Summary Plan Description

Retiree Benefits

Welfare Plan 145/345 (Detroit)

Effective August 1, 2024

This Summary Plan Description supersedes and replaces all materials previously issued.

Benefits not vested

Retiree benefits provided through the Fund are not vested or accrued benefits. This means the retiree benefits are not guaranteed to continue indefinitely. The Trustees have full and exclusive authority to change or terminate the benefits and the eligibility requirements at any time.

INTRODUCTION

Under certain circumstances UNITE HERE HEALTH (the Fund), formerly called the Hotel Employees and Restaurant Employees International Union Welfare Fund, provides retiree coverage for you. UNITE HERE HEALTH serves participants working for employers in the hospitality industry and is governed by a Board of Trustees made up of an equal number of union and employer trustees. Each employer contributes to the Fund based on the terms of specific Collective Bargaining Agreements (CBAs) between the employer and the union.

This is your new, updated Summary Plan Description (SPD). It explains the Class VII retiree benefits contained in the official Plan Document. Other SPDs explain the benefits for other Plan Units, including the active benefits under Plan Unit 345 (Actives).

This SPD explains:

- How to tell if you are entitled to coverage;
- What the Plan covers;
- What's not covered;
- How to file a claim; and
- What to do if benefits are denied.

However, this SPD is only a summary of your benefits. The complete rules and regulations appear in the Plan Document. If this summary is inconsistent with the rules and regulations in the Plan Document, the terms of the Plan Document will govern.

Under the Trust Agreement creating the Welfare Fund, the Trustees have the sole right to interpret all Plan provisions and to amend the Plan at any time. If the Plan is amended, you will receive updated information.

Please inform the Fund promptly of any change in your name, address, retirement status, or to change your beneficiary.

If you have any questions about eligibility or your entitlement to benefits, contact the Fund:

UNITE HERE HEALTH
P. O. Box 6020
Aurora, IL 60598-0020

Toll-free Number: (800) 419-4373
TTY: (855) 386-3889

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WHO IS ELIGIBLE

The Trustees expressly reserve the right in their sole discretion, at any time and without notice to participants, retirees, dependents, beneficiaries, employers, the Union and others affected hereby, but upon a non-discriminatory basis, to increase, decrease, change or terminate benefits, eligibility rules, or other provisions of the Plan of Benefits as they may find it necessary for the sound and efficient administration of the Fund, provided that the changes are not inconsistent with the law or with the provisions of the Trust Agreement.

The Plan provides the coverage shown in the schedule of benefits (see page 3) for the class of retirees identified below. No benefits are provided for dependents.

Eligible Retirees

You are eligible for coverage at age 65, if:

- you retired after August 1, 1962 but before April 1, 1989; and
- you were eligible for welfare benefits under Plan Unit 145/345 immediately before retirement; and
- you were employed in the hospitality industry with a Detroit contributing employer for at least 25 years at the time you retired; and
- you are:
    - totally retired (not working in the industry), or
    - in receipt of a pension benefit from the H.E.R.E.I.U. Pension Fund; and
- you are not eligible for welfare benefits under Plan Unit 145/345 as an active employee.

If you retired before age 65 because of total disability, are receiving a disability pension from the H.E.R.E.I.U. Pension Fund, and otherwise meet the above requirements, you are entitled to coverage at age 65.

TERMINATION OF COVERAGE

Your coverage ends on the first of the following to occur:

- the day the Plan is terminated;
- the day you become entitled to Plan Unit 145/345 welfare benefits as an active employee;
- when you are no longer eligible for pension benefits from the H.E.R.E.I.U. Pension Fund; or
- upon your death.

SCHEDULE OF BENEFITS

	Maximum Benefit
The benefits shown below are provided directly by the Welfare Fund.	
Death benefit	$1,000
Accidental death and dismemberment benefit	$1,000
Hospital Disability Income Benefit	
Daily benefit:	
Day 1	Medicare Part A deductible
Day 2 through day 60	None
Day 61 through day 92	$20
Maximum days per period of hospital confinement	92 days
Surgical Benefit	
Maximum benefit per period of disability	$375

HOSPITAL DISABILITY INCOME BENEFIT

If you are hospitalized because of injury or sickness, the Plan provides the applicable Hospital Disability Income Benefit shown in the schedule of benefits for each day the hospital makes a room and board charge.

