fund is allowed an additional 30 days if the Fund gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. The requests described above should be submitted in writing to the Fund Office at the address at the end of this Notice.

Right to Receive Paper Copy of This Notice Upon Request.

You have the right to receive a paper copy of this Notice, contact the Fund's Privacy Officer who may be contacted at (212) 586-6400.

This right applies even if you have agreed to receive the Notice electronically.

THE FUND'S DUTIES

Maintaining Your Privacy.

The Fund is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices. In addition, the Fund may not (and does not) use your genetic information that is PHI for underwriting purposes.

This Notice is effective beginning on September 23, 2013 and the Fund is required to comply with the terms of this Notice as of such date. However, the Fund reserves the right to change its privacy practices and to apply changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI.

If material changes are made to this Notice, it will be posted on the Fund's website promptly by the effective date of the material change, and thereafter the Fund will send a hard

copy of the revised notice in its next annual mailing. If the Fund does not post a revised notice on its website, it must provide such notice within 60 days of the effective date of the material revision to this Notice.

Material changes are changes to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Fund, or
- Other privacy practices stated in this Notice.

Minimum Necessary Standard.

When using or disclosing PHI or when requesting PHI from another covered entity, the Fund will make reasonable efforts to limit the use or disclosure of PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to you or pursuant to an authorization initiated by you;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures required for the Fund's compliance with the HIPAA privacy regulations.

De-Identified Information.

This Notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

YOUR RIGHT TO FILE A COMPLAINT WITH THE FUND OR HHS

Questions/Complaints.

If you believe that your privacy rights have been violated or have any questions regarding this Notice or the subjects addressed in it, you may file a complaint with or submit your questions to the Fund's Privacy Officer who may be contacted at (212) 586-6400.

You may also file a complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. Filing instructions are available at: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html All complaints must be submitted in writing.

The Fund will not penalize or retaliate against you for filing a complaint.

Genetic Information Non-Discrimination Act (GINA)

Effective June 1, 2009, GINA prohibits discrimination by group health plans such as the Fund against an individual based on the individual's genetic information. Group health plans and health insurance issuers generally may not request, require or purchase genetic information for underwriting purposes, and may not collect genetic information about an individual before the individual is enrolled or covered. Pursuant to the applicable requirements of GINA, the Fund is also prohibited from setting premium and contribution rates for the group on the basis of genetic information of an individual enrolled in the Fund.

As indicated above, the HIPAA Privacy regulations were amended to treat genetic information as protected health information. GINA prohibits the use of genetic information for underwriting purposes and makes the definitions of genetic information and underwriting consistent with GINA.

Pre-existing Condition Exclusions

In accordance with the applicable coverage madate under PPACA, the Fund does not impose preexisting condition exclusions or limitations of any kind.

RETIREE HEALTH COVERAGE OPTIONS

BEFORE YOU RETIRE
There are many questions you'll want to ask *before* retirement. Who will provide your health coverage? Who will provide your family's health coverage? What will your budget be after retirement? The sooner you answer these questions, the easier it will be to make crucial decisions about your health coverage and finances. Below are some steps you should take before retiring if you wish to continue coverage with the Fund.

Check Your Pension Status
After retirement, your ability to continue coverage with the Fund depends on your Pension status. We recommend that you file a Pension application one year prior to your intended retirement date, or at least 30 days prior to your last day of work with a covered employer. For full Pension benefit rules, including requirements when submitting a Pension application, see the Pension Fund Summary Plan Description, available online at **www.hotelhunds.org** or through our offices. If you have any questions regarding your Pension, or if you wish to submit an application for a Pension, contact the Retirement Services department at (212) 586-6400 ext. 4125.

Become Familiar with Medicare
Continuing coverage with the Fund after retirement also depends on eventually becoming eligible for Medicare. We highly recommend that you become familiar with your Medicare options, especially Part B enrollment and its monthly premiums. If you wish to continue coverage with the Fund, you'll need to enroll in Medicare Part B and assign it to the Fund.

The Fund offers an "Integrated Plan" to Retirees, meaning that Medicare Part B (Professional Charges) and Part D (prescription) benefits are provided under the same plan. Once you retire, you cannot be enrolled in an outside Medicare Part D plan, a Health Maintenance Organization (HMO) or a Medicare Advantage plan. Enrollment in these disqualifying plans will permanently

terminate your health coverage with the Fund. (You may, however, be enrolled in a supplemental or “Medigap” policy.)

Creditable Coverage: The Fund has determined that its prescription drug coverage is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. This means it is considered “creditable coverage”. Having creditable coverage allows you to maintain Fund coverage after retirement and not pay a higher premium, but if you later decide to enroll in Medicare prescription drug plan, you would lose Funds coverage.

More detailed information about Medicare is available in the “Medicare & You” Handbook, which you should receive in the mail from the government as you approach retirement age. For additional information:

Visit **www.Medicare.gov** for personalized help,

Call your State Health Insurance Assistance Program (New York: 800-701-0501; New Jersey: 877-222-3737; Connecticut: 860-424-5862),

Call 1-800-MEDICARE (800-633-4227) (TTY users: 877-486-2048).

ELIGIBILITY FOR RETIREE HEALTH COVERAGE

To Continue Health Coverage after Retirement, You Must:

☑ Be a “Hotel Industry Retiree” - This means that you must work for a Contributing Employer until you’re eligible for a Pension benefit beginning with the calendar month after your last day of Covered Employment.

☑ Been a part of the Fund for at least 36 months during your career - You must be enrolled in the Fund and be part of the plan for at least 36 months during your career prior to your date of retirement. You must also have medical coverage in the three consecutive calendar months prior to your retirement date.

Eligible spouses and dependents of Hotel Industry Retirees may also continue health coverage for certain time periods, which may incur a cost.

PLAN & BENEFIT RULES

1) Retiree Health Plan

When you become eligible for Medicare, you can keep the same **Health Center, Health Center-referral medical coverage and Health Center pharmacy benefits** by designating the Health Center to be a Medicare Part B provider. This will enroll you in the **Retiree Health Plan**.

- There are no deductibles or co-insurances paid by the Retiree or Retiree’s spouse when using the Health Center, except for pharmacy co-pays. (Prescriptions are provided by the Health Center through a mandatory generic program. $5 co-pay for generic drugs on formulary; $15 co-pay for brand-name drugs on formulary but not available generically. Drugs not on formulary may be provided at actual cost to the Fund.)

- With a Health Center referral, you will not have the standard deductibles or 20% co-pays for outside Part B Professional Charges.

- You must maintain your monthly Medicare Part B premiums through your social security checks, to remain in the Retiree Health Plan.

- **Medicare Part A services are paid by Medicare and all related deductibles and co-insurances are the responsibility of the beneficiary/member.**

- **UnitedHealthcare EPO coverage is <u>not</u> available under the Retiree Health Plan.**

ENROLLING IN AN OUTSIDE PLAN
Enrolling in plans like Medicare Part D, HMO, or Medicare Advantage plans may terminate your Retiree Health Plan.

USING OUTSIDE PROVIDERS
After you retire, you may still choose any outside providers that accept Medicare insurance — as long as you are not eligible through Covered Employment. However, in these cases you will be responsible for all deductibles, co-insurances and any other related charges.

If you are eligible through Covered Employment after retirement, services at an outside provider will not be covered by Medicare. These services will only be covered through a referral from one of our Health Centers.

2) Retiree Complimentary Coverage

Regardless of whether any health coverage plan is elected upon retirement, **Dental, Pre-Paid Legal and Members' Health Assistance Program (MHAP)** benefits are available for free to the Retiree, Retiree's spouse and eligible dependents for the life of the Retiree or Retiree's spouse, whichever is longer. **Optical** benefits are only available to the Retiree. Counseling services are provided by or through MHAP. The Retiree must have been eligible for each benefit prior to retirement in order to receive them under the Retiree Complimentary Plan.