Benefits begin with the first day the hospital makes a room and board charge and are payable up to the maximum number of days shown in the schedule of benefits for any one period of disability.

Successive Periods of Hospital Confinement

Successive periods of hospitalization due to the same or related causes will be treated as one period of hospital confinement unless they are separated by a return to normal activity for at least 60 days.

Exclusions and Limitations

In addition to the Plan's general exclusions and limitations (see pages 12–13), no benefits are provided for any hospitalization not recommended and approved by your physician.

SURGICAL BENEFIT

If, because of injury or sickness, you incur allowable charges for the professional services of a surgeon, the Plan will provide benefits up to a maximum determined by the schedule of operations.

Multiple Surgical Procedures
If multiple surgical procedures are performed during an operative session through the same incision, natural opening, or on the same foot, the applicable surgical benefit shall be limited to the amount for the major procedure plus 50% of the amount for each lesser procedure. No benefits will be payable for incidental procedures.

If multiple surgical procedures other than podiatric surgical procedures are performed during an operative session through different incisions or natural openings, total surgical benefits shall equal the sum of the amounts for each procedure.

However, in no event shall the total amount paid exceed the maximum per period of disability shown in the schedule of benefits.

Successive Surgical Operations
Successive surgical operations due to the same or related causes will be considered to be performed during one period of disability unless they are separated by your return to normal activity for at least 60 days.

Organ Transplantation
Surgical benefits are provided for the following organ transplants: bone marrow, cornea, heart, heart\lung, kidney, liver, or pancreas, provided that:

- all benefits for covered transplants must be pre-approved in writing by the Fund,
- benefits for donor expenses are only available to the extent that the donor has no other coverage, and
- no benefits are provided if you are a donor.

Exclusions and Limitations
In addition to the Plan's general exclusions and limitations (see pages 12–13), no benefits are provided for:

- Charges for professional services other than the services of the physician performing the operation;
- Charges for or in connection with any dental care or treatment;

- Charges for surgical procedures to modify jaw relationships, including LeFort type operations, osteoplasty, or genioplasty;
- Charges for alveolar ridge augmentation or implant procedures to stabilize or otherwise alter natural or artificial teeth; and
- Charges for or in connection with the treatment of temporomandibular joint disorders, craniofacial disorders, or orthognathic disorders, unless treatment is pre-approved by the Fund in writing, and then only for the following conditions:
    - severe rheumatoid arthritis involving multiple joints in which there is significant pathology,
    - traumatic injury causing disk rupture or ligament perforations, or
    - removal of prosthetic devices when their presence creates clear medical risk to the patient.

SCHEDULE OF OPERATIONS

Description of Operation	Maximum Benefit
Abdomen	
Appendectomy	$74.00
Colon resection, partial	$120.00
Laparotomy, exploratory	$74.00
Arthrotomy *(Exploration-removal of fluid or particles)*	
Ankle	$92.50
Elbow	$92.50
Hip	$129.50
Knee or shoulder	$92.50
Breast	
Mastectomy	
Simple	$55.50
Radical	$129.50
Benign tumor or cyst, removal of	
Unilateral	$27.75
Bilateral	$46.25
Cardiovascular system	
Aortic valvuloplasty	$370.00
Atrial septal defect, repair	$333.00

Description of Operation	Maximum Benefit
Chest	
Bronchoscopy	$27.25
Lung, removal	$185.00
Dislocation *(Simple, closed reduction of)*	
Ankle	$18.50
Elbow, jaw, shoulder, or wrist	$9.25
Ear, nose and throat	
Sinusotomy, frontal, external, simple	$37.00
Laryngectomy, without neck dissection	$185.00
Eye	
Cataract, unilateral	$148.00
Detached retina	$129.50
Fractures	
Ankle, simple, closed reduction	$37.00
Femur, shaft, simple or compound, open reduction	$83.25
Fibula, shaft, simple, closed reduction	$27.75
Radius, shaft, simple, closed reduction	$27.25
Genito-urinary tract	
Dilation and curettage, independent procedure	$27.75
Hysterectomy, total	$111.00
Prostatectomy	$148.00