3) Retiree Continuation Coverage

Retiree Continuation Coverage is intended to provide coverage to Retirees and Retirees' spouses until they become eligible for Medicare. Generally, this plan includes the same **Health Center, Health Center referral, Health Center pharmacy and Hospitalization/Out-of-Area Emergency benefits** under the same terms as actively working member coverage.

Hospital coverage terminates for any Retiree Continuation Coverage participant (Retiree, spouse or dependent) on the day he/she becomes eligible for Medicare Part A – typically his/her 65th birthday but may be earlier in the case of disability.

UnitedHealthcare EPO coverage is <u>not</u> available under this plan.

4) COBRA

All employees and eligible dependents that lose group health coverage have the right to continue their same health benefits through self-pay coverage under the COBRA laws. When you retire, you will be provided with a COBRA Election Notice which explains your rights and the process for electing COBRA continuation coverage. COBRA is the only option to continue out-

of-area UnitedHealthcare EPO plan. When enrolling in Retiree Continuation Coverage or the Retiree Health Plan, out-of-area EPO coverage will terminate.

5) Disability Retiree Continuation Coverage

Members who qualify for a Disability Pension — but who are not yet eligible for Medicare — may continue coverage through COBRA. When the initial 18-month period of COBRA continuation coverage has ended, the Disability Retiree Continuation Coverage Plan is available. This plan includes the same benefits under the same rules as Retiree Continuation Coverage except for its cost. The monthly premium for Disability Retiree Continuation Coverage is the same as each year's current 150% rate for the 11-month disability extension available under COBRA.

As with Retiree Continuation Coverage, Disability Retiree Continuation Coverage can be continued until the participant is Medicare-eligible, at which point he or she must enroll in the Retiree Health Plan according to the deadlines stated above.

Eligibility for Disability Retiree Continuation Coverage is dependent upon the Retiree's continued "Totally Disabled" status as determined by the Social Security Administration.

ELECTION DEADLINES

In order to continue Retiree health coverage, you must not experience any lapse in medical coverage. This will typically mean that the deadline for enrolling in Retiree Continuation Coverage or in the Retiree Health Plan will be the same as for electing COBRA after losing coverage, which is sixty days from the last day of regular coverage or sixty days from the date you are provided with the COBRA election notice – whichever is later.

Additionally, once you and your spouse are eligible for Medicare, you each must separately enroll in the Retiree Health Plan to continue coverage. **It is you and your spouse's responsibility to enroll in the Retiree Health Plan. Both you and your spouse must bring your Medicare cards into our Funds office and complete the Medicare Part B Authorization Form.**

Retiree Health Plan Election Deadline:

If you ...	**The deadline for enrolling in the Retiree Health Plan is ...**
Retire *before* your 65th birthday	At least 30 days *before* your 65th birthday
Retire on or after your 65th birthday	3 calendar months after your last day of Covered Employment
Are awarded a Disability Pension	3 calendar months after you become eligible for Medicare, if this date occurs prior to retirement.

Medicare-eligible participants cannot remain on the Retiree Continuation Coverage Plan beyond the above deadline. If you are a spouse of a Retiree, you must elect the Retiree Health Plan by the earliest applicable scenario listed above. Retirees and/or Retirees' spouses may choose to

exhaust their eligible COBRA continuation coverage timeframe (18, 29 or 36 months) and still enroll in the Retiree Health Plan. However, a participant still must not experience any lapse in medical coverage to be able to enroll in the Retiree Health Plan or Retiree Continuation Coverage after COBRA coverage ends.

SPOUSES AND DEPENDENTS

Family coverage is available under the Retiree Continuation Coverage Plan through either the Retiree's or Retiree's spouse's policy.

All spouse and dependent eligibility under Retiree Continuation Coverage is subject to the Retiree maintaining continuous medical coverage through Retiree Continuation Coverage, COBRA or the Retiree Health Plan. In addition, your spouse and/or dependent(s) must also maintain continuous medical coverage in order to continue any form of Retiree coverage.

As long as the Retiree maintains continuous medical coverage, the spouse may separately elect Retiree Continuation Coverage or the Retiree Health Plan. Dependents are covered according to the regular terms of the Fund, e.g. they may remain eligible through the day before their 26th birthday.

Only spouses, and not dependents, can elect the Retiree Continuation Coverage Plan as a policyholder. In this case, or in the case of the death of a member on Retiree Continuation Coverage, the spouse can then maintain Retiree Continuation Coverage under the same terms until this spouse becomes Medicare eligible, regardless of the spouse's current age. However, if a Retiree's spouse loses medical coverage, the Retiree and any eligible dependents may still retain coverage.

Surviving Spouse Terms: If a spouse takes a Pre-Retirement Surviving Spouse Pension Benefit or the lump sum cash payment, this spouse is not eligible for any retiree coverage (the Retiree Complimentary Plan, Retiree Continuation Coverage or Retiree Health Plan).

TERMINATION DUE TO MEDICARE PART D, HMO OR MEDICARE ADVANTAGE ENROLLMENT

A Retiree or Retiree's spouse must not enroll in a Medicare Part D plan, a Health Maintenance Organization (HMO) or a Medicare Advantage plan or else his or her Retiree Continuation Coverage or the Retiree Health Plan will be terminated. (Note that you may still purchase a supplemental or "Medigap" policy.) He or she may have been enrolled in a Part D plan prior to the last day of Covered Employment but must disenroll to be eligible for either the Retiree Health Plan or Retiree Continuation Coverage. Any enrollment after that point in the above disqualifying plans automatically terminates all eligibility for Health Center medical and pharmacy services. If the Retiree's eligibility is terminated, the spouse and/or dependents automatically lose eligibility as well and may not reenroll at any time in the future.

RETIREE CONTINUATION COVERAGE AND COBRA

The Retiree Continuation Coverage Plan qualifies as continuation coverage and meets the Fund's obligation to offer COBRA to beneficiaries who have lost health coverage. For this reason, time covered under Retiree Continuation Coverage qualifies as concurrent time COBRA would be available.

Example: A 64-year-old Retiree takes Retiree Continuation Coverage for himself and a dependent child. One year later, he signs over Medicare Part B to the Fund (enrolling in the Retiree Health Plan), which causes the dependent child to lose coverage under Retiree Continuation Coverage. The dependent child will be offered COBRA for 24 months instead of the typical 36 because 12 months of extended coverage have already been provided under the Retiree plan.

RETURNING TO COVERED EMPLOYMENT AFTER RETIREMENT

All members that return to Covered Employment after having retired and received a Pension must earn working Health Benefits Fund coverage by meeting the minimum number of hours requirement, as described in the SPD, rather than the function-based criteria that applies to banquet waiters and certain other job categories before retirement.

If Your Spouse, Partner or Dependent Dies

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

To Do: If Your Dependent Dies

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

If You Die

If you die while working, in most instances your dependents lose eligibility for coverage. However, they may elect to continue coverage through COBRA for up to thirty-six (36) months. See the section on ***Continuing Coverage (COBRA)*** on page 25. for more information. Your dependents and/or beneficiaries should contact the Fund Office to report your death, and obtain information on submitting any claims for benefits payable because of your death and continuing Fund coverage through COBRA.

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

NOTE - It's important to note that benefits under the Retiree Health Coverage Plan are offered through the Fund and are not part of the benefits provided by the New York Hotel Trades Council and Hotel Association of New York City, Inc. Pension Fund or any other benefit plan sponsored by the Union. Like all benefits under the Fund, the benefits provided under the Retiree Health Coverage Plan are not guaranteed. The benefits may be amended, modified or terminated at any time for those who are or may become covered by these benefits.