Description of Operation	Maximum Benefit
Salpingectomy, independent procedure	$83.25
Stones, ureter, endoscopic removal	$55.50
Hernia	
Inguinal, unilateral	$64.75
Rectum	
Fistulotomy, subcutaneous	$15.00
Hemorrhoidectomy, internal and external	$55.50
Skull	
Osteoplastic craniotomy (Brain tumor excluded)	$185.00
Trephination, unilateral not followed by surgery	$55.50
Spine or spinal cord	
Laminectomy for spinal cord decompression	$185.00
Thyroid gland	
Thyroidectomy, total	$129.50
Varicose veins	
Saphenous veins, complete stripping	
Unilateral	$55.50
Bilateral	$92.50
Injection of sclerosing solution, leg vein	$1.85

This schedule is a list of some of the most commonly performed surgical procedures. The Fund has a complete listing available upon request. If you need information regarding any operation not listed, contact the Fund for further information.

DEATH BENEFIT AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Death Benefit
The applicable Death Benefit shown in the schedule of benefits will be paid to your beneficiary when you die.

Accidental Death and Dismemberment Benefit
UNITE HERE HEALTH also provides an Accidental Death and Dismemberment Benefit (AD&D benefit) and will pay the applicable benefit amount shown in the Schedule of Benefits to your beneficiary if you die in an accident.

It will also pay a benefit to you if you lose a hand or foot or your eyesight due to an accident. The dismemberment of a hand or foot (severed at or above the wrist or ankle joints) or the complete and permanent loss of eyesight in one eye will result in a benefit equal to one-half the applicable AD&D benefit. Regardless of the extent of your loss, you can never receive more than the applicable maximum AD&D benefit amount.

To be eligible for the Accidental Death and Dismemberment Benefit, death or dismemberment must occur within 90 days of the accident.

This benefit does not cover losses caused by:

- war or any act of war, whether declared or not;
- suicide, attempted suicide, or any intentional self-injury, while sane or insane;
- disease or infection, except when resulting directly from an accident;
- injury sustained while committing a felony;
- injection, inhalation or ingestion of a nonpoisonous substance for purposes other than those prescribed by a physician; or
- ingestion of poison or inhalation of poisonous gases, except when accidental.

Beneficiaries for the Death Benefit
Death Benefits will be paid to your named beneficiary. However, if you have not named a beneficiary or your beneficiary predeceases you, Death Benefits will be paid to your surviving spouse or, if you do not have a surviving spouse, equally to the members of the first surviving class shown below:

- Your children;
- Your parents;
- Your brothers and sisters;
- Your estate.

In the absence of a surviving beneficiary, the Fund may pay up to the full amount of the death benefit to reimburse the retiree’s burial expenses.

Any payment made in good faith will discharge the Fund's liability to the extent of the payment made.

GENERAL EXCLUSIONS AND LIMITATIONS

No benefits are available and no payment will be made for any charge resulting from any Plan exclusion or limitation. The decision of the Trustees as to whether an exclusion or limitation applies to a claim for benefits will be final. Exclusions and limitations are as follows:

- Any bodily injury or sickness for which you are not under the care of a physician.
- Any injury or sickness which arises out of or in the course of any occupation or employment, or for which a retiree has received or is entitled to receive benefits under a Workers' Compensation or Occupational Disease law, whether or not application has been made or approved for such benefits.
- Any treatment, services or supplies:
    - for which no charge is made; or
    - for which the retiree is not required to pay; or
    - which are furnished by or payable under any plan or law of a federal or state government entity, or provided by a county, parish or municipal hospital when there is no legal requirement to pay for such treatment, services or supplies.
- Any charge which is in excess of the Plan's allowable charge.
- Treatment, services or supplies not recommended or approved by the attending physician, or not medically necessary in treating the injury or sickness.
- Experimental treatment or treatment that is not in accordance with generally accepted professional medical or dental standards.
- Any treatment of drug abuse.
- Cosmetic, plastic or reconstructive surgery, unless for the correction of injuries from an accident, or for breast reconstruction following a mastectomy.
- Any elective procedure that is not for the correction or cure of bodily injury or sickness. If there is a question as to the elective nature of the procedure, the decision of the Trustees will be final.
- Any expense or charge incurred while you are confined in an institution that is primarily a place of rest, a place for the aged, or a nursing home.