Medical Benefits

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

The In-Area Plan: Health Center Program

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

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

Covered Medical Services

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

-General medicine (including physical exams and routine check-ups)
-Internal medicine
-Pediatrics
-Pre-surgical testing, pre/post surgical & post-surgical follow-up
-Obstetrics/Gynecology
-Laboratory services and Pathology
-Mammography
-Radiology & Ultrasound
-Cardiology
-Dermatology
-Allergy
-Neurology
-Pulmonology
-Orthopedics
-Chiropractic
-Physical therapy
-Urology
-Podiatry
-Ophthalmology
-Otolaryngology (Ear, Nose & Throat)
-Gastroenterology
-Endocrinology
-Urgent Care
-Medically necessary ambulance transport arranged by the Health Center

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

Making an Appointment

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

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

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

➲ **Whenever the Health Centers are closed, you can reach a nurse through the UnitedHealthcare NurseLine at 1-800-846-4678 for advice.**

In Case of an Emergency

If there is a medical emergency at home or at work when the Health Centers are closed, call the UnitedHealthcare NurseLine at **1-800-846-4678** for advice on what to do. UnitedHealthcare NurseLine personnel are trained to assess your condition and refer you to the appropriate source for care. Remember to show your UnitedHealthcare ID card to the admitting clerk when going to a hospital for emergency services. If you are billed for the emergency service, you must bring a bill or receipt to the Fund Office for reimbursement or payment.

If You Are Away From Home

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

If You Live Out of the Area: UnitedHealthcare - Out-of-Area Coverage

If you live outside of the operating areas of the Health Centers (Bronx, Brooklyn, Manhattan, and Queens), your major medical benefits (physicians' services and diagnostic tests) are provided through the UnitedHealthcare - Out-of-Area Coverage and your hospital benefits are provided by the Fund under an administrative services contract between the Fund and UnitedHealthcare. Refer to the Summary for the UnitedHealthcare - Out-of-Area Coverage for specific information on your major medical benefits.

Hospital Benefits

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

The following information applies whether you live in the service area of a Health Center or participate in the out-of-area UnitedHealthcare - Out-of-Area Coverage program.

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

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

Where to Obtain Care

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

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

Maximizing Your Benefits

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

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

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

If You Have Questions

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

Notification

You are required to call UnitedHealthcare for certain services and situations outlined below. Either you or a representative, such as a family member, can reach a program representative by

calling **1-866-660-7179**. This telephone number also appears on the back of your UnitedHealthcare ID card. Business hours are 8:30 a.m. to 5:00 p.m., Monday through Friday.

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

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

When to Notify UnitedHealthcare

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

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

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

You do ***not*** have to call the program if you or your dependent(s) are admitted to a hospital outside the continental United States, or your primary health coverage is Medicare.

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

After you have Notified UnitedHealthcare

Pre-admission Review

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

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

Medical Necessity Review

Most of the time, UnitedHealthcare staff can certify your admission to a hospital or continued hospital stay without having to talk with your physician. On occasion, it may be necessary for a Program physician to review your case and discuss it with your physician.

Usually, the physicians reach an agreement during this discussion about the necessity of the admission or continued stay in the hospital. Either the Program's physician will agree on the in-patient setting, or your physician will agree that an alternative setting (such as an out-patient surgery unit) is appropriate.

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

During Your Hospitalization

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

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

Out-Patient Surgery

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

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

Individual Case Management

If you and your family face a catastrophic illness or injury, UnitedHealthcare individual case management staff can provide assistance and support. You will have access to social workers and nurses who can help you and your family plan for post-hospital care.
Examples of such situations include:

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

Newborn Infants Requiring Specialized Care

The birth of a new baby is usually a happy time. Hospitals typically discharge you and your baby within a few days, but this is not always the case. Because of a complicated or premature delivery or an illness discovered shortly after birth, your baby may remain in the hospital after you return home. You must call UnitedHealthcare within twenty-four to forty-eight (24-48) hours if your baby must remain hospitalized for any reason after your discharge. Program case managers are available to help you arrange for the often highly technical care that may enable your baby to go home sooner than would otherwise be possible.

In-patient Stays

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

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

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

Covered Hospital Services

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

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

Maternity Care – Newborns' and Mothers' Health Protection Act of 1996

Your benefits cover pregnancy and any pregnancy-related treatment. It is important to notify the Health Center as soon as you are aware that you are pregnant. In accordance with federal law, the Fund may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight (48) hours after childbirth for any delivery other than a cesarean section. Following a cesarean section delivery, the plan provides, at a minimum, coverage for a hospital stay of at least ninety-six (96) hours. You and your spouse are automatically eligible for the above hospital lengths of stay following childbirth. If you or your spouse requires an extended hospital stay, you must call UnitedHealthcare at 1-866-660-7179 immediately.

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

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

Newborn Children

Hospital benefits are available from birth for:

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

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

If your newborn requires an extended hospital stay, you must call UnitedHealthcare at 1-866-660-7179 immediately to avoid any loss of benefits.

Out-patient Services

Out-patient services must be performed by a United Healthcare participating provider. **Services performed by non-participating providers are not covered by the Fund.** However, emergency room services will be covered at eighty percent (80%) of the allowed amount.

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

Pre-Surgical Testing

You are covered for diagnostic tests performed at the Funds' Health Centers for tests prescribed by your doctor and are preliminary to scheduled surgery.

Chemotherapy

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

Mammography Screening

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

Mastectomy

Breast Reconstruction Surgery Benefits Following Mastectomy

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

- All stages of reconstruction of the breast on which the mastectomy is performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation between the attending physician and the patient. To the extent permitted by applicable law, this coverage is subject to applicable copays, referral requirements, annual deductibles and coinsurance provisions that may apply under the Fund. If you have any questions, please contact the Fund Office.

Cervical Cytology Screening

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

Dialysis for Kidney Failure

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

In a participating hospital or freestanding facility – The Fund will pay the cost of necessary treatment if the facility's dialysis program is approved by the appropriate governmental authorities.

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

Emergencies

WHAT IS AN EMERGENCY? An emergency is defined as the sudden beginning of a medical condition with symptoms of great severity; including severe pain that a person with average knowledge of medicine/health could expect that immediate medical attention is required to avoid any of the following:

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

Any visit to the Emergency Room that does not match the criteria above, may result in a bill you will be responsible for paying.

Emergency Room Tips:

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

Your benefit covers the ***first*** visit for treatment of an emergency condition delivered in a participating hospital's emergency or operating room.

➲**Covered ER services will be covered at the Fund's fee schedule, which may vary from the actual bill.**

➲ **AVOID EMERGENCY ROOM BILLS -** To prevent paying unnecessary charges for visiting a hospital's emergency room when it is not medically necessary, and ensure you receive the correct, prompt medical attention, observe the following instructions:

What to do afterhours or in an emergency

1. If you have questions about health situations and/or emergencies, you should call the UnitedHealthcare NurseLine at **1-800-846-4678.** This free 24-hour service links you to professional nurses who can give you medical information and direct you to the appropriate healthcare setting.
2. If medically necessary, go directly to an emergency room. Emergency care does not require your doctor's prior approval. If possible, go to the emergency room of the hospital where your Primary Care Physician is affiliated.
3. When you arrive at the emergency room, show your UnitedHealthcare identification card. If you are admitted, you or your representative must contact UnitedHealthcare within 24 – 48 hours (or as soon as reasonably possible).