- Any dental treatment of teeth or their supporting structures or services or supplies associated with such treatment.
- Any charges incurred for education, training or room and board while confined to an institution that is primarily an institution of learning or training.
- Any treatment, services or supplies provided by an individual who is related by blood or marriage to the retiree or who normally lives in the retiree's home.
- Any treatment, services or supplies purchased or provided outside the 50 United States of America, unless for the treatment of a medical emergency. The decision of the Trustees in determining the emergency will be final.
- Any charges incurred for treatment, services or supplies as a result of a declared or undeclared war or any act thereof.
- Any expense greater than the Plan's maximum benefits, or any expense incurred before coverage begins or terminates, unless specifically otherwise provided for under the Plan.
- Any expense or charge for failure to appear for an appointment as scheduled, or charge for completion of claim forms, or finance charges.
- A service or item that is not covered under the Plan's claims processing guidelines or any other internal rule, guideline, protocol or similar criterion that the Plan relies upon.
- Charges or claims incurred as a result, in whole or in part, of fraud, false information, or misrepresentation.
- Reimbursement of any Medicare Part A Deductible for in connection with any coverage a retiree may elect under Medicare Part C (Medicare + Choice), Title XVIII of the Social Security Act of 1965, as amended.

GENERAL CLAIM PROVISIONS

Submitting a Claim

Your claim for benefits must include the following information:

- Your name;
- Your Social Security number; and
- A description of the injury, sickness, symptoms, or other condition upon which your claim is based.

In addition to the above information, a claim for the Surgical Benefit should include the following information:

- Diagnoses;
- Dates of service;
- Identification of the specific service(s) furnished;
- Charges incurred for each service(s); and
- Name and address of the provider.

Claims for the Death Benefit must include a certified copy of the death certificate.

All claims must be mailed to:

UNITE HERE HEALTH
P.O. Box 6020
Aurora, IL 60598-0020

Deadlines for Filing a Claim

The Fund will consider only those benefit claims that are filed in a timely manner. The following filing deadlines apply:

- Hospital Disability Income Benefit and Surgical Benefit claims must be filed not later than 18 months after the date of service.
- Claims for the Accidental Death or Dismemberment Benefit must be filed not later than 90 days after the date of your accident or death.

No filing deadlines apply to claims for the Death Benefit.

If you fail to file a benefit claim by the appropriate deadline, your claim will be denied

unless you can show that it was not reasonably possible to comply with the filing requirements within the time allotted, and that you filed your claim as soon after the deadline as was reasonably possible.

Individuals Who May File a Claim

You, a health care professional (under certain circumstances), or an authorized representative acting on your behalf may file a claim for benefits under the Plan.

Who Is an Authorized Representative?

You may give someone else the authority to act for you to file a claim for benefits or appeal a claim denial. If you would like someone else (called an "authorized representative") to act for you, you and the person you want to be your authorized representative must complete and sign form acceptable to the Fund. Call UNITE HERE HEALTH to obtain a form and submit it to:

UNITE HERE HEALTH
Attention: Claims Manager
P.O. Box 6020
Aurora, Illinois 60598-0020

If the Fund determines that you are incompetent or otherwise not able to pick an authorized representative to act for you, any of the following people may be recognized as your authorized representative without the appropriate form:

- Your spouse (or domestic partner);
- Someone who has your power of attorney, or who is executor of your estate.

Your authorized representative may act for you until the earlier of the following dates:

- The date you tell UNITE HERE HEALTH, either verbally or in writing, that you no longer want the authorized representative to act for you; or
- The date a final decision on your appeal is issued.

Payment of Claims

The Fund will notify you of its decision within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days.

The Fund reserves the right to extend this 30-day period for a single time for up to an additional 15 days if it determines that the extension is necessary due to matters beyond its control, and notifies you prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of the time and date by which it expects to render a decision. If this extension is necessary because you failed to submit the information necessary to enable the Fund to decide the claim, you shall be afforded 60 days from the receipt of such notice within which to provide the necessary information.