Emergency care outside the Plan's service area

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

Important Reminder Regarding Non-Referred or Out-of-Network Emergency Services

For claims that involve a participating hospital in UHC's network, UHC (not the Fund) is responsible for processing and adjudicating hospital based services including emergency services on behalf of the Fund. Any visit to the emergency room that does not match the criteria above, may result in the patient being billed for the entire amount of such service. In the case of medical emergency services, the Fund will cover and reimburse such costs; provided that the matter is referred through the Plan's health centers. If, however, the medical emergency services occur outside the health center service area or are not referred through the Fund's health centers regardless of whether such hospital-based emergency services are performed by a participating hospital, the Fund will reimburse such eligible claims based on its fee schedule. This is also the case for emergency services rendered by a non-participating provider. The Plan's fee schedule based on (but is not equivalent to) the government's Medicare schedule.

Although the Fund's participating provider network is designed to cover a broad range of service providers, **please keep in mind that a high percentage of providers in certain specialties, particularly anesthesia, radiology and pathology, do not participate.** A list of participating providers is available without charge upon telephone or written request to the health centers or to UHC. If possible, you should always discuss billing procedures prior to receiving treatment from a non-participating provider.

➲ If you must go to an emergency room, show your UnitedHealthcare ID card at the hospital.

Home Health Care Benefits

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

Home care must be approved in advance by calling United Healthcare at 1-866-660-7179.

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

When care is provided without prior hospitalization or through a non-participating agency, you must pay a fifty dollar ($50) deductible. You will receive an allowance equal to 75% of the agency's allowed charges for up to a maximum of forty (40) home care visits per calendar year.

Covered services include:

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

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

- Medical social work visits
- X-ray and EKG services

Hospice Benefits

The Fund provides a lifetime maximum of up to three hundred and sixty five (365) days during the entire period of time you are covered by the Fund of the following:

Hospice care must be approved in advance by calling United Healthcare at 1-866-660-7179.

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

The following conditions apply:

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

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

Typically, covered hospice and out-patient services include:

- Bed patient care, either in a designated hospice unit or in a regular hospital bed.
- Day care services provided by the hospice organization.
- Home care and out-patient services provided by the hospice and billed by the hospice, such as:

    - Intermittent care by an RN, LPN or Home Health Aide
    - Physical therapy
    - Speech and occupational therapy
    - Respiratory therapy
    - Social services
    - Nutritional services
    - Laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms
    - Medical supplies
    - Drugs and medications prescribed by a physician which are considered approved under the US Pharmacopoeia and/or National Formulary (not covered when the drug or medication is of an experimental nature)
    - Medical care provided by the hospice physician
    - Five (5) visits for bereavement counseling for the covered person's family, either before or after the covered person's death
    - Durable medical equipment (rental only)

Skilled Nursing Facility Benefits

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

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

Benefits are subject to the following requirements:

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

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

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

➲ **Skilled Nursing Facility care must be approved in advance by calling UnitedHealthcare at 1-866-660-7179.**

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

1. A written treatment plan
2. The projected length of stay
3. An explanation of the services the patient needs to receive

Treatment will continue based upon medical necessity

Prescription Drug Benefits

How to fill prescriptions and costs

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

You may review or download a copy of our formulary from our website:

www.hotelfunds.org

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

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

➲ **90-day prescriptions are available for specific medications listed on our formulary, which can be reviewed or downloaded from www.hotelfunds.org.**

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

Benefits Provided

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

Vision Benefits

Eye care for you and your family

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

Benefits Provided

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

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

To find out more about the Direct Pay plan, or for locations, product availability, call 1-800-VISION-1, visit www.generalvision.com or visit your nearest GVS location.

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

Direct Pay Plan

A Direct Pay plan is available to retirees' spouses and dependents.

Dental Benefits

Location of providers and what's covered

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

Dental Office Locations

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

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

Benefits Provided

The following is an outline of dental services provided:

Diagnostic Panoramic, full mouth and bite wing x-rays Oral exam & treatment plan Study models Biopsy Vitality test Special consultation	**Operative Dentistry** Amalgam fillings Inlays and onlays Fillings: composite and sedative Composite bonding

Dental Benefits continued

The following is an outline of dental services provided:

Endodontics

Pulpotomy
Pulp capping
Root canal therapy
Apicoectomy
Retrograde fillings

Periodontics

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

Fixed Prosthetics

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

Removable Prosthetics

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

Oral Surgery

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

Miscellaneous Services

Space maintainers
Topical fluoride treatment
Emergency treatments
Mouth guards

Excluded Services

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

Members' Health Assistance Program (MHAP)

We all face personal challenges including family issues, job stress, marital problems, substance abuse, mental illness or other personal matters. At times, these challenges may become too difficult to manage on our own. On such occasions, the Members Health Assistance Program (MHAP) offers confidential consultative and crisis intervention assistance to all employees and their eligible family members.

MHAP Office Location

14 Penn Plaza, Suite 407
New York, NY 10122
212-237-3037 or 1-888-615-6427

MHAP Hours of Operation

Monday – Friday 7:30 am to 7:00 pm; *Closed Saturday and Sunday*

All MHAP services must be arranged through the MHAP office, regardless of whether you live inside or outside of the Health Center service area (outside Manhattan, Brooklyn, Queens and The Bronx). The only exception is for in-patient behavioral health care, which is handled by UnitedHealthcare (800-660-7179).

Benefits Provided

The MHAP team is comprised of social workers, psychologists and psychiatrists. The team works with members and their families to provide a number of services, including: ongoing group and individual counseling, evaluation and assessment; referrals to appropriate resources; crisis/short-term counseling; and prescription of psychiatric medication. The MHAP service is committed to providing professional and confidential counseling services in a comfortable atmosphere.

Out-patient Behavioral Health Program

Eligible individuals may use the MHAP out-patient counseling center without limitation (as clinically indicated). This includes group and individual counseling and psychiatrist visits.

If an eligible member lives outside of the Health Center service area (outside Manhattan, Brooklyn, Queens and The Bronx), he/she is covered for outpatient behavioral health services with a referral to a provider from the MHAP office.

In-patient Behavioral Health Services

In order to receive in-patient psychiatric services, a member or his/her dependents must be eligible for medical benefits. Inpatient treatment for psychiatric issues is managed by United Healthcare. Members and/or their dependents seeking such treatment must be pre-approved for admission by United Healthcare. United Healthcare will monitor the member's treatment from admission through discharge, and will coordinate aftercare services with MHAP. Upon

discharge from the hospital, the member's doctor and/or United Behavioral Health will schedule a follow-up appointment at MHAP.

In-Patient Substance Abuse Services
If it is medically necessary for you to be hospitalized for the diagnosis and treatment of alcoholism or substance abuse, you must first contact the MHAP office. MHAP will arrange for your care with an MHAP-paneled provider. These services are separate from United Healthcare.

Prior authorization for all substance abuse services (inpatient and outpatient) is required by MHAP.

Out-patient Substance Abuse Services
MHAP has its own out-patient substance abuse program for eligible individuals. The service is confidential, and takes place in the MHAP Counseling Center.

If you live outside of the Health Center Service Area (outside Manhattan, Brooklyn, Queens and The Bronx), you may receive care for the treatment and diagnosis of alcoholism/substance abuse by an MHAP-paneled provider in his/her area. These providers are separate from United Healthcare, and, as with other MHAP services, prior authorization must first be obtained from MHAP.

Mental Health Parity Act of 2008 ("MHPA")

MHPA generally requires that group health plans ensure that the financial requirements and treatment limitations for mental health and substance use benefits are no more restrictive than the requirements and limitations applied to the medical hospital and major medical coverage offered under the plan. Effective January 1, 2012, the Plan will apply the same standards for deductibles, copays, coinsurance and out-of-pocket expense maximums for mental health and substance use disorder benefits as it applies to medical and surgical benefits, in accordance with, and subject to the requirements of MHPA.

Benefit Limitations and Exclusions

Services Not Covered

Benefits are not provided by the Fund for the following:

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

Medically Necessary/Medical Necessity:

A. A medical or dental service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:

1. is provided by or under the direction of a physician or other duly licensed health care Practitioner who is authorized to provide or prescribe it or dentist if a dental service or supply is involved; and
2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
3. is determined by the Plan Administrator or its designee to meet all of the following requirements:
    - It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
    - It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and
    - It is an **"Appropriate"** service or supply given the patient's circumstances and condition; and
    - It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient; and
    - It is safe and effective for the illness or injury for which it is used.

B. A medical or dental service or supply will be considered to be **"Appropriate"** if:

1. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
2. It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

C. A medical or dental service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

D. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.

E. A Hospitalization or confinement to a health care facility will not be considered to be Medically Necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

F. A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a hospital or health care facility or other more costly facility.

G. The non-availability of a bed in another health care facility, or the non-availability of a health care practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is Medically Necessary.

H. A medical or dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital or health care facility.

Life Insurance Benefits

Important information for your family

Benefits Provided

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

Converting Your Life Insurance

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

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

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

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

Waiver of Premium

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

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

Life Insurance Benefits continued

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

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

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

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

NOTE: This is not a complete description of the Life Insurance benefit or a contract, and should only be viewed as a summary to assist you in understanding your life insurance benefits. The terms, conditions, limits and exclusions are outlined in the Certificate of Insurance/policy issued by The Standard and if there is any difference between the provisions of the Certificate/policy and this description, the provisions of the policy will govern.

If you would like to a copy of the Certificate, please contact the Fund Office.

Accidental Death and Dismemberment (AD&D) Benefits

Benefits for you or a beneficiary in case of an accident

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

Benefits Provided

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

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

Loss:	**Benefit Paid:**
Loss of Life	Ten thousand dollars ($10,000) (Paid to the beneficiary)
Loss of: • Both hands • Both feet • Sight of both eyes • One hand and one foot • One hand and sight of one eye • One foot and sight of one eye	Ten thousand dollars ($10,000) (Paid to the employee)
Loss of: • One hand • One foot • Sight of one eye	Five thousand dollars ($5,000) (Paid to the employee)

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

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

NOTE: This is not a complete description of the AD&D benefits or a contract, and should only be viewed as a summary to assist you in understanding your AD&D benefits. The terms, conditions, limits and exclusions are outlined in the Certificate of Insurance/policy issued by The Standard and if there is any difference between the provisions of the Certificate/policy and this description, the provisions of the Certificate/policy will govern.

If you would like a copy, please contact the Fund Office.

Accident and Sickness Weekly Benefits

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

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

Benefits Provided

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

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

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

Benefits are payable from the first (1st) day of disability due to an accident, or from the eighth (8th) consecutive day if disability is due to sickness. However, if disability due to sickness continues until the eighth (8th) day, benefits are retroactive to the first (1st) day. Payment of Weekly Benefits ends on the earlier of: (i) the date on which you are no longer disabled; or (ii) after 26 weeks of disability benefits have been paid.

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

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

New York State Disability Benefits Law

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

NOTE: This is not a complete description of the Short-Term Disability benefits or a contract, and should only be viewed as a summary to assist you in understanding your short-term disability benefits. The terms, conditions, limits and exclusions are outlined in the Certificate of Insurance/policy issued by The Standard and if there is any difference between the provisions of the Certificate/policy and this description, the provisions of the Certificate/policy will govern.

If you would like a copy of the Certificate, please contact the Fund Office.

Claims Procedures

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

The Board of Trustees are responsible for administering the Fund to provide the health benefits described in this SPD to eligible employees and their eligible family members. The Trustees, through the Fund Executives, have hired physicians, dentists, pharmacists, nurses, aides, technicians and administrative personnel to staff the Health Center operations and have contracted with UnitedHealthcare to pay and provide hospital benefits. Any dispute as to eligibility, type or amount of benefits will be resolved by the Appeals Committee of the Fund's Board of Trustees.

Types of Claims - Definitions

A claim is a request that health benefits or services be provided or paid according to the terms of this Plan. There are generally no claims to file under the Plan because most of the services you will receive will be from Participating Providers. However, if you receive services from a Non-Participating Provider either you or the Provider must file a claim. If the Non-Participating Provider is not willing to file the claim form, you will need to file it. Claims for services must include all information necessary to process the claim, including, but not limited to, member identification number, name, date of birth, date of service, type of service, the charge for each service, procedure code for the service as applicable, diagnosis code, name, address and federal tax identification number of the provider making the charge, and other supporting medical records or information reasonably required by the Fund, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from the Fund Office.

The claims procedures will vary depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, a Post-Service Claim, or a Disability Claim.

Pre-service Claim - This is any claim for which the terms of the Plan condition, receipt of the benefit, in whole or part, is on approval of the benefit in advance of obtaining medical care.

If you improperly file a Pre-Service Claim, the claims administrator will notify you as soon as possible but not later than 5 days after receipt of the claim, of the proper procedures to be followed in filing a claim. This notification may be oral, unless you (or your representative) request a written notification. You will only receive notification of a procedural failure if your claim is received by the organization responsible for making the claim determination and it includes your name, your specific medical condition or symptom, and a specific treatment, service or product for which approval is requested. Unless the claim is refiled properly, it will not constitute a claim.

For properly filed Pre-Service Claims, you will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the claims administrator and you are notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the claims administrator needs additional information from you, the extension notice will specify the information needed. In that case you and/or your

doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The claims administrator then has 15 days to make a decision on a Pre-Service Claim and notify you of the determination.

If your claim is either entirely or partially denied, you have the right to appeal the denial of your Pre-Service Claim. See the following sections on appeals procedures for more information.

Urgent Care Claim - This is a pre-service claim that (1) involves emergency medical care needed immediately in order to avoid serious jeopardy to your life, health or ability to regain maximum function; or (2) in the opinion of a Physician, with knowledge of your medical condition, would subject you to severe pain if your claim were not dealt within the "urgent care" time frame described below. Whether your claim is one involving urgent care will be determined by an individual acting on behalf of the Plan, applying an average layperson's knowledge of health and medicine. If a Physician with knowledge of your medical condition determines that your claim is one involving urgent care, the claims administrator will treat your claim as an urgent care claim. Post-service claims are not urgent care claims because pre-approval is not required before you can receive treatment.

If you improperly file an Urgent Care Claim, the claims administrator will notify you as soon as possible but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

If you are requesting precertification of an Urgent Care Claim, the time deadlines are different. claims administrator will respond to you [and your doctor] with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan. The determination will also be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the claims administrator will notify you [and your doctor] as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within 48 hours after receiving this notice. If the information is not provided within that time, your claim will be denied. If your claim is entirely or partially denied, you have the right to appeal the denial of your Urgent Care Claim. See the following sections on appeals procedures for more information.

Notice of the decision will be provided no later than 48 hours after the claims administrator receives the specified information or the end of the period given for you to provide this information, whichever is earlier. The determination will also be confirmed in writing or electronically within three (3) days.

Concurrent Care Claim - This is any claim to extend a course of treatment beyond the period of time or number of treatments that the Plan has already approved as an ongoing course of treatment to be provided. A concurrent care claim can be an urgent care claim, a pre-service claim or a post-service claim.

A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a benefit will be made by the claims administrator as soon as possible, but in any event early enough to allow the claimant to have an appeal decided before the benefit is reduced or terminated. Any request by a claimant to extend approved Urgent Care treatment will be acted upon by the claims administrator within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. If your claim is entirely or partially denied, you have the right to appeal the denial of your Concurrent Care Claim. See the following sections on appeals procedures for more information.