The necessary information that you must submit to the Fund will be specified in the notice of extension. If you do not provide the required information within 60 days, your claim will be denied, and any benefits otherwise payable will not be paid.

If a Claim Is Denied

If your claim for benefits is denied, either in full or in part, you will receive a written notice explaining the reasons for the denial, including:

- The specific reason or reasons why your claim was denied;
- Reference to the specific SPD provisions on which the denial is based;
- Description of any material necessary to process the claim properly and why the materials are needed;
- A description of the Plan's review procedures and any time limits applicable to such procedures;
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial of your claim on appeal;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in denying your claim, a statement that a copy of such rule, guideline, protocol or criterion will be provided to you free of charge upon request; and
- If your claim was denied based upon a determination of medical necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your medical circumstances will be provided to you free of charge upon request.

APPEALING THE DENIAL OF A CLAIM

If your claim for benefits is denied, in whole or in part, you may file an appeal.

All appeals must be in writing, signed, and should include the claimant's name, address, and date of birth, and the participant's Social Security Number. You should also provide any documents or records that support your claim.

To file an appeal you must make application, within 12 months of the date the claim was denied, to:

The Appeals Subcommittee
UNITE HERE HEALTH
711 N. Commons Dr.
Aurora, Illinois 60504

The Appeals Subcommittee will not enforce the Plan's 12-month filing limit when:

- It was not reasonably possible to file the appeal within the 12-month filing limit due to:
    - circumstances beyond the person's control if the appeal was filed as soon after the filing limit as was reasonably possible, or
    - circumstances in which the claim was not processed according to the Plan's claim processing requirements; or
- The Appeals Subcommittee, consistent with its prior decisions, would have overturned the original benefit denial.

Review of Appeals

All appeals will be reviewed in accordance with the following provisions. During review of your appeal, you or your authorized representative are entitled to:

- Examine and obtain copies, free of charge, of all plan documents, records and other information that affect your claim;
- Submit written comments, documents, records, and other information relating to your claim;
- Information identifying the medical or vocational experts used in connection with the denial of your claim (you are entitled to this information even if it was not relied on in denying your appeal);
- Designate someone to act as your authorized representative in the review procedure if you wish.

In addition, your appeal must be reviewed in accordance with the following rules:

- The review may not afford deference to the initial denial of your claim.
- Review of your appeal must be conducted by a named fiduciary who was neither the individual who initially denied your claim, nor a subordinate of such individual.
- If denial of your initial claim was based, in whole or in part, on a medical judgment (including decisions as to whether a drug, treatment, or other item is experimental, investigational, or not medically necessary or appropriate), a named fiduciary must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional cannot be an individual who was consulted in connection with the initial determination on your claim, nor the subordinate of such individual.

Notice of the Fund's Decision

You will be notified of the decision on your appeal. Such notice will be provided to you within a reasonable period of time, but not later than 60 days after the receipt of your appeal.

If your appeal is denied, you will be provided with a written notice of the denial which includes the following information:

- The specific reason or reasons for the denial of your appeal;
- Reference to the specific provisions on which the denial is based;
- A statement that you are entitled to receive, free of charge upon request, access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- A statement explaining your right to bring a civil action under Section 502(a) of ERISA following the denial of your claim on appeal;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your claim on appeal, a statement that a copy of such rule, guideline, protocol or criterion will be provided to you free of charge upon request;
- If your claim is denied on appeal based on a determination of medical necessity, experimental treatment, or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of coverage to your medical circumstances will be provided free of charge upon request.

Legal Action

Neither you, your beneficiary, nor any other claimant may commence a lawsuit against the Plan (or its Trustees, providers, or staff) for benefits denied until the Plan's internal appeal procedures have been exhausted. If you finish all internal appeals and decide to file a lawsuit against the Plan, that lawsuit must be commenced no more than 12 months after the date of the appeal denial letter. If you fail to commence your lawsuit within this 12-month time frame, you will permanently and irrevocably lose your right to challenge the denial in court or in any other manner or forum. This 12-month rule applies to you and to your beneficiaries and any other person or entity making a claim on your behalf.