Post-service Claim - This is any claim for a benefit that is not a pre-service claim. In the case of this type of claim, you request reimbursement after medical care has already been provided.

Ordinarily, you will be notified of the decision on your Post-Service claim within 30 days from the claims administrator's receipt of the claim. This period may be extended one time by the claims administrator for up to 15 days if the extension is necessary due to matters beyond the control of the claims administrator. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the claims administrator expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The claims administrator then has 15 days to make a decision on a Post-Service Claim and notify you of the determination. If your claim is entirely or partially denied, you have the right to appeal the denial of your Post-service Claim. See the following sections on appeals procedures for more information.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination.
- Reference to the specific Plan provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.
- A description of the appeal procedures and applicable time limits.
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notification.

For Urgent Care Claims and Pre-Service Claims, you will receive notice of the determination even when the claim is approved.

REQUEST FOR REVIEW OF AN ADVERSE CLAIMS DETERMINATION (APPEALS PROCEDURES)

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the claims administrator within 180 days after you receive notice of denial. Claims are not accepted by the Fund later than 120 days from the date of service. Appeals involving Urgent Care Claims may be made orally by calling the claims administrator at the number listed in this booklet.

Review Process

The review process works as follows:

- You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or it constitutes a statement of plan policy regarding the denied treatment or service.

- Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

- Your claim will be reviewed by a person at a higher level of management than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

- If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

For Hospital and Out-of-Area Appeals - Administered by UnitedHealthcare

Simple inquiries about the plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

Level 1 Appeals and Timeframes

An appeal is a request to review and change an adverse determination made by UnitedHealthcare that was based on ***medical necessity***. You have one hundred eighty (180)

calendar days from the date on the adverse determination notice to appeal. Appeals must be made in writing.

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

There are two basic types of appeals:

- **Prospective:** An appeal to overturn an adverse determination that was made *prior to* or *during* a patient's medical service.
- **Retrospective:** An appeal to overturn a claim-related adverse determination that was made *after* the service was provided. Retrospective appeals will not be expedited.
  UnitedHealthcare (UHC) will notify you in writing whenever your benefits will be reduced, which will include the reason for the determination and reference to the specific plan provision(s) on which the determination is based. You may appeal this decision by telephone or in writing within one hundred eighty (180) calendar days of a benefit reduction or denial of a claim if:
- You believe extenuating circumstances prevented you from complying with Medical Management requirements.
- You followed the treating doctor's recommendation even though it was contrary to the Medical Management's opinion as to the appropriate setting or type of care.
- You believe that benefits were otherwise reduced incorrectly by UnitedHealthcare.

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

- **Request additional information necessary to make an Appeal decision:** A detailed explanation of the required information will be requested by UnitedHealthcare in writing within fifteen (15) calendar days from your provider. You will receive a copy of this request. If only some of the information requested is received, UnitedHealthcare will notify you within five (5) business days.
  If additional information is requested, the final decision (either upheld or overturned) will be made within forty-five (45) business days from the initial date, regardless of whether the requested information is received. This will be communicated to you in writing within five (5) business days of that decision.
- **Deny the Appeal:** A letter will be sent to you with a detailed explanation (clinical rationale) of why UnitedHealthcare is denying, in whole or in part, the appeal.
- **Approve the Appeal*:*** A letter will be sent that notifies you UnitedHealthcare is approving the appeal.

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

Level 2 Appeals and Timeframes

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

days from the initial receipt date of the Level 2 Appeal. The decision will be communicated to you in writing within five (5) business days of the decision.

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

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

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

When requested under these circumstances the following timeframes will apply:

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

To make an appeal to **UnitedHealthcare,** call 1-866-660-7179 if you have any questions on how to initiate an appeal. Qualified professionals consisting of clinicians and physicians who were not involved in your original adverse benefit determination will review your appeal. They will advise you, the attending doctor, and the hospital of the decision within thirty (30) calendar days but no later than forty-five (45) business days from when the additional information is requested.

For Medical (Non-Hospital) and Dental Appeals

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

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

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

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

Expedited Appeals

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

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

When requested under these circumstances the following timeframes will apply:

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

To make an appeal, write to the following address:

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

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

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

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

Appeals Decision Timeframe

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

Notice of Determination

All appeal decisions made by the Trustees' Appeals Committee will be in writing and will include the following information:

- The specific reason(s) for the determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents, records and other information relevant to your claim, upon request and free of charge;
- If an internal rule, guideline or protocol was relied upon, either information about the internal rule, guideline or protocol or a statement that the rule, guideline or protocol is available upon request at no charge; and
- If the determination was based on a lack of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your claim or a statement that such an explanation will be provided free of charge upon request.

The Trustees' Appeals Committee, or its designee, shall make each claim determination solely in the interest of the Plan and all the participants in a uniform and non-discriminatory manner and without any bias or conflict of interest.

You may not start a lawsuit to get benefits until after you have exhausted the Plan's mandatory claims and appeal procedures and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. **If your final appeal is ultimately denied in whole or in part, you have the right to file a lawsuit under ERISA Section 502(a). However, any such lawsuit must be filed within one (1) year from the date of the Fund's notice of denial of the appeal or other final adverse determination, and also within any statute of limitations which may apply.**

Subrogation and Third-Party Liability

The Fund has the right, whether by subrogation or reimbursement, or any other equitable or legal relief available under state or federal law, to recover from you, your dependents or any other person or trust in possession of such monies sought by the Fund, all benefits paid by the Fund on you or your dependents' right or behalf for injuries or disabilities that you or your dependents have suffered as a result of the negligence or wrongdoing of others for which you receive a "Recovery." Recovery includes without limitation any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from your uninsured or underinsured motorist, home owners or other insurance coverage related to the illness or injury, without reduction for any attorneys' fees paid or owed by you or on your behalf, and without regard to whether you or your dependent have been "made whole" by the Recovery. Accordingly, the Fund does not recognize the "Make Whole Doctrine." The Recovery also includes all monies received regardless of how held, and **i**ncludes monies directly received by the Participant or eligible dependent, as well as any monies held in any account or trust on their behalf, such as an attorney-client trust account.

If you and/or your dependents are injured as a result of the negligence or other wrongful acts of a third party and you/your dependents apply to the Fund for benefits and receive such benefits, the Fund shall then have a first-priority lien on any Recovery for the full amount of the benefits that are paid to you and/or your dependents. In addition, in the event you and/or your dependents fail to seek to recover any monies from the third party that caused the injuries, the Fund shall be subrogated to your right of recovery against that third party. You and your eligible dependents are responsible for all expenses incurred to obtain payment for third parties, including attorney fees, which amounts will not reduce the amount due to the Fund as restitution. Accordingly, the Fund expressly rejects the "Common Fund" doctrine with respect to the payment of attorney fees.