LEGAL INFORMATION

Interpretation of Plan Provisions

The Plan gives full discretion and sole authority to make the final decision in all areas of Plan interpretation and administration, including eligibility for benefits, the level of benefits, if any, provided, and the meaning of all Plan language, including this SPD, to the Trustees of UNITE HERE HEALTH.

In the event of a conflict between this SPD and the rules and regulations governing the Plan, the provisions of the Plan will govern. The decisions of the Trustees are final and binding on all those dealing with or claiming benefits under the Plan, and if challenged in court, the Plan intends for such decisions to be upheld unless determined to be arbitrary and capricious. Benefits under this Plan will be paid only if the Board of Trustees of UNITE HERE HEALTH, in their sole and exclusive discretion, decide that the applicant is entitled to them.

Amendment or Termination of the Plan

The Trustees reserve the right to amend or terminate UNITE HERE HEALTH, either in whole or in part, at any time, in accordance with the Trust Agreement. For example, the Trustees may determine that UNITE HERE HEALTH can no longer carry out the purposes for which it was founded, and therefore should be terminated.

In accordance with the Trust Agreement, the Trustees also reserve the right to amend or terminate your Plan or any other Plan Unit, or to amend, terminate or suspend any benefit schedule under any Plan Unit at any time. Such termination or suspension, as well as the termination, expiration, or discontinuance of any insurance policy under UNITE HERE HEALTH shall not necessarily constitute a termination of UNITE HERE HEALTH.

If UNITE HERE HEALTH is terminated, in whole or in part, or if your Plan, any other Plan Unit or any schedule of benefits is terminated or suspended, no employer, participant, beneficiary or other employee benefit plan will have any rights to any part of UNITE HERE HEALTH's assets. This means that no employer, plan or other person shall be entitled to a transfer of any of UNITE HERE HEALTH's assets on such termination or suspension. The Trustees may continue paying claims incurred before the termination of UNITE HERE HEALTH or any Plan Unit, as applicable, or take any other actions as authorized by the Trust Agreement. Payment of benefits for claims incurred before the termination of UNITE HERE HEALTH, any Plan Unit, or any schedule of benefits will depend on the financial condition of UNITE HERE HEALTH.

Your Plan and all other Plan Units in UNITE HERE HEALTH are all part of a single employee health plan funded by a single trust fund. No Plan Unit and no schedule of benefits shall be treated as a separate employee benefit plan or trust.

Providers

The decision to use the services of particular hospitals, clinics, doctors, dentists, or other health care providers is voluntary, and the Plan makes no recommendation as to what provider you should use, even when benefits may only be available for services furnished by providers designated by the Plan. You should select a provider or treatment based on all appropriate factors, only one of which is coverage under the Plan.

Providers are not agents or employees of UNITE HERE HEALTH, and the Plan makes no representation regarding the quality of service provided.

Type of Plan

The Plan is a welfare plan providing death benefits and other benefits. The Welfare Fund is maintained through Collective Bargaining Agreements between UNITE HERE (formerly the Hotel Employees and Restaurant Employees International Union) and certain employers. For a reasonable charge, you can get copies of the Collective Bargaining Agreements by writing to the Plan Administrator. Copies are also available for examination at the Aurora, Illinois, Fund Office, and within 10 days of a request at the following locations: regional fund offices, the main offices of employers, at which at least 50 participants are working, or the main offices or meeting halls of local unions.

This Plan provides all benefits on a self-funded basis. Self-funded means that none of these benefits are funded through insurance contracts. Benefits and associated administrative expenses are paid directly from UNITE HERE HEALTH.

Who Pays for Your Benefits?

In general, Plan benefits are provided by the money (contributions) employers participating in the Plan must contribute on behalf of eligible employees under the terms of the Collective Bargaining Agreements (CBAs) negotiated by your union.

Employer and Employee Organizations

You can get a complete list of employers and employee organizations participating in the Plan by writing to the Plan Administrator. Copies are also available for examination at the Aurora, Illinois, Office and within 10 days of a request at the following locations: regional offices, the main offices of employers at which at least 50 participants are working, or the main offices or meeting halls of local unions.

Plan Administrator

The Plan Administrator and the agent for service of legal process is the Chief Executive Officer (CEO) of UNITE HERE HEALTH. The CEO's address is:

UNITE HERE HEALTH
Chief Executive Officer
711 North Commons Drive
Aurora, IL 60504
(630) 236-5100

Service of legal process may also be made upon a Plan Trustee.

Employer Identification Number

The Employer Identification Number assigned by the Internal Revenue Service to the Board of Trustees is EIN# 23-7385560.

Plan Number

The Plan Number is 501.

Plan Year

The Plan year is the 12-month period established by the Board of Trustees for purposes of maintaining the Welfare Fund's financial records. Plan years begin each April 1 and end the following March 31.

Remedies for Fraud

If you or a dependent submit information that you know is false or if you purposely do not submit or you conceal important information in order to get any Plan benefit, the Trustees may take actions to remedy the fraud, including: asking for you to repay any benefits paid, denying payment of any benefits, deducting amounts paid from future benefit payments, and suspending and revoking coverage.

Limited Retroactive Terminations of Coverage Allowed

Your coverage under the Plan may not be terminated retroactively (this is called a rescission of coverage) except in the case of fraud or an intentional misrepresentation of material fact. In this case, the Plan will provide at least 30 days advance notice before retroactively terminating coverage. You have the right to file an appeal if your coverage is rescinded. If the Plan terminates coverage on a prospective basis, the prospective termination of coverage (termination scheduled to occur in the future) is not a rescission. The Plan may retroactively terminate coverage in any of the following circumstances, and the termination is not considered a rescission of coverage:

- Failure to make contributions or payments towards the cost of coverage, including COBRA continuation coverage, when those payments are due.
- Untimely notice of death or divorce.
- As otherwise permitted by law.

Benefits Not Vested

Retiree benefits provided through the Fund are not vested or accrued benefits. This means the retiree benefits are not guaranteed to continue indefinitely. The Trustees have full and exclusive authority to change or terminate the benefits and the eligibility requirements at any time.

Restriction of Venue

Any action, claim, controversy, or dispute relating to or arising under the Fund, Plan, Summary Plan Description, and/or Trust Agreement shall be brought and resolved only in the United States District Court for the Northern District of Illinois and in any courts in which appeals from such court are heard.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

If you have any questions about this statement or 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. Dept. of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

Receive Information About Your Plan and Benefits

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites 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 U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may make a reasonable charge for copies not required by law to be furnished free-of-charge.

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

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 make a written request for a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relation's order or 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 U.S. Department of Labor or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, 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.

DEFINITIONS

Allowable Charge
The allowable charge is the amount upon which benefits are based for covered treatment, services or supplies. As shown in the schedule of benefits, the maximum benefit is the lesser of the applicable percentage of allowable charges or the applicable percentage of the covered expense.

The Trustees have sole and complete authority and discretion in determining the schedule of allowable charges, and their determination shall be final and binding.

Calendar Year
The period commencing on January 1 of each year and ending on December 31 of the same year.

Cosmetic or Reconstructive Surgery
Any surgical procedure performed primarily:

(a) to improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or

(b) to prevent or treat a mental or nervous disorder through a change in bodily form.

Covered Expense
A covered expense is the amount charged for treatment, services or supplies which are covered as a benefit under one or more Articles of the Plan, as they may apply to specific classes of employees. Benefits payable for covered expenses are determined by the allowable charge for such covered expense, as defined above, and are subject to all Plan provisions, including limits, exclusions and benefit maximums.

Eligible or Eligibility
Entitlement to the benefits payable under the provisions of the Plan by virtue of having fulfilled the eligibility requirements of the Plan, which are summarized on page 1 of this SPD.

Expense
An expense is the dollar amount charged by a provider of medical treatment, services or supplies, which may or may not be covered under the Plan. An expense may also include non-medical charges, such as charges for dental or vision services, and is considered incurred on the date the treatment, services or supplies are received, except where explicitly stated otherwise.

Experimental, Investigational, or Unproven Procedures
Experimental, investigational, or unproven procedures are those which are classified that way by agencies or subdivisions of the federal government such as the Food and

Drug Administration (FDA) or the Office of Health Technology Assessment of the Centers for Medicare & Medical Services (CMS); or according to CMS's Medical Coverage Issues Manual. Procedures and supplies that are not provided in accordance with generally accepted medical practice, or that the medical community considers to be experimental or investigative will also meet the definition of experimental, investigational, or unproven.