No benefits will be paid unless you sign an agreement to the subrogation rules as follows:

> If you or your dependent's injury or illness was, in any way, caused by a third party who may be legally liable or responsible for the injury or illness, no benefits will be payable nor paid under any coverage of the Fund unless you contractually agree in writing, in a form satisfactory to the Fund, to do all of the following:
>
> 1. Provide the Fund with a written notice of any claim made against the third party for damages as a result of the injury or illness;
> 2. Agree to reimburse the Fund for benefits paid by the Fund from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party or from your own uninsured or underinsured motorist, homeowners or other insurance coverage;
> 4. Ensure that any Recovery is kept separate from and not co-mingled with any other funds and agree in writing that the portion of any Recovery required to satisfy the lien of the Fund is held in trust for the sole benefit of the Fund until such time as it is conveyed to the Fund;

5. Execute a lien in favor of the Fund for the full amount of the Recovery which is due for benefits paid by the Fund;
6. Periodically respond to information requests regarding the status of the claim against the third party, and notify the Fund, in writing, within ten (10) days after any Recovery has been obtained;
7. Direct any legal counsel retained by you or any other person acting on your behalf to hold that portion of the Recovery to which the Fund is entitled in trust for the sole benefit of the Fund and to comply with and facilitate the reimbursement to the Fund of the monies owed to it (as described and defined below);
8. Assign, upon the Fund's request, any right or cause of action to the Fund;
9. Fully cooperate with the Plan Administrator in all respects in the Fund's enforcement of its equitable (or other) rights to restitution and keep the Fund informed of any important developments in your action;
10. Not settle, without the prior written consent of the Plan Administrator, any claim that you or your eligible dependents may have against a third party, including an insurance carrier;
11. Agree to the entry of judgment against you and, if applicable, your dependent, in any court for the amount of benefits paid on your behalf with respect to the illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the costs of such collection, including but not limited to the Fund's attorney fees and costs; and
12. Take all other action as may be necessary to protect the interests of the Fund.

If you or your dependent fails to comply with any of the aforementioned requirements, no benefits will be paid with respect to the injury or illness. If benefits have already been paid, they may be recouped by the Fund.

We strongly recommend that, if you are injured as a result of the negligence or wrongful act of a third party, you contact your attorney for advice and counsel. However, the Fund cannot and does not pay for the fees your attorney might charge. Should you seek to recover any monies from any third party that caused your injuries, it is the Fund's rule that you must give notice of same to the Fund Office within ten (10) days after either you or your attorney first attempts to recover said monies, and if litigation is commenced, you are required to give notice to the Fund of any pretrial conferences within five (5) days of the same. Representatives of the Fund reserve the right to attend such pretrial conference.

The Fund's lien is contractual and is a lien on the proceeds of any compromise, settlement, judgment and/or verdict received from either the third party or his insurance carrier. By applying for and receiving benefits from the Fund in such third-party situations, you must reimburse the Fund the full amount of the benefits that are paid to you and/or your dependents from the proceeds of any such compromise, settlement, judgment and/or verdict, to the extent permitted by law. By applying for benefits, you agree that the proceeds of any compromise, settlement, judgment and/or verdict to the extent permitted by law. By applying for benefits, you agree that the proceeds of any Recovery, if paid directly to you, will be held by you separate from and not commingled with any other funds, in constructive trust for the Fund.

By accepting benefits, you agree that the proceeds of any Recovery paid to any other person or entity other than you, including but not limited to, a trust, an attorney or any agent thereof, shall be held by such other person, entity or trust in constructive trust for the Fund. The Fund reserves the right to seek recovery from such person, entity or trust and to name such person, entity or trust as a defendant in any litigation arising out of the Fund's subrogation or restitution rights. By applying for benefits, you agree that except where mandated by statute, any lien the

Fund may seek will not be reduced by any attorney fees, court costs or disbursements that you might incur in your action to recover from the third party, and these expenses may not be used to offset your obligation to reimburse the Fund for the full amount of the lien. Further, you agree that any Recovery will not be reduced by and is not subject to the application of the "Common Fund" doctrine theory for the recovery of attorney fees.

Remember, the Fund does not require you to seek any recovery whatsoever against the third party, and if you do not receive any recovery from the party, you are not obligated in any way to reimburse the Fund for any of the benefits that you applied for and accepted. However, the Fund is entitled to obtain restitution of any amounts owed to it either from third-party funds received by you or your eligible dependents, regardless of whether you or your eligible dependents have been fully indemnified for losses sustained at the hands of the third party. Accordingly, in the event that you do not pursue any and all third parties and responsible sources, the Fund is authorized to pursue, sue, compromise or settle (at the Board's discretion) any such claims on your behalf and you agree to execute any and all documents necessary to pursue said claims and, furthermore, to fully cooperate with the Fund in the prosecution of such claims. In accordance with this authority, a Fund representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Fund's equitable (or other) right to obtain restitution. To this end, by participating in the Fund, you and your eligible dependents acknowledge and agree to the terms of the Fund's equitable (or other) rights to full restitution. You and your eligible dependents also agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Plan Administrator, including the signing of any documents or agreements necessary for the Fund to obtain full restitution.

In the event you fail to notify the Fund as provided for above, and/or fail to reimburse the Fund as provided for above, the Fund reserves the right, in addition to all other remedies available to it by law or equity, to withhold any other monies that might be due you from the Fund for either past or future claims, until such time as the Fund's lien is discharged.

Any amounts received from a third party by judgment, settlement, or otherwise must be applied first to reimburse the Fund for the amount of medical expenses paid on behalf of a participant or beneficiary. The Fund's lien is a lien of first priority. Where the recovery from the third party is partial or incomplete, the Fund's right to reimbursement takes priority over the participant's or beneficiary's right of recovery, regardless of whether or not the participant or beneficiary has been made whole for his or her injuries or losses.

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

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

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

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

A decision by the Appeals Committee shall be made within sixty (60) days after the receipt of the appeal. An additional sixty (60) days may be required under special circumstances. If additional time or information is needed, you will be notified in writing of the reasons before the first 60-day period expires. In no case will the extension exceed one hundred twenty (120) days from the date your appeal was received. The notice of the decision will contain specific reasons for the decision and a specific reference to the provisions of the Plan or policy on which the decision is based.

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

You may not start a lawsuit to get benefits until after you have exhausted the Plan's mandatory claims and appeal procedures and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. **If your final appeal is ultimately denied in whole or in part, you have the right to file a lawsuit under ERISA Section 502(a). However, any such lawsuit must be filed within one (1) year from the date of the Fund's notice of denial of the appeal or other final adverse determination, and also within any statute of limitations which may apply.**

Claims and Appeals Procedures – Short-Term Disability Benefits

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

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

An employee whose claim for short-term disability benefits has been denied in whole or in part by The Standard may appeal the decision to the Appeals Committee of the Board of Trustees of

the Fund. An appeal to the Appeals Committee must be in writing, submitted to the Chief Executive Office of the Fund within one hundred eighty (180) days of the initial denial of the claim, accompanied by a statement giving the reasons the denial is believed to be incorrect. You will be given full access by The Standard to all documents or other information that relate to your claim for this purpose, including the identity of any medical or vocational professionals who were consulted by The Standard.

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

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

You may not start a lawsuit to get benefits until after you have exhausted the Plan's mandatory claims and appeal procedures and a final decision has been reached on review, or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. **If your final appeal is ultimately denied in whole or in part, you have the right to file a lawsuit under ERISA Section 502(a). However, any such lawsuit must be filed within one (1) year from the date of the Fund's notice of denial of the appeal or other final adverse determination, and also within any statute of limitations which may apply.**

Plan Information

General resource about how the Plan is administered and funded

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

Official Name of Plan	The New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund
Sponsor Name and Address	Board of Trustees, The New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund, 305 West 44th St, 3rd Floor, New York, NY 10036
Employer Identification Number (EIN) Assigned by the Internal Revenue Service	13-1531223
Plan Number	501
Type of Plan	Employee Welfare Benefit Plan
Plan Administrator	Dr. Robert H. Greenspan, Chief Executive Officer, The New York Hotel Trades Council and Hotel Association of New York

	City, Inc. Health Benefits Fund, 305 West 44th St, 3rd Floor, New York, NY 10036
Plan Administration	Jointly trusteed administration by Union and Employer representatives The following benefits are provided through insurance policies: Life Insurance, AD&D, Accident & Sickness Weekly benefits: The Standard (Insured and Administered) Hospital and out-of-area (PPO) benefits: UnitedHealthcare Vision Benefits: General Vision Services Service of Legal Process may be made upon UnitedHealthcare, General Vision, or Union Labor Life for those insured benefits.
Agent for service of legal process	Dr. Robert H. Greenspan, Chief Executive Officer, The New York Hotel Trades Council and Hotel Association of New York City, Inc. Health Benefits Fund, 305 West 44th St., 3rd Floor, New York, NY 10036 Service of Legal Process may be made upon any individual plan trustee in addition to the CEO. For disputes arising under those portions of the Plan insured by The Standard, service of legal process may be made upon the Standard at the address listed in the front of this document, one of its local offices, or upon the supervisory official of the State Insurance Department.
Source of Contributions	Employers in accordance with collective bargaining agreements with the Union, or a participation agreement.