The Board of Trustees has the sole authority to determine what constitutes experimental or investigational procedures. In all cases, the Trustees' determination will be final and binding. However, those determinations are solely for the purpose of establishing what services or courses of treatment are covered by the Plan. All decisions regarding medical treatment are between you and your doctor and should be based on all appropriate factors, only one of which is the level of benefits available under the Plan.

Hospital

A Hospital shall be defined as an institution that:

(a) is constituted, licensed and operated in agreement with the laws that apply to Hospitals; and

(b) maintains on its premises facilities necessary to diagnose and medically and\or surgically treat injury and sickness; and

(c) provides treatment for compensation by or under the supervision of Physicians; and

(d) provides treatment on an inpatient basis; and

(e) has continuous, 24-hour nursing service by registered graduate nurses; and

(f) provides services under Medicare; and

(g) is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations and the appropriate state or local agency as meeting the standards for such licensing; or in the sole discretion of the Trustees is a Hospital with equivalent standards and otherwise meets the requirements set forth herein.

A hospital will include an institution which qualifies as a psychiatric hospital or tuberculosis hospital and meets the above requirements.

However, a hospital is not an institution or part of an institution that is primarily a nursing home or a place for rest or the aged.

Hospital Room and Board
Charges for the cost of a room, patient meals, and services by hospital employees for nursing, housekeeping and administration. Hospital room and board charges do not include those charges for professional services which are otherwise not covered expenses or subject to limitations under the Plan.

Medically Necessary
Medically necessary care and treatment means services, supplies, or places where treatment is received which:

- Are consistent with and effective for the injury or sickness being treated;
- Constitute good medical practice according to professional standards recognized by the organized medical community in the United States; and
- Are neither experimental, investigational, nor unproven as determined by appropriate governmental agencies, the organized medical community in the United States, or standards or procedures adopted from time-to-time by the Trustees.

However, any determinations of medical necessity pertaining to mastectomies and associated reconstructive treatment shall be deemed to be satisfied if allowable charges for covered expenses are incurred as a result of treatment determined in consultation between the person and her doctor.

The Board of Trustees has the sole authority to determine what constitutes medically necessary care and treatment, and experimental or investigational procedures. In all cases, the Trustees' determination will be final and binding. However, those determinations are solely for the purpose of establishing what services or courses of treatment are covered by the Plan. All decisions regarding medical treatment are between you and your doctor and should be based on all appropriate factors, only one of which is the level of benefits available under the Plan.

Medicare
Benefits provided under Title XVIII of the United States Social Security Act of 1965, as amended.

Physician
A person who is licensed to practice medicine and surgery as a Doctor of Medicine or Osteopathy, or a person who is a licensed dentist, podiatrist, chiropractor, or optometrist who is practicing within the scope of his profession. For purposes of the Plan, the term "physician" does not include the retiree or any person who is related to the retiree by blood or marriage, or who normally resides in the retiree's home, even if he otherwise satisfies the above-described requirements.

Plan of Benefits or Plan
The plan, program, method and procedure adopted by the Trustees for eligible retirees under Plan Unit 145\345, for the payment of health and welfare benefits from the Welfare Fund, permissible under 29 U.S.C. 186 in accordance with such rules and regulations relating to eligibility, amount and nature of benefits, as are adopted by the Trustees, and all amendments to the Plan, which may be adopted by the Trustees hereunder.

Plan Year
The period commencing on April 1 of each year and ending on March 31 of the following year.

Trust Agreement or Trust
The Agreement and Declaration of Trust (as amended from time to time) under which UNITE HERE HEALTH is established and maintained.

Trustees or Board Of Trustees
The Trustees designated in the Trust Agreement, together with their successors designated and appointed in accordance with the terms of the Trust Agreement.

Welfare Fund or Fund
The Trust Fund formulated and created under the Agreement and Declaration of Trust and any amendments thereto, and any trust fund established for similar purposes which merges with, and transfers its assets to, the Welfare Fund.

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