Funding Medium and Benefits

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

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

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

Participating Employers

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

Plan Year

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

Information You or Your Dependent Must Furnish to the Plan

In addition to information you must furnish in support of any claim for plan benefits under this Plan, it is your responsibility to be aware of the rules of the Fund. The Fund Office offers many options for maintaining communication with you regarding critical matters that can affect your benefits, such as our web-site, regular mail, e-mail and text messaging. But none of those options work if we do not have your most up-to-date contact information. Please remember that when your contact information changes in any way, you should inform the Fund Office immediately. In this regard, it is also your responsibility to notify the Fund Office immediately if any of the following occurs:

- Change of name
- Change of address. (Advise the Fund Office promptly so its records will be up-to-date to communicate with you about any matters concerning your coverage.)
- The marriage, divorce, legal separation, or death of you or any covered spouse or dependent child
- Any information regarding the status of your dependent child, including, but not limited to:
  - Your dependent child's reaching the Plan's limiting age
  - Confirmation that a newly enrolled/re-enrolled child over age (26) does not have healthcare available to them through their own place of employment
  - The existence of any physical or mental handicap
  - The marriage of your dependent child
- Medicare enrollment or dis-enrollment
- Social Security disability benefits award or termination
- The existence of other medical or dental coverage

In addition, your spouse or other family member must notify the Fund Office in the event of your death.

As a reminder, you need to inform the Fund Office separately even if you have updated your information with the Union, since the Fund is a separate legal entity. If changing all of your contact information is too burdensome because of many changes or temporary situations, please at least update the communication channel that is most likely to be used by you.

Overpayments

If a payment to a participant or dependent or assigned to a provider is determined to be paid in error or otherwise be an overpayment, the Board of Trustees or the Fund may commence legal action to recover the overpayment and offset future claim payments to recover the amount overpaid.

Important Notice Regarding Annual Dollar Limits

In accordance with applicable law, the Fund does not impose lifetime or annual dollar limits on "essential health benefits" as such term is defined under Section 1302(b) of the Affordable Care Act. A determination as to whether a benefit constitutes an "essential health benefit" will be based on a good faith interpretation by the Plan Administrator of the guidance available as of the date on which the determination is made. Additional information regarding the specific application of these rules may be furnished in a future communication as regulatory and other guidance governing the law is issued by the government.

Not a Contract of Employment

This SPD is not a contract of employment (including without limitation Covered Employment) – it neither guarantees employment or continued employment with your Contributing Employer or any Contributing Employer, nor diminishes in any way the right of Contributing Employers to terminate the employment of any employee.

Facility of Payment

Every person receiving or claiming benefits through the Plan will generally be presumed to be mentally and physically competent and of age. However, if the Plan Administrator (or its designee) determines that a person entitled to receive benefits hereunder is a minor, or is physically or mentally incompetent to receive the payment or to give a valid release for benefits, the Fund may issue payments to the person's legally appointed guardian, committee or representative (upon proof of the appointment) or, if none, to another person or entity that the Trustees determine appropriate in their sole and absolute discretion. Any payment made in accordance with this provision will discharge entirely the obligation of the Fund.

Plan Administrator's Authority

The Board of Trustees, as the Plan Administrator of the Fund's benefit programs, (or its duly authorized designee(s)) has full discretion and exclusive authority to make the final decision regarding all areas of plan interpretation and administration, and to decide all matters arising in connection with the operation and administration of the Fund or Trust. Without limiting the generality of the foregoing, the Board (or its authorized designee(s)) shall have the sole and absolute discretionary authority to do the following:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Fund;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Fund in accordance with the terms of the Fund;
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Fund;

- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Fund, including this book, the Trust Agreement or other Fund documents;
- Process and approve or deny benefit claims; and/or
- Determine the standard of proof required in any case.

The decision of the Plan Administrator is final and binding on all participants, beneficiaries, and any other individuals dealing with or claiming benefits under the Fund. The Board may delegate any other such duties or powers as it deems necessary to carry out the administration of the Fund. Accordingly, no participating employer, employer organization or labor organization, nor any individual employed thereby, has authority to answer questions on behalf of the Fund and the Plan. Please refer all questions to the Board of Trustees.

Severability

If any provision of this SPD is held invalid, unenforceable or inconsistent with any law, regulation or requirement, its invalidity, unenforceability or inconsistency will not affect any other provision of the SPD, and the SPD shall be construed and enforced as if such provision were not a part of the SPD.

Construction of Terms

Words of gender shall include persons and entities of any gender, the plural shall include the singular and the singular shall include the plural. Section headings exist for reference purposes only and shall not be construed as part of the SPD.

Applicable Law

The Fund shall be construed and enforced according to the laws of the State of New York to the extent not preempted by ERISA and any other applicable federal law.

No Vested Interest

Except for the right to receive any benefit payable under the Fund in regard to a previously incurred claim, no person shall have any right, title, or interest in or to the assets of any Contributing Employer because of the Fund.

Assignment of Plan Benefits

Your right to receive any benefit or reimbursement under the Fund is not alienable by you by assignment or any other method of transfer and is not be subject to being taken by your creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law. You cannot pledge benefits owed to you for the purpose of obtaining a loan. Accordingly, benefits are not subject to any creditor's claim or to legal process by any creditor of any covered individual, except under a QMCSO and to the extent as may be required by law. For more information on QMCSO, please refer to page 19.

Plan Termination or Amendment

The Board of Trustees intends to continue the benefit programs described in this SPD indefinitely. Nevertheless, it reserves the right, subject to the provisions of any pertinent

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

Under no circumstances will any Plan benefits become vested or non-forfeitable with respect to active or retired employees or their beneficiaries or dependents.

Plan benefits and qualification rules if you are active, retired or disabled:

- Are not guaranteed;
- May be changed or discontinued by the Board of Trustees at any time, in their sole discretion;
- Are subject to the rules and regulations adopted by the Board of Trustees;
- Are subject to the Trust Agreement that establishes and governs the Fund's operations; and
- Are subject to the provisions of the group insurance policies, if any, purchased by the Trustees.

Rights and Responsibilities

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

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

Information about this federal benefits protection law

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

- Examine, without charge, at the Fund Office and at all other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the US Department of Labor.
- Obtain, upon written request to the Administrator, copies of documents governing operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated SPD. The Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

- 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 SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan (if applicable), 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, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusions for 12 months (18 months for late enrollees) after your enrollment date in your coverage. Please note, however, that this Plan does not contain any preexisting condition exclusions.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to one hundred ten dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court within one year from the date of the Fund's notice of denial of the appeal or other final adverse benefit determination, and also within any statute of limitations which may apply. In addition, please follow the instructions described earlier in the SPD, which provides for a claims review procedure that must be followed before you may file a suit. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may

order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if (for example) it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-800-998-7542 or visit its website at www.dol.gov/ebsa.

